

Michael J. Fisch, MD

Interview #61

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Michael J. Fisch, MD

Interview #61

Interview Profile

Interview Information:

Three sessions: 5 February 2015, 13 February 2015, 18 February 2015

Total approximate duration: 5.5 hours.

Interviewer: Tacey A. Rosolowski, Ph.D.

For a CV, biosketch, and other support materials, contact:

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About the Interview Subject:

Dr. Michael J. Fisch (b. 11 June 1964, Queens, New York) joined MD Anderson in 1999 as an Assistant Professor in the Department of Palliative Care and Rehabilitative Medicine. In 2004 he became Director of the Community Clinical Oncology Program and in 2009 became Chair of the Department of General Oncology. He is tenured in that Department. This interview is conducted shortly before Dr. Fisch's departure from MD Anderson for a new opportunity.

Dr. Fisch is known for research has focused on symptom experience, symptom management and cardio-oncology. He conducted a landmark study of chemotherapy and depression. His equally important survey of the management of symptoms related to cardio-toxicity of anthracyclines contributed to the formation of the new field of cardio-oncology.

Dr. Fisch helped establish MD Anderson's program in palliative care and worked on programs that led to the formation of the new Department of General Oncology

General Topics Covered:

Personal and educational background.

History of and observations about the evolving field of General Medical Oncology

Relationships between general medical oncology, supportive care, and palliative care

Integrating these practices into MD Anderson treatment programs

Research into patient experience and symptom management

Anecdotes about work with patients at MD Anderson and VIP patients overseas

Social media and its potential for use in healthcare

Original Interview Profile #61: Michael J. Fisch, MD

Submitted by: Tacey A. Rosolowski, Ph.D.

Date: 25 February 2015

This interview with Dr. Michael J. Fisch (b. 11 June 1964, Queens, New York) takes place in three sessions in February 2015 (total approximate duration, 5.5 hours).

Dr. Fisch joined MD Anderson in 1999 as an Assistant Professor in the Department of Palliative Care and Rehabilitative Medicine. Since 2004 he has been the Director of the Community Clinical Oncology Program and since 2009 he has served as Chair of the Department of General Oncology. He is tenured in that Department. This interview is conducted shortly before Dr. Fisch's departure from MD Anderson for a new opportunity. Tacey A. Rosolowski, Ph.D. is the interviewer.

Dr. Fisch earned his Bachelor of Arts at the University of Virginia in Charlottesville in 1986 and continued at the University of Virginia Medical School, earning his MD in 1990. He continued at the same institution for his Residency in Internal Medicine (1993), then went to Indiana University at Bloomington for Fellowships in Hematology/Oncology and General Internal Medicine. He earned a Master's in Public Health from that institution in 1997, then took a faculty position in the Department of Medicine at the University of Virginia Health Science Center in Charlottesville.

Dr. Fisch came to MD Anderson to help Dr. Eduardo Bruera establish a program in palliative care. He became Principal Investigator of the MD Anderson Community Clinical Oncology Program (CCOP) Research Base, and this became the starting point for a new Department of General Oncology, which he led from its inception in 2008. The department components he has led include the Lyndon Baines Johnson General Hospital (LBJGH) Medical Oncology Program (providing cancer care to the underserved throughout Harris County), the Integrative Medicine Program, the International Cancer Assessment Center, and the Regional Care Centers (providing cancer care in suburban satellite locations). Dr. Fisch's research has focused on symptom experience, symptom management and cardio-oncology. He conducted a landmark study of chemotherapy and depression. His equally important survey of the management of symptoms related to cardio-toxicity of anthracyclines contributed to the formation of the new field of cardio-oncology. Dr. Fisch has served as Chair of the ECOG Symptom Management Committee since 2006, and Co-Chair of the NCI Symptom Management and Quality of Life Committee since 2007. He also serves on the NCI National Clinical Trials Network (NCTN) Working Group.

General Medical Oncology is a relative new field, and in this interview, Dr. Fisch tells the story of entering this area of work before it was formally recognized as a discipline. He offers definitions of general medical oncology, supportive care, and palliative care. He also explains the current controversies over where the borders between these fields lie and how this has an impact on funding and insurance reimbursement, for example. Dr. Fisch tells the story of how these fields took root at MD Anderson and the challenges of integrating them with traditional practice areas. He talks about his research into patient experience and symptom management and tells anecdotes about work with patients at MD Anderson and on care teams sent to treat VIP patients overseas. Dr. Fisch also talks about his fascination with social media and its potential for use in healthcare.

Michael J. Fisch, MD

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Building a Palliative Care Program at MD Anderson

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Michael J. Fisch, MD

Interview #61

Segment Summaries

Interview Session One: 5 February 2015, about 1 hour 50 minutes

Segment 00A
Interview Identifier

Segment 01
A: Personal Background;
An Interest in Sports Shapes a Fascination with the Body
1:42 – 8:19

Story Codes
A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Inspirations to Practice Science/Medicine;
A: Influences from People and Life Experiences;
C: Formative Experiences;
C: Discovery, Creativity and Innovation;

Dr. Fisch begins the interview by sketching his family background and then talking in detail about his lifelong interest in sports. He explains that he “understands the world through sports and sports metaphors.” He explains the process of visualizing how to execute a series of plays and links this to mindfulness skills he would become interested in as a medical professional. He cites his mentor, Dr. Waun Ki Hong [Oral History Interview] who told him (ironically) that his job is “easy,” since meeting healthy goals is a step-by-step process. He observes that his interest in sports probably led to his fascination with the physical body.

Segment 02
A: Personal Background;
An Early Desire to Become a Doctor and a Range of Interests and Gifts
8:19 + -- 24:34

Story Codes
A: Character, Values, Beliefs, Talents;
A: Personal Background;
C: Discovery, Creativity and Innovation;
A: Professional Path;
C: Leadership;

Dr. Fisch recalls that he decided to become a physician at the age of eleven, inspired by physicians on TV shows. He notes that his grandmother took his interest very seriously and bought him *Gray's Anatomy*. He also observes that he was “drawn to complexity” very early and that this interest became a theme in his career.

Dr. Fisch talks about his high school experience, recalling that he was a motivated, hard worker with many extracurricular activities. He also explains why he considers himself a creative person, noting that his style creativity lends itself to working in groups, a characteristic important for conducting team science. Dr. Fisch explains that he loves team science for the way it brings together people from different disciplines. He makes observations about his inspirational style of leadership, noting that his love of leadership roles began in high school. He also notes that he is at his best when he is in the state referred to as “flow.”

Segment 03

A: Educational Path;

Challenges in College and Medical School; Seeking a Specialty

24:34 – 34:00

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

In this segment, Dr. Fisch talks about selecting his college (University of Virginia at Charlottesville, BA conferred 1986) for financial reasons and explains the value of a state education. He notes that he was not a top student and had to work very hard as an undergraduate. He notes that he discovered his lack of visual/spatial ability, which made certain courses very difficult and caused him to consider a career in nursing.

Next, Dr. Fisch talks about his medical education at the University of Virginia Medical School (MD conferred in 1990), noting how he loved surgery, but his lack of visual/spatial ability made this specialty impossible for him. By working with surgeons, however, he learned to love clinical medicine and post-operative patients in particular because they were “endlessly complicated.”

Segment 04

A: Educational Path

Early Research Experiences Leads from Infectious Diseases to Hematology/Oncology;

34:00 – 41:20

Story Codes

A: The Researcher;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

D: Ethics;

Dr. Fisch describes the evolution of his interests leading to his focus on oncology.

He discusses a college research projects and tells an anecdote about an ethical mistake he made while interacting with participants.

Next, Dr. Fisch explains that he discovered hematology/oncology during his rotations and he was attracted to the field because it afforded the opportunity to build long-term relationships with patients and their families. **[HIPAA – 2-c –no authorization needed. He also notes that he was inspired by experiences of an uncle and his grandfather with cancer.]**

[The recorder is paused about five minutes.]

Dr. Fisch explains why he tracked into hematology/oncology and was always focused on academic medicine and a career in research. He describes his studies in medical school reflects on his residency (Internal Medicine, University of Virginia, 1990-1993).

Segment 05

A: The Researcher;

Bringing Focus to Patients' Emotions

Story Codes

A: The Researcher;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

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

D: The History of Health Care, Patient Care;

C: Patients;

C: Patients, Treatment, Survivors;

In this segment, Dr. Fisch describes the process of entering a fellowship program in Hematology/Oncology and General Internal Medicine at Indiana University at Bloomington. He then explains that it was during this time that he became interested in “things that were happening to cancer patients that we weren’t talking about.” He gives examples, first discussing the problem of depression in cancer patients. He then explains that on the transplant service, patients were uninformed about treatments and he did a project on the effect of informed consent on emotions.

Segment 06

A: The Researcher;

Entering the New Field of Symptom Experience

about 11 minutes

Story Codes

A: The Researcher;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

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

D: The History of Health Care, Patient Care;

In this segment, Dr. Fisch explains how his career path evolved once he decided, during the second year of his fellowship, to focus on symptom experience. He was involved in a research project on cisplatin adducts when he decided to focus on quality of life research and realized he needed additional training to work in this new field. He took another fellowship in general internal medicine and worked with Dr. Robert Diddis, who advised him to do a Masters in Public Health (Indiana University, Bloomington, Indiana; MPH conferred in 1997). He explains how this training benefited his approach to quality of life problems.

Segment 07

A: Joining MD Anderson/Coming to Texas;
Coming to MD Anderson to Learn Palliative Care on the Job
about 10 minutes

Story Codes

A: Joining MD Anderson;
A: Professional Path;

In this segment, Dr. Fisch explains how he moved to MD Anderson from a position as Assistant Professor at the University of Virginia Health Science Center in Charlottesville. He recalls management issues in Charlottesville that helped convince him to take another position. He talks about presenting a paper on cancer and depression at a conference held by the American Society of Clinical Oncology. There he met Dr. Eduardo Bruera, who had been recruited to set up a palliative care program at MD Anderson. Dr. Fisch describes the advantages of the offer he was made to join MD Anderson to help establish that program, working from the Department of Critical Care and Anesthesiology.

Segment 08

B: Building the Institution;
Building a Palliative Care Program at MD Anderson
about 12 minutes

Story Codes

B: MD Anderson History;
B: MD Anderson Culture;
A: Overview;
A: Definitions, Explanations, Translations;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
B: Obstacles, Challenges;
C: Professional Practice;
C: The Professional at Work;

In this segment, Dr. Fisch talks about the challenges faced as he and others set up palliative care program at MD Anderson from scratch. He defines palliative care, which he stresses is much broader than pain management. He also explains how the culture of MD Anderson worked against acceptance of palliative care. Dr. Fisch notes that the palliative care program stressed quality of life and that a decision was made to change the name to the Supportive Care

Center to help overcome resistance . He gives examples of how he and other palliative care providers would figure out how to “create an interface” with treating oncologists, so they would integrate a palliative care provider into the team.

Segment 09

B: An Institutional Unit;

A Precarious Time for the Palliative Care Program
about 4 minutes

Story Codes

B: MD Anderson History;

B: Obstacles, Challenges;

B: Institutional Politics;

B: Controversy;

In this segment, Dr. Fisch talks about a period when the Palliative Care Program seemed less valued than anesthesiology and the administration was splitting off groups from the department of Anesthesiology and Critical Care. He recalls that Dr. Bruera interviewed for a new job and he himself began calling about positions in Virginia. He tells an anecdote about where he was on 11 September 2001. He explains why he remained at MD Anderson and how, after a meeting with leaders, the situation for the department and program seemed to improve.

Segment 10

B: An Institutional Unit;

Building the Reputation of Palliative Care

Story Codes

C: Patients;;

C: Patients, Treatment, Survivors;

C: Discovery and Success;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

C: Professional Practice;

C: The Professional at Work;

In this segment, Dr. Fisch sketches how the talented team in palliative care was successful in securing regular referrals from a few oncologists, building the program's reputation. He tells anecdotes about the surprising and positive results they would get from integrating palliative approaches into treatment protocols.

At the end of this segment, Dr. Fisch shares lessons he learned about how to interact successfully with oncologists to ensure they would call on him as a palliative care providers.

Interview Session Two: 13 February 2015, about 2 hours

Segment 00B

Interview Identifier
about 30 seconds

Segment 11
A: Overview;
Defining the Scope of General Medical Oncology
00:30 – 11:30

Story Codes
A: Joining MD Anderson;
A: Overview;
A: Definitions, Explanations, Translations;
A: The Researcher;
A: The Clinician;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
C: Controversies;

Dr. Fisch begins with an explanation of why he felt like a disciplinary “refugee” when he arrived at MD Anderson and joined the Department of Critical Care and Anesthesiology.

He then defines the purpose and scope of General Medical Oncology as a practice: the long-term care of patients with cancer when overall care is the focus, including delivery of pharmaceuticals and injections and after care following surgery, radiation or chemotherapy. The GMO clinician work with a patient over a lifetime. He notes some controversy in the field over when the GMO clinician “lets go” of a patient who is transitioning to survivorship.

Segment 12
A: Overview;
Reimbursement for General Medical Oncology; the Value of Generalists in a Field of Subspecialties

Story Codes
D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;
A: Overview;
A: Definitions, Explanations, Translations;
A: The Researcher ;
A: The Clinician;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
C: Controversies;
C: Patients;
C: Patients, Treatment, Survivors;

Dr. Fisch begins this segment by explaining the challenges of arranging insurance reimbursement for services and value that general medical oncologists deliver. He also notes that losing connection with the GMO clinician can be very setting for a patient, and he gives examples of problems that can arise.

Dr. Fisch also explains that “people’s health stories are not completely oncology.” They often have co-morbidities and challenges can arise in bringing together specialists to fully treat a patient. In a fragmented system organized by subspecializations, often the patient must serve as “project manager” of his or her own care.

Next Dr. Fisch talks about the value of having a generalist perspective in this situation. He then talks about LBJ Hospital. He comments that eventually generalists will define the pathways into a patients care and then specialists will take over.

Segment 13

B: Building the Institution;

The Community Clinical Oncology Program (CCOP)

20:46 – 30:29

Story Codes

A: The Researcher;

A: The Clinician;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

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

D: The History of Health Care, Patient Care;

C: Research, Care, and Education;

B: Beyond the Institution;

B: MD Anderson Culture;

B: The MD Anderson Brand, Reputation;

In this segment, Dr. Fisch talks about the history of the Community Clinical Oncology Program (CCOP). (He has served as Medical Director since 2004.) He notes NCI involvement providing funds for community based initiatives and explains the purpose: to develop clinical trials linked to the community contexts where eighty percent of patients are treated. He characterizes MD Anderson’s reputation as a “solution shop” driving treatment, with the CCOP’s different approach to treatment and research, including that community practice has something to teach about treatment.

He then notes that, as Medical Director, he served as a facilitator and broker for trials. He talks about how CCOP trials and research worked at MD Anderson, including how biases against randomized trials worked into the planning process, with efficacy trials conducted with MD Anderson patients and Phase 3 trials conducted in the community. He gives an example.

Segment 14

B: Building the Institution;

The Community Clinical Oncology Program (CCOP); Transitioning to Research in Cancer Control and Prevention

30:29 – 41:50

Story Codes

A: The Researcher;

A: The Clinician;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
C: Research, Care, and Education;
B: Beyond the Institution;

In this segment, Dr. Fisch explains how research conducted via the CCOP transitioned from a focus on treatments to a focus on prevention, cancer control, and symptom management.

He first talks about his role as a facilitator setting structures for research collaborations. He notes that community settings offered a comprehensive view of patients, driving his own interest in symptom management. He talks about the overlap of different specialties whose borders are all debated. He illustrates with the example of pain management.

Next he sketches the factors that led to his decision to “sunset” the treatment focused trials. He was partnering with Dr. Blyer, who shared his vision. The NCI was also requiring that more research focus in these areas. Many regional research groups were putting together trials focused on prevention and control.

Segment 15

B: An Institutional Unit;
The Community Clinical Oncology Program (CCOP); Finances, Organization of Research, Some Examples
41:50 – 53:11

Story Codes

A: The Administrator;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Beyond the Institution;
C: Patients;
C: Patients, Treatment, Survivors;
C: The Institution and Finances;
D: Business of Research;
C: Leadership;

Dr. Fisch begins this segment by noting that he began looking for experts to begin developing the new focus of the CCOP. He explains why MD Anderson physicians need community based patients.

He explains finances: the program pays for the infrastructure, not the drugs and other related costs. He discusses strategies researchers use to address this challenge. He gives an example of a trial run by Dr. Lorenzo Cohen comparing the impact of meditation versus relaxing music on patients’ inflammation cascade. He discusses how to convince community physicians of the value of such studies.

Dr. Fisch notes his role as facilitator and stresses the importance of being respectful of the research issues that behavioral scientists confront. He gives some examples.

Segment 16

B: Building the Institution;

A New Department of General Medical Oncology

53:11 - 1:09:55

Story Codes

B: MD Anderson History;

B: Beyond the Institution;

D: On the Nature of Institutions;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

Dr. Fisch notes that the Community Clinical Oncology Program (CCOP) offered a platform to create a new Department of General Medical Oncology. He tells the history of how the department was formed. He explains how the program at LBJ Hospital was involved as well as Dr. James Cox's [Oral History Interview] mandate to expand radiation oncology services beyond MD Anderson proper.

Given this complexity, Dr. Fisch notes, it made sense to put all generalists together in a new department. He lists the functions included and talks about the challenges of creating cohesion in the diverse department.

Segment 17

B: Institutional Change;

Concern about the MD Anderson Brand as the Satellite System Grows

1:09:55 – 1:35:02

Story Codes

B: MD Anderson History;

B: Institutional Mission and Values;

B: MD Anderson Culture;

B: The Business of MD Anderson;

B: The MD Anderson Brand, Reputation;

B: Building/Transforming the Institution;

B: Growth and/or Change;

B: Controversy;

Dr. Fisch responds to a question about the growing acceptance of General Medical Oncology at the institution.

He first explains the concerns about brand and quality of care that faculty have had as the satellite system grows. Dr. Fisch explains decisions that had to be made about protocols offered in satellite centers. He talks about his own view of the controversy and notes that it takes skill to work with community people and subspecialists alike.

He notes that “the MD Anderson story has been about subspecialization” and “becoming like our competitors is difficult.” He explains that MD Anderson’s general medical oncologists have raised the bar of care in the community and at the satellite centers. He also stresses the importance of building shared research programs and harmonizing budgets to stress that satellite centers create a shared win for MD Anderson rather than competition.

Segment 18

A: Professional Path;

Accomplishments at MD Anderson and a New Career Opportunity

1:35:02 – end of session

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Professional Path;

B: MD Anderson History;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: Institutional Politics;

D: Fiscal Realities in Healthcare;

D: The Healthcare Industry;

Dr. Fisch notes his contributions to MD Anderson: faculty recruitments, the growth and success of each program within the department and their acceptance by the administration. He next talks about his growth as a leader.

Dr. Fisch then talks about his plans to leave MD Anderson for a position as Medical Director of Medical Oncology Solutions at Ames Specialty Health in Chicago, Illinois. He notes that, with changes at the institution, general oncology and cancer control are not top priorities, and he wanted a new opportunity to rise to the next level.

Dr. Fisch talks about the skill set he will bring to Ames, where he will be assessing value-driven quality care. It is also an opportunity for him to learn a great deal, saying “It will be like doing a fellowship in managed care” and give him an opportunity to have an impact on care.

Interview Session 3: 18 February 2015

Segment 00C

Interview Identifier

Segment 19

A: The Clinical Provider;

International Travel and Providing Team Care to VIP Patients

00:41 – 16:54

Story Codes

A: The Clinician;

A: Activities Outside Institution;
B: Beyond the Institution;
B: The Business of MD Anderson;
D: Cultural/Social Influences;
D: Global Issues –Cancer, Health, Medicine;
C: Patients, Treatment, Survivors;
C: MD Anderson Impact;
A: Personal Background;
B: The MD Anderson Brand, Reputation;

Dr. Fisch notes that global oncology has become an increasingly important dimension of MD Anderson's business. He explains that, as MD Anderson set up links with international partners, he helped them set up team-based treatment plans, multi-disciplinary care, and research. He gives examples of the types of research projects that might be set up.

Dr. Fisch talks in depth about his participation in international clinical care teams making "global house calls." He explains that his role was to offer palliative care, manage anxiety, sleeplessness, and rehabilitation, sometimes spending weeks abroad. He notes that these special trips helped clarify the services he could offer as a general medical oncologist and demonstrate their value to the patients and the institution. He also describes how people would receive MD Anderson faculty overseas, which helped increase his own feeling for the institution.

Segment 20

A: The Researcher;

The PREDICT Trial: A Unique Study of Biomarkers for Cardiotoxicity

16:54 – 11:38 (a new file is made in here)

Story Codes

A: The Clinician;
A: The Administrator;
A: The Leader;
A: Career and Accomplishments;
A: Overview;
A: Definitions, Explanations, Translations;
C: Discovery and Success;
B: Multi-disciplinary Approaches;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;

In this segment, Dr. Fisch talks about the PREDICT trial, a landmark study he conducted in the late 2000s on predictors for cardiotoxicity in patients treated with anthracyclines. He explains the effects that anthracyclines can have on the heart and notes that this is a survivorship treatment issue. The study asked Can you use point-of-care biomarker testing to assess cardiac toxicity of chemo regimens. Dr. Fisch notes that when this project began around 2007, cardiac studies were very new. He describes some challenges enrolling patients (eventually enrolling over five hundred) and reports the outcomes. He says that it was a good descriptive study, unique in the realm of oncology. His role, he explains, was facilitating set up and implementation of the project and executing the trial as part of a team effort.

Segment 21

A: The Researcher

A Landmark Study on Chemotherapy and Depression;

11:38 – about 21:00

Story Codes

A: The Clinician;

A: The Administrator;

A: The Leader;

A: Career and Accomplishments;

A: Overview;

A: Definitions, Explanations, Translations;

C: Discovery and Success;

B: Multi-disciplinary Approaches;

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

D: The History of Health Care, Patient Care;

B: Beyond the Institution;

Dr. Fisch begins this segment by explaining that as Chair of the Eastern Cooperative Oncology Group's Symptom Management Committee, he wanted to study how to manage patient symptoms, but there was a lack of basic data about symptom experience. This led to a landmark study of more than three thousand patients that surveyed a broad range of symptoms and practice patterns for lung, breast, colorectal and prostate cancers. (He observes that such long-term studies sometimes fail, discouraging some researchers in the process.)

Dr. Fisch notes that the SOAPP study continues to make a unique contribution. An unusual feature is that the study has a website (<http://www.ecogsoapp.com/>) to facilitate dissemination of information. Data also is available through twelve published papers, with more coming. Dr. Fisch talks about the difficulties of maintaining the website when money runs out.

Segment 22

A: The Researcher;

An Emerging Field of Cardio-Oncology

about 21:00 – 24:10

Story Codes

A: The Clinician;

A: The Administrator;

A: The Leader;

A: Career and Accomplishments;

A: Overview;

A: Definitions, Explanations, Translations;

C: Discovery and Success;

B: Multi-disciplinary Approaches;

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

D: The History of Health Care, Patient Care;

In this segment, Dr. Fisch notes that field of cardio-oncology emerged over the last seven or eight years, concurrent with the PREDICT trial. He observes that the field is becoming

important because new classes of drugs are cardio-toxic and many of the molecular and genetic pathways involved in cancer are also important to cardiologists. He notes that his own contributions to this field have become increasingly important.

Segment 23

A: The Researcher ;
Compassionate Care
24:00 – 29:48

Story Codes

A: Overview;
A: The Clinician;
C: Human Stories;
C: Offering Care, Compassion, Help;
C: Patients;

Dr. Fisch begins this segment by defining compassionate care along with the division of labor required between symptom management, communication and inter-disciplinary team work. He stresses that “words matter, how you talk about things matters,” and notes the importance of learning how to ask patients questions to encourage them to tell their story, though current time pressures make this challenging. He stresses, however, that there are skills a physician can learn to make patients feel they are receiving compassionate care.

Segment 24

B: Building the Institution;
The Schwarz Rounds at MD Anderson and Mindful Medical Practice
29:48 – 44:23

Story Codes

A: Overview;
A: The Clinician;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
C: Human Stories;
C: Offering Care, Compassion, Help;
C: Patients;
D: Understanding Cancer, the History of Science, Cancer Research;
C: The Life and Dedication of Clinicians and Researchers;
D: The History of Health Care, Patient Care;

Dr. Fisch talks about the Schwarz Rounds implemented at MD Anderson in 2007. He describes the focus on the experiences of the care providers and the emotions that come up for them while offering care to patients. He explains that the need for the Schwarz Rounds arose because the Medical Oncology fellows were experiencing fatigue and burnout. Dr. Fisch explains why the program stopped.

Next, Dr. Fisch talks about mindful medical practice, which helps reduce burnout and fatigue among. He gives examples of the stresses of an oncologist’s job. He notes that the value of

awareness is increasingly recognized in medicine. He has worked to bring visibility to the issue at MD Anderson by drawing attention to research that shows how mindfulness can ensure delivery of high quality care.

Segment 25

B: Institutional Processes;

Exploring Uses of Social Media

44:23 – 1:09:00

Story Codes

D: Technology and R&D;

C: Discovery, Creativity and Innovation;

B: Building/Transforming the Institution;

B: Growth and/or Change;

B: MD Anderson in the Future;

B: Critical Perspectives on MD Anderson;

Dr. Fisch talks about his fascination with social media and his attempts to introduce its creative use at MD Anderson to communicate more effectively with patients and the public.

[the recorder is paused]

Dr. Fisch talks about his introduction to Twitter and his efforts to use it in healthcare, beginning with the Community Clinical Oncology Program. He explains why ASCO now has a Social Media Working Group. (Dr. Fisch serves on that committee.) Dr. Fisch explains the impact that social media can have on individuals and institutions and stresses the importance of making education about social media part of medical curricula. He states that MD Anderson has made some headway in this area, and he lists the consequences of not keeping up.

Dr. Fisch next talks about his involvement in a clinical trial that proposed to use social media to increase patient enrollment. He contributed to the grant, which the South Western Oncology Group has funded.

Segment 26

B: Building the Institution;

MD Anderson's Focus on Patient Experience

1:09:00 – end of session

Story Codes

B: Building/Transforming the Institution;

C: Patients;

D: The History of Health Care, Patient Care;

C: Leadership;

B: Critical Perspectives on MD Anderson;

B: Institutional Mission and Values;

B: MD Anderson Culture;

B: The Business of MD Anderson;

B: The MD Anderson Brand, Reputation;

Dr. Fisch talks about two initiatives to involve patients as partners in planning processes: the Patient Experience Steering Committee and the Patient and Family Advisory Council. Dr. Fisch notes that though he received invitations to serve on both committees, he was given no charge or mission and there is no natural momentum on patient experience at the institution. He talks about the advantages to the institution of addressing patient experience and notes that MD Anderson's attention to this matter is a response to an Institute of Medicine report that other institutions are moving ahead.

Dr. Fisch then observes that if an institution is not patient-centered, shifting focus is difficult. He suggests ways in which MD Anderson communicates that it is not patient centered. He then talks about Leadership Rounds, which help leaders see the institution from a patient's perspective. He acknowledges that the institution is listening to patients more and coming up with creative ways of reorganizing care.

At the end of the session, he makes some final comments about working at MD Anderson.

Michael Fisch, MD

Interview Session 1 – February 5, 2015

About transcription and the transcript

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

The views expressed in this interview are solely the perspective of the interview subject. They are not to be interpreted as the official view of any other individual or of The University of Texas MD Anderson Cancer Center.

Chapter 00A

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

So now we are officially recording. (laughs)

[00:00:05]

Michael Fisch, MD

[00:00:06]

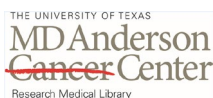
Okay. Good morning.

[00:00:07]

Tacey Ann Rosolowski, PhD

[00:00:08]

Good morning. So let me just put the identifier on. I'm Tacey Ann Rosolowski, and this morning I'm interviewing Dr. Michael J. Fisch for the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Dr. Fisch joined MD Anderson in 1999 as an assistant professor in the Department of Palliative Care and Rehabilitative Medicine. Is that correct?



Making Cancer History®

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[00:00:34]

Michael Fisch, MD

[00:00:35]

That's correct.

[00:00:35]

Tacey Ann Rosolowski, PhD

[00:00:36]

Okay. Since 2004 he has been the Director of the Community Clinical Oncology Program, and since 2009 has served as Chair of the Department of General Oncology. He is tenured in that department. I will also say that Dr. Fisch will soon be leaving the institution for a new opportunity, and I'm sure we'll have an opportunity to talk about that a bit later.

This session is being held in a conference room in the Department of General Oncology in the Faculty Center on the main campus of MD Anderson. This is the first of two planned interview sessions. Today is February 5th, 2015, and the time is about thirteen minutes after ten.

So thank you very much for—

[00:01:15]

Michael Fisch, MD

[00:01:15]

You're welcome.

[00:01:15]

Tacey Ann Rosolowski, PhD

[00:01:16]

—agreeing to participate at this very busy time when you're packing and getting ready to leave, leave Houston.

[00:01:22]

Michael Fisch, MD

[00:01:22]

Well, I'm delighted. I'm delighted to have a chance to reflect with you.

[00:01:25]

Chapter 01

A: Personal Background;

An Interest in Sports Shapes a Fascination with the Body

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

C: Formative Experiences;

C: Discovery, Creativity and Innovation;

Tacey Ann Rosolowski, PhD

[00:01:25]

It's a pleasure.

Well, as I mentioned before we turned on the recorder, I kind of organized this as a chronological story, so I wanted to ask you where you were born and when and where you grew up.

[00:01:39]

Michael Fisch, MD

[00:01:40]

Well, I was born in Queens, New York, in 1964. Both of my parents were born and were raised and lived in Brooklyn, New York. I didn't stay long in New York. My parents moved to Maryland by 1967 and then to Chantilly, Virginia, in Fairfax County, Virginia, shortly thereafter, and that's where I was born and raised. So I spent basically my entire childhood in Chantilly, Virginia, and went to Chantilly High School. My mom was an elementary school teacher at a nearby elementary school, and my dad worked in the defense industry with defense contractor companies and then for the Pentagon.

[00:02:36]

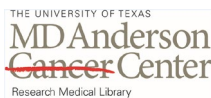
Tacey Ann Rosolowski, PhD

[00:02:36]

What did he do?

Commented [T1]:

Dr. Fisch begins the interview by sketching his family background and then talking in detail about his lifelong interest in sports. He explains that he "understands the world through sports and sports metaphors." He explains the process of visualizing how to execute a series of plays and links this to mindfulness skills he would become interested in as a medical professional. He cites his mentor, Dr. Waun Ki Hong [Oral History Interview] who told him (ironically) that his job is "easy," since meeting healthy goals is a step-by-step process. He observes that his interest in sports probably led to his fascination with the physical body.



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[00:02:37]

Michael Fisch, MD

[00:02:38]

He was in electronic surveillance defense. He was an electronic engineer. He had gone to City College in New York and my mom had gone to Brooklyn College. And like a lot of people in the northern Virginia area, they worked in D.C. or surrounding industries.

[00:02:59]

Tacey Ann Rosolowski, PhD

[00:03:01]

Your birth date?

[00:03:02]

Michael Fisch, MD

[00:03:02]

June 11th, 1964.

[00:03:05]

Tacey Ann Rosolowski, PhD

[00:03:07]

Now, tell me a little bit about your education and kind of what you were thinking about doing when you were a kid. I mean, I was interested in how many interests you have right now, I mean how many facets.

[00:03:18]

Michael Fisch, MD

[00:03:18]

Yes.

[00:03:18]

Tacey Ann Rosolowski, PhD

[00:03:19]

How did your interests start evolving?

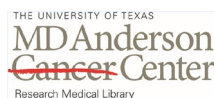
[00:03:21]

Michael Fisch, MD

[00:03:22]

Well, so I've always been interested in sports, first of all, so when I think about my childhood, I think about the sports, playing baseball, basketball, football, hockey, street hockey.

[00:03:37]



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Tacey Ann Rosolowski, PhD

[00:03:37]

You were a doc-jock. (laughs)

[00:03:38]

Michael Fisch, MD

[00:03:39]

Yeah. Well, I mean, that's where my mind was, and that's where my mind actually has continued to be.

[00:03:44]

Tacey Ann Rosolowski, PhD

[00:03:44]

Interesting.

[00:03:45]

Michael Fisch, MD

[00:03:45]

In many levels, I've sort of come to understand the world through sports, sports analogies. And even one of my sort of proud moments here recently was getting to write a medical article about a sports metaphor, talking about evaluating physician performance in Medical Oncology. Money ball becomes impact ball, and so it's basically kind of a money ball type story in our field. And coauthoring that with Waun Ki Hong, my boss, and Jim Abruzzi, head of GI Medical Oncology, also big baseball fans, and we always think and talk in baseball terms, so actually having that project together and publishing that was really quite a thrill for me. So sports was a big theme, but—

[00:04:38]

Tacey Ann Rosolowski, PhD

[00:04:38]

Can I ask you kind of a little follow-up question about that?

[00:04:41]

Michael Fisch, MD

[00:04:41]

Yeah, sure.

[00:04:41]

Tacey Ann Rosolowski, PhD

[00:04:41]

Because, I mean, people who are really adept at sports, I mean, they have like a physical confidence, I mean a physical awareness, and I'm wondering if that connects somehow to meditation or, you know, the ability to kind of put the mind inward and understand your own body states, your body movements.

[00:04:59]

Michael Fisch, MD

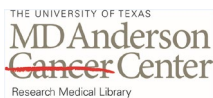
[00:05:00]

Well, I think there's a lot to be said for that, right? So if I'm talking to my son about how to be an effective pitcher, so much of it is not just the mechanics of pitching, the strength, the working out, but it's noticing where your mind goes and noticing what your job is to do, you know, and to prevent yourself from catastrophizing, like, "If I walk this guy and then another guy gets a hit, then they're going to tie the game and we're going to lose." Your mind can't have those thoughts as a pitcher. You have to be able to get back to where you are, tune out those thoughts and other sorts of distracters, and execute the next pitch. That's all you can do, execute the next pitch. And then that seemed like it would have been a strike, but the umpire called it a ball, you've got to get over that thought and then execute the next pitch. (laughs) That's all you can do.

You see this come to fruition in sports, in the most recent NFL playoffs and Super Bowl. It's a remarkable year, 2015, where a lot of unlikely things happened, but they happened because the athletes and their coaches were able to execute the next play, the series of plays that were required. Sometimes it would seem unlikely that a series of things would have to happen for them to get the best result, but they had to be able to have that vision and focus and find that opportunity. To create an opportunity for that to happen required tremendous mindfulness skills, highly developed, extraordinary mindfulness skills of the sort that none of the fans watching these games could possibly bring to bear, but the players could, and it's just really a remarkable thing. So I think that has a lot to do with sports.

And, in fact, very recently since the playoffs started, I was talking to a patient who had a condition which was very serious and the possible causes of the condition were extremely frightening. So we talked about the sports mentality and noticing where the mind goes and knowing that there's just a series of steps that need to happen and sort of figure out how to walk through the step-by-step process.

I remember when Dr. Hong, my boss, when I first became chair of General Oncology, I remember him saying, "Your job is very easy."



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And I paused, like, “Really?”

He said, “Healthy goals. Step-by-step processes.”

And I think of that all the time. I always think, “Your job is very easy.” It could be you can impute that to a patient. “Your job is very easy as you wait to see what this diagnosis is and how you’re going to be a member of your own healthcare team, and how you’re going to manage the reactions of your husband and of your children and of your mom and of your family and perceive your future in the way—.” There’s all this stuff that needs to happen, and without saying this to the patient, because it may not be an effective to say, but, “Your job is very easy.” Healthy goals. What’s the goal? Step-by-step process. What’s the step-by-step process I need to get from here to there? For that patient, it was from pre-diagnosis, about to have a series of diagnostic tests, and you can’t really plan until you get through those, and then there’ll be a diagnosis. There’ll be no more mystery, and then the goals of care and ways of navigating can be thought of then. But you sort of have to shorten the game, just like, again, sports teams learn to shorten the game so that they can get the best results.

So sports has always been important to me and probably led to my fascination with the body, right? You know, your muscles, your injuries, how you make your body work in sports. So I was interested in that. And I pretty much decided when I was eleven years old that I wanted to be a doctor.

[00:09:30]

Chapter 02

A: Personal Background;

An Early Desire to Become a Doctor and a Range of Interests and Gifts

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

C: Discovery, Creativity and Innovation;

A: Professional Path;

C: Leadership;

Tacey Ann Rosolowski, PhD

[00:09:32]

Was there something that tipped you into that decision?

[00:09:34]

Michael Fisch, MD

[00:09:35]

I think the thing that tipped me into it is a totally immature thing, which was the TV show *Emergency! Squad 51*. It was, like, a paramedic show. People of a certain age may remember this show. It's an old-fashioned show with a couple of paramedics, but they were popular and they were helping people and doing dramatic things to make sick people better, and it just seemed awesome.

And as a little kid, when I showed interest in that sort of thing, I got lots of positive feedback from my family. I have no physicians or health professionals in my family, but being interested in that realm seemed to get positive attention, so it became, you know, the typical snowball. And then I remember my grandmother, who, ironically, whose last name is Doctor, Gus Doctor, D-o-c-t-o-r, she's not a doctor, but shortened from Doctorowitz [phonetic], Russian Jewish ancestry. But Gus Doctor, my grandmother, got me *Gray's Anatomy*, a big daunting anatomy book when I was eleven.

[00:10:46]

Tacey Ann Rosolowski, PhD

[00:10:47]

Wow.

[00:10:47]

Michael Fisch, MD

[00:10:47]

Of course, I had shown this interest in this sort of stuff, and then I started trying to read *Gray's*

Commented [T2]:

Dr. Fisch recalls that he decided to become a physician at the age of eleven, inspired by physicians on TV shows. He notes that his grandmother took his interest very seriously and bought him *Gray's Anatomy*. He also observes that he was "drawn to complexity" very early and that this interest became a theme in his career.

Dr. Fisch talks about his high school experience, recalling that he was a motivated, hard worker with many extracurricular activities. He also explains why he considers himself a creative person, noting that his style creativity lends itself to working in groups, a characteristic important for conducting team science. Dr. Fisch explains that he loves team science for the way it brings together people from different disciplines. He makes observations about his inspirational style of leadership, noting that his love of leadership roles began in high school. He also notes that he is at his best when he is in the state referred to as "flow."

Anatomy and trying to see the body and trying to name the names of the muscles that were the ones that I was using when I was playing ball in the yard. Where's my deltoid and where's my gastrocnemius? You know, stuff that is super cool when you're eleven years old to try to figure out. And there's so much information and so much complexity, so I became drawn to complexity, which is really, in a sense, the theme of my career is trying to manage complex information and put them into conceptual frameworks and try to discover new ways of doing things that work well for patients, for care delivery, things like that. So that's sort of how it all got started for me, sort of at the intersection of sports and the body and then medicine.

[00:11:52]

Tacey Ann Rosolowski, PhD

[00:11:52]

Yeah. So tell me about selecting a college. What were you thinking about doing at that time?

[00:11:57]

Michael Fisch, MD

[00:11:58]

Right, yeah. So at that time I went to Chantilly High School, where I played baseball there on varsity team, and I had played some basketball up through JV before focusing on baseball. I was also on the debate team and was interested in—again, that was sort of information management complexity, right? We used to carry these file boxes with all this evidence, these little file cards with arguments and evidence and things you could speak about in your debate. So managing that information and trying to articulate it was fun for me.

In high school, it was sort of foretelling because it's true today as much as it was then, I sort of had a very ordinary raw ability mentally. My SAT scores were good but not extraordinary. I wasn't a National Merit Scholar guy. I wasn't somebody who wowed anybody in the sort of raw intellect, but I was really a grinder, and I had more "want to" than anybody. I loved to learn, so I got the math award and the science award, and I think I got three or four awards at graduation, where I was clearly—like I would be on the math team where none of my scores would count, like I was a disqualified math—and I think on the math team I never solved a math team problem in my whole career. I mean, I couldn't figure anything out that I hadn't been taught. You know what I mean? But I was a good math student. I got pretty good grades because I worked at it. I was interested enough to even endure being on the math team and maybe be a junior or a senior and have basically seventh or eighth graders who were really the scorers, right? Sort of in a sports sense, that would be very insulting to have the younger guys—girls and guys who could outperform you dramatically. But, anyway, it took a certain humility to even do that, but sort of a lot of "want to," a lot of enthusiasm for learning and applying knowledge.

[00:14:15]



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Tacey Ann Rosolowski, PhD

[00:14:16]

Well, and interesting, too, that you were—so many people, particularly in younger grades, they’re looking for simplicity. I mean, that’s often what you’re taught in school is what a real answer is. You strip away complexity and you go for simplicity. But you had, very early, this sort of inner compass that said, “No, complexity is where my center of gravity is, my intellectual center of gravity is.” So that’s unusual. That’s interesting. It kind of goes against the current. (laughs)

[00:14:44]

Michael Fisch, MD

[00:14:44]

Yeah, I think so. And to bring that back to sports, it just sort of occurs to me that in the most recent Super Bowl, the hero of the Super Bowl was an undrafted free agent who happened to be on the field at the biggest moment in the Super Bowl and happened to make the biggest play in the history of the Super Bowl. So sometimes it’s not the people whose pedigree would predict great things, but it has to do with timing and opportunity and “want to.” I mean, not knowing that player in a lot of detail, I bet you if you were interviewing that player, the story would be that that player loves the game, has always worked at it, and was thick-skinned and willing to do what it took to kind of get himself in the position to be able to play the game he loved, and then happened to be in a position to do something spectacular.

So, you know, I don’t claim to have done anything spectacular, but I would sort of more resemble that kind of person in my field as compared to a first-round draft pick, you know, a National Merit Scholar who went to Harvard and who has achieved in the top 1 percent on everything they’ve tried to do. That’s not my story.

[00:16:06]

Tacey Ann Rosolowski, PhD

[00:16:07]

Do you consider yourself a creative person?

[00:16:09]

Michael Fisch, MD

[00:16:09]

Yes, I do consider myself creative, and I'm drawn to roles and opportunities where there's creative potential, but I'm not at all creative in the aesthetic sense. Actually, I just took some test called a NEO-PI in an academic leadership course, and it was judging different parameters of you. Like many of these things do, they characterize you. But I scored very low in aesthetics, so I don't make things prettier, you know, but I'm creative. So I can't draw and do graphic art or have any sense of that, but I'm creative in the sense that I like to be asked questions, "How might we—?" blah, blah, blah, you know. "How might we drive better value in cancer care delivery? How might we think about suffering in patients who are towards the end of life due to advanced malignancy?"

But these "how might we" questions that lead to conceptual creativity, that's where I'm creative, yeah, and that sort of work doesn't lend itself to individual achievement. These are often, by their essence, team projects, so team science is what I love and being able to interact with others, not just individually interact with patients and families as a physician, but interact with teams of doctors and teams of researchers and people across disciplines, because how we might have one perspective, depending on whether you're a social worker or physical therapist or whether you're a sociologist or an epidemiologist or basic scientist. I mean, these very different perspectives lend themselves to these "how might we" brainstorming.

And then it's one thing to brainstorm, it's another to execute, right? So execution is everything. It's everything in sports, right? You can brainstorm and have all these theoretical plays. If you can't execute any of the plays, nothing good will happen for your team. You can brainstorm a whole pitching game plan. If you can't execute any of the pitches, you're going to lose. So "how might we" is conceptual but then also an execution issue and relational issue and requires leadership to execute. You have to inspire others to follow willingly along some sort of conceptual plan, and if you can do that, there's a chance that you and your group will execute something, and if you never get there, then nothing comes of your ideas. And your ideas, by the way, are a little hard to identify as your ideas anyway. Attribution of ideas becomes very unimportant, in a sense.

[00:19:13]

Tacey Ann Rosolowski, PhD

[00:19:15]

Do you consider yourself an inspirational leader in that sense, or charismatic or—yeah, I know it's sort of hard sometimes to apply those words to yourself.

[00:19:22]

Michael Fisch, MD

[00:19:22]

Yeah, I don't know. I think so. I mean, I think I'm drawn to want to be inspirational and charismatic, and when I'm at my best, when I'm in a role that's working and I'm in flow, I think I'm that. I think that's a fair description of me. So I think that that's right, but it might be like asking somebody, "Are you a homerun hitter?" And they might say, "Well, when I'm at my best, when I'm doing what I'm trying to do, when I'm effective, I am." Not everybody would say that, right? Some people hit for average and are effective in other ways. But in that sense, that is the kind of hit I'm trying to make many times and so—

[00:20:09]

Tacey Ann Rosolowski, PhD

[00:20:10]

When did you know that about yourself? When did you first experience flow, for example?

[00:20:15]

Michael Fisch, MD

[00:20:16]

That's a very good question. Yeah, that's a good question. I think most people experience flow for the first time in their lives when they're in sports. You find flow in maybe playing basketball with others, where you seem to know where to go, you seem to have a feel for where your teammates are going to be, you seem to know how to stop the other team from doing what they're trying to do, and you just feel like there's a certain flow to what it is you're doing, and you're also kind of focused and locked in. So you're just enjoying, you know, concentrating and watching and sort of effortlessly seeing the right things happen. That's, I guess, what flow feels like, and you probably experience that, if you like sports, in some sort of sports endeavor. Maybe for some people it's a swimmer who gets into flow, but for me it would be in a team sport where there's other people to relate to and to have a sense of where they're at, how they feel, where they're moving and such, and have a sense of your opponent, being able to sort of gauge or anticipate your opponents. So I experienced it there.

I think I experienced it some early in my life in debate where you need a certain flow at times. You know, it can either click or not click or flow or not flow. And writing is another place where flow can occur or not occur when you're trying to put ideas into some form that can be seen and shared and revisited and giving birth to that. So I don't write creative things. I don't write music. I remember trying creative writing at different times in my early life and always being very impressed with my creative writing and finding that everybody who read my creative writing was very unimpressed with that. (laughter) But writing of ideas rather than stories, the ability to create stories, again, sort of newly imagined stories didn't work for me. To me, maybe creative writing and music would require the same sort of domain of talent that I didn't seem to have. But sharing ideas and then trying to lucidly lay those out was something I could do better and found that I could do better. So I'd say critical writing about creative writing, right, like writing about *Hamlet* or something in English class, that's a different thing, so I could do that sort of thing in school.

Then I liked to lead. I think I was involved with Student Council in high school, and I was involved in college as a resident advisor and with a coed service fraternity called Alpha Phi Omega that had the chance to lead projects and to be basically doing teamwork with other people, you know, how might we serve our community by building a playground and how are we going to pull that off and when are we going to do it and what do we need to do it and how do we get the right donations to get—you know, those kind of things where you needed leadership and execution and some amount of imagination.

[00:23:49]

Tacey Ann Rosolowski, PhD

[00:23:49]

Yeah, sort of multifaceted projects and—yeah.

[00:23:53]

Michael Fisch, MD

[00:23:53]

Multifaceted, and you had to have a sense of what you could contribute and what you were good at or not good at. So I wouldn't, like, be the guy who would be the architectural designer or anything, right? I'd be the guy who'd carry a piece of wood from Point A to Point B at the time of the project. (laughs) You know, got to know who you are.

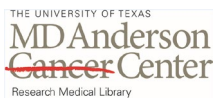
[00:24:12]

Tacey Ann Rosolowski, PhD

[00:24:13]

Yeah. But maybe you could get donations. (laughs)

[00:24:14]



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Michael Fisch, MD

[00:24:14]

Yeah, get donations or think of it, or get people to want to even do the project, to attract, to mastermind it, in a sense.

[00:24:22]

Chapter 03

A: Educational Path;

Challenges in College and Medical School; Seeking a Specialty

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

Tacey Ann Rosolowski, PhD

[00:24:22]

Interesting. Tell me more about your college experience. Why did you choose to go—let's see.

You went to University of Virginia in Charlottesville. So tell me about making that choice.

[00:24:32]

Michael Fisch, MD

[00:24:32]

So I didn't really want to go there at first. I had grown up—actually, again in sports—I was rooting for the University of Maryland college sports teams, so the idea of going to UVA didn't seem like it made any sense to me. But I think I had applied and gotten into Johns Hopkins, which was way too expensive for my family, and I really liked William & Mary in Williamsburg and just thought that would be great, but that was also pretty expensive.

I remember going to UVA in the summer and not liking it that much. There was a lot of construction, it was hot, and it didn't really turn me on that much, and telling my parents that I think I liked William & Mary. They said, "That's good. Why don't you look at UVA one more time before you decide." So I went back one more time, and it wasn't, you know, jackhammers in the street, it wasn't as hot, and decided to go there. I was lucky to be able to go there because it's a great school, it was a tremendous value. Again, my parents, middle-class and we didn't have tons of money, the value of in-state tuition at UVA for the quality of the education and the affordability of it was fantastic.

I had a great experience. I was a resident advisor my second, I think—I want to say certainly my second—probably my second, third, and fourth year. So, anyway, that saved costs and it also gave a chance to lead and learn and work with people and trying to—you know, it's not so much—I guess a resident advisor is not exactly a leader. It's a certain kind of leadership role, but it's not like project oriented as a different sort of thing. But it's one that I enjoyed and made connections with people and learned a lot from. It was very eye-opening to be in that role and to see how

Commented [T3]:

In this segment, Dr. Fisch talks about selecting his college (University of Virginia at Charlottesville, BA conferred 1986) for financial reasons and explains the value of a state education. He notes that he was not a top student and had to work very hard as an undergraduate. He notes that he discovered his lack of visual/spatial ability, which made certain courses very difficult and caused him to consider a career in nursing.

Next, Dr. Fisch talks about his medical education at the University of Virginia Medical School (MD conferred in 1990), noting how he loved surgery, but his lack of visual/spatial ability made this specialty impossible for him. By working with surgeons, however, he learned to love clinical medicine and post-operative patients in particular because they were "endlessly complicated."

various other people experience college and what problems they have and things that would be off your radar become on your radar in that sense.

[00:26:38]

Tacey Ann Rosolowski, PhD

[00:26:39]

So were you premed?

[00:26:40]

Michael Fisch, MD

[00:26:41]

Yes, I was premed, and, again, you know, I was not the smartest premed, but I was willing to work endlessly. (laughter) I was willing to work as hard as one needed to work to learn whatever it was we were trying to learn, and I had to learn also how to deal with things that didn't go well.

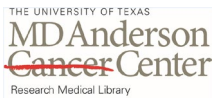
I'm having this sort of flashback of another Dr. Hong aphorism to me, or not aphorism, words of wisdom to me at one point in my career when I was involved with some disappointments or conflicts with some other groups. And I remember him looking at me and saying, "You've got to learn how to lose. You've got to learn how to lose. You can't fight and win every battle. You're not going to always win." Of course, you sort of know that your whole life, but sometimes it's hard to see that, or you need to hear that kind of advice.

But my learn-how-to-lose moments in undergrad was, I think, the first semester I took organic chemistry I got a C, and I was very disappointed with that, because, trust me, I put in everything I knew how to try to learn organic chemistry. In the end, there's a lot of visual spatial work in organic chemistry, in enantiomers and other things, and that's my Achilles heel. That's the lack of aesthetics and lack of visual spatial ability made that rough.

Then I thought, well, that might clock me out of being in medical school. I mean, I don't know that I will be able to go into medical school after getting a C in organic chemistry. And I remember going to my premed advisor, a guy named Dick Pearson [phonetic], I think, a very nice man, and I remember talking to him about my C and then saying, "You know, I was thinking about my career and I was wondering what I should be, and I was thinking maybe I would go into nursing," because I wanted to go into healthcare and caring for sick people, but I was sort of ready to acquiesce that if you get a C in organic chemistry, you'd better not focus on medicine. That's probably not going to work out for you.

And I remember him looking at me and saying, "Well, is that what you want to do? You want to be a nurse?"

I said, "No. I want to be a doctor."



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He said, “Well, then be a doctor; i.e., don’t exit now, just stay on the course. If you want to be a doctor, this is not a disqualifying moment. Start there.” (laughs)

So I think I was able to scrape a *B* the next semester and I had very good grades in the other classes, again, a lot of *A*-minuses, *A*’s, a few *B*-pluses, but a good grade-point average, and so it went. I got good enough MCAT scores and got into UVA Medical School, which I remember getting that letter. Again, this is the era when you didn’t get an email or something, but you opened up an envelope and it said what you wanted. It was a really big thrill.

And the other sort of similar experience that I had in med school, the same sort of problem, my visual/spatial stuff got me in anatomy. I think I got a *C* one of the semesters in anatomy, and I was just devastated, because again, like organic chemistry, I was studying anatomy *endlessly*. This is obviously not the era where you have apps and stuff, so you have four or five sort of manuals and atlases of anatomy open with different perspectives on the anatomy. So I was just trying to figure it out in 2D, in the 2D world I had available to me. And then I was best at managing lists, so I’d try to convert it into 2D lists, but anatomy is sort of endlessly complicated if you’re just going to make lists of things. You’ve got to picture it. If you can’t picture it, it’d be like turning architecture into a rote thing. Pretty tough. You just either see it or you don’t.
[00:31:12]

Tacey Ann Rosolowski, PhD

[00:31:13]

Mm-hmm. It’s kind of funny, because, I mean, I often ask people if they’re visual thinkers, and so many of them don’t know what I’m talking about, though they clearly are. I mean, people in radiology, surgeons, I mean, if they don’t have that ability, they can’t practice.
[00:31:26]

Michael Fisch, MD

[00:31:26]

You can’t function, yeah.

[00:31:27]

Tacey Ann Rosolowski, PhD

[00:31:27]

No. So it’s interesting that you had to confront it, because you were not able to work easily in that mode [unclear].

[00:31:35]



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Michael Fisch, MD

[00:31:35]

Yeah. So I got a C and I was devastated by that, but—

[00:31:38]

Tacey Ann Rosolowski, PhD

[00:31:38]

But, again, it wasn't a determining factor.

[00:31:40]

Michael Fisch, MD

[00:31:40]

No. So what it told me is you'd better not want to be, say, an intervention radiologist, probably not a surgeon. And I remember thinking, "But I love surgery." That's the thing. I went into my clinical rotations, my very first rotation was surgery, and, man, did I love it. First of all, because I love clinical medicine, I was just ready to eat up clinical medicine at the first opportunity, so I was overjoyed to be in clinical medicine. And I loved the surgical culture. You know, the surgeons were cool, and they said funny, cool things, and they did funny, cool things, and they were great to hang around. And then I loved caring for the post-op patients, because they were wildly complicated. They had all kinds of things. You know, they had wounds and metabolic abnormalities and infectious complications and clots and things. You know, things started to happen in the post-op world that required you to tune in and be effective, and so I liked caring for the post-operative patient.

Time in the OR was pretty okay as a clinical clerk, because you didn't really have to do much, right? You're just watching and retracting and being in the room and seeing cool things and having school experiences. The problem is if you have to do any surgeries.

So then we had like a dog lab, and we had to do a splenectomy on a dog, and, man, I could not figure it out. I mean, I'd get lost. If you're a dog, you don't want me to be taking your spleen out, because I'm going to struggle. So I found out that—you know, and I could sort of sense. I mean, it's no mystery to me that that was not going to be—you don't get to be a surgeon by being a post-op care provider. I thought I could probably learn how to do whatever surgeries need to be done. Like I could learn how to take out a spleen in a dog and I can learn how to do repair a hernia, and I could do it all. Kind of like I could learn how to do organic chemistry and maybe not fail it and maybe even get from C to B, but I'll never be A-plus. I will never be the one that you would want, so why would I want to go into a specialty where I have that sort of limitation of my potential? Go into something where I can find my own flow and not make life such a struggle. (laughs)

[00:33:57]

Chapter 04

A: Educational Path

Early Research Experiences Leads from Infectious Diseases to Hematology/Oncology;

Story Codes

A: The Researcher;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

D: Ethics;

Tacey Ann Rosolowski, PhD

[00:33:58]

So when did you kind of figure out what direction that was going to be?

[00:34:02]

Michael Fisch, MD

[00:34:02]

So during medical school I started to do research in infectious diseases. My mentor was Barry Farr, F-a-r-r, hospital epidemiologist and a wonderful and brilliant man, and very generous man. I'd actually gotten involved with research with him as an undergrad. I had seen, when I was in organic chemistry, like on some noteboard, "Summer opportunity, medical research," and it turned out to be research which involved prisoners. There was a pathology resident and a medical resident who were going to Powhatan in Virginia, where the Virginia prisoners intake would happen. The idea was doing a serosurvey for hepatitis and HIV in prisoners. This is late eighties. I mean, this is just the very first bubble of HIV.

Now I realize that this is why I was able to get this sort of thing, because most people didn't want to go deal with prisoners. The women were not so thrilled about going to interview prisoners, and this didn't seem like, you know, maybe the sexiest gig in the world, but, to me, to drive to Powhatan with two doctors and do anything in the Medical Center was awesome, and I loved it. I soaked up the mentoring and friendship with these two great guys. One guy was Dr. Richard Tucker. He was the medicine resident. And Mike Gaffey, G-a-f-f-e-y, was the pathology resident. They became great friends and mentors.

I went and interviewed Virginia prisoners and actually sort of made a famous ethical mistake, because I wasn't professionalized at the time. So my job was to go and one of these guys would draw blood from the prisoners. We'd first talk to a group of them, get their consent, draw some blood, and then my job was to take the blood back to the lab, and they would spin it down. I didn't have to do too much with the blood, but I was just a helper, and I spent some time doing

Commented [T4]:

Dr. Fisch describes the evolution of his interests leading to his focus on oncology.

He discusses a college research projects and tells an anecdote about an ethical mistake he made while interacting with participants.

Next, Dr. Fisch explains that he discovered hematology/oncology during his rotations and he was attracted to the field because it afforded the opportunity to build long-term relationships with patients and their families. **[HIPAA – 2-c –no authorization needed. He also notes that he was inspired by experiences of an uncle and his grandfather with cancer.]**

[The recorder is paused about five minutes.]

Dr. Fisch explains why he tracked into hematology/oncology and was always focused on academic medicine and a career in research. He describes his studies in medical school reflects on his residency (Internal Medicine, University of Virginia, 1990-1993).

sort of interviews with the prisoners. So I'd ask them about, "Have you had tattoos? Have you ever had sex with another man?" I had to ask prisoners kinds of questions that were a little uncomfortable if you're not a trained interviewer, right, just some undergrad.

So the ethical thing was my job was to get consent, and I would go into a roomful of prisoners, and I remember saying, "I hope that you will agree to give blood. This is for an important project, and this will look good to the Parole Board," sort of a famously unacceptable and coercive statement, made very sort of innocently, because it seemed to me, well, wouldn't it? You know, why wouldn't the Parole Board look favorably to somebody who contributed to science? So, to me it was logical, but I had no ethical sense at the time, and in hindsight look back at that and say, gosh, my first medical experience was a catastrophic ethical failure, unknowingly.

And I remember sometimes saying that and getting shouted at by some prisoners, like, "That's nonsense," or various things that they would say. They'd get angry to hear me say such a thing. And then the guards would just shut them up, would just sort of stifle the pushback. So, very interesting experience.

So I got involved with that with Dr. Farr, and actually, ethically, they didn't allow us to actually do the HIV part of that serosurvey, so it became a hepatitis serosurvey.

[00:38:17]

Tacey Ann Rosolowski, PhD

[00:38:18]

Why wasn't that allowed?

[00:38:19]

Michael Fisch, MD

[00:38:19]

Because they were not prepared to deal with the information. So, telling Virginia State Prison System that x percentage of the intake people have HIV, when you have no plan, they weren't prepared to do it. They didn't think that was an ethical idea. So they just stopped it.

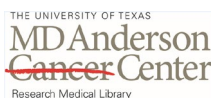
[00:38:37]

Tacey Ann Rosolowski, PhD

[00:38:38]

Now, who stopped it? Was it the Medical Center?

[00:38:40]



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Michael Fisch, MD

[00:38:41]

The IRB or some—it just didn't fly.

[00:38:44]

Tacey Ann Rosolowski, PhD

[00:38:45]

That in itself was an ethical lesson.

[00:38:47]

Michael Fisch, MD

[00:38:47]

That didn't fly. It was a very puzzling to me and disappointing to this team.

But then seeing the abstract come out and seeing my name in an abstract book in tiny little print, and then these doctors' names and then just "M. Fisch" in tiny print, I got such a thrill out of that. I was just—I just wanted to do more of that. Here's a project with a hypothesis, and we had to execute, and it turned into a piece of information that we were ready to share, and I just thought, "That's fantastic." So I became, basically, driven to want to do more research.

And then I got involved with Dr. Farr with some other projects. He would counsel me and just talk with me and inspire me, and I did a—maybe the next summer, stayed over in Charlottesville for the summer and was involved with a chart review study.

[00:39:51]

Tacey Ann Rosolowski, PhD

[00:39:51]

Now, was this in medical school or still undergrad?

[00:39:54]

Michael Fisch, MD

[00:39:54]

I think this is late undergrad. I'm trying to think. This might be, like, summer after my senior year.

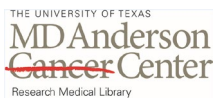
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Tacey Ann Rosolowski, PhD

[00:40:03]

Okay. So just prior.

[00:40:04]



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Michael Fisch, MD

[00:40:04]

Or maybe right around then, yeah. And did a chart review on looking at risk factors for pneumococcal bacteremia, so that was fascinating, like looking at all these charts, talking to Dr. Farr about just all the concepts that go in with a project like that, the way you set up a project like that. And I remember after going through many, many charts over maybe a week and then writing down which people had the bacteremia, and I think I had written the names of the organism but not like pneumococcus pneumoniae or strep pneumonia. I think I only wrote like one part of that, like strep or whatever, and I remember after doing all these charts, he's like, "You're going to need both parts of this organism." So I thought, "Oh-oh. Okay." And, oh, my gosh, that was a bunch of charts to go through again. So I learned some things the hard way, but just being around that was a lot of fun.

[00:41:13]

Chapter 05

A: The Researcher;

Bringing Focus to Patients' Emotions

Story Codes

A: The Researcher;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

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

D: The History of Health Care, Patient Care;

C: Patients;

C: Patients, Treatment, Survivors;

Tacey Ann Rosolowski, PhD

[00:41:14]

So when in medical school did you kind of select a research focus, or did it happen then?

[00:41:19]

Michael Fisch, MD

[00:41:20]

So I was interested in ID, so I have this mentor who's in Infectious Diseases, and ID was perfect because multi systems involved, the complexity, right? All organ systems, all ages, happens in young, happens in old, happens in the hospital, happens in the community setting. Lots of bugs, lots of drugs.

UVA was famous for its infectious disease expertise. They had Mandell, Douglas, and Bennett's *Principles and Practices of Infectious Diseases*. They called it the PPID. It was like the bible of ID, and many of those authors were from UVA. Mandell was the head of ID at UVA, and Dr. Farr was on the faculty and had some chapters in there. So this was the strength of the department, and a big, thick book, chapter after chapter of infections and all kinds of cool things.

So I loved the complexity and I liked ID, and at some point that was sort of my mindset. I guess when I first started med school, when I first went into medicine, I was wanting to be a pediatrician, I guess, because that's what I knew from my own pediatrician. But then my pediatrics rotation was more inpatient oriented, and I just saw developmentally devastated children and that you couldn't really talk to, and that didn't appeal to me that much.

Commented [T5]:

In this segment, Dr. Fisch describes the process of entering a fellowship program in Hematology/Oncology and General Internal Medicine at Indiana University at Bloomington. He then explains that it was during this time that he became interested in "things that were happening to cancer patients that we weren't talking about." He gives examples, first discussing the problem of depression in cancer patients. He then explains that on the transplant service, patients were uninformed about treatments and he did a project on the effect of informed consent on emotions.

But ID, with all these smart guys doing clever diagnostic thinking and quite a lot of science about the biology of infections, and so anyway, I liked that. But then I think in the course of my training, my dad would sort of cross-examine me and poke some holes in this idea of infectious diseases, because it seemed to him—and he's not in medicine, but it seemed to him that there is no special angle that the ID—like nobody's afraid to prescribe antibiotics, and so you didn't really have your turf. I mean, everybody can do, and they can do it wrong, but you didn't have any exclusivity, and it's a very intellectual field. But he was interested in me keeping an open mind.

Then as I did my hem/onc rotations, I found, well, here's another realm of the same sort of things that I like, right? Multiple systems involved, the whole body, full range of ages, and lots of cancers, lots of drugs, different tumors, different—so chemo and tumors was to microorganisms and antibiotics, same general premise of wild complexity, multisystem, except instead of being largely a consultative arena, it was longitudinal; that is, making relationships with patients and families, helping them understand “What's happening to me? What's going to happen to me? What can be done to help me?” That was part of the skill set, so that whole personal part, mapped with the complexity, really got me interested. And then also my own family history. I had some family experiences with cancer, including during medical school a grandfather who had cancer and an uncle who had a cancer. So I was, I guess, becoming more interested in cancer medicine in the course of those personal experiences, plus just realizing it mapped my skill set reasonably well.

[00:45:03]

Tacey Ann Rosolowski, PhD

[00:45:03]

Were those individuals treated at MD Anderson?

[00:45:05]

Michael Fisch, MD

[00:45:05]

No, none of them came to MD Anderson.

I might take a—

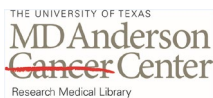
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Tacey Ann Rosolowski, PhD

[00:45:11]

Absolutely. We're taking a quick break at about eight minutes of twelve.

[00:45:16]



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[recorder paused]

Tacey Ann Rosolowski, PhD

[00:45:17]

So I will let us resume. Okay, we are back after a brief break, and it is about two minutes of eleven. I misstated the time. It was 10:53 when I turned off the recorder.

All right. So you were talking about research on—or your kind of tracking into hematology and oncology.

[00:45:42]

Michael Fisch, MD

[00:45:43]

Yes, tracking into that. Even though my mentor was in infectious diseases, some of the research I'd done was in infectious diseases, I'd just gotten hungry for formulating hypotheses, figuring out how to configure experiments of some sort, whether it's a retrospective cohort study or some sort of prospective study that would help answer the question, but becoming intrigued with hematology/oncology because it had some of the same good features of infectious diseases but also it seemed to have its own special turf, like other people don't give chemotherapy because they just want to see if they might be able to get it right. They seemed to respect that they're not going to be doing that unless they're totally qualified, whereas, again, antibiotic world seemed open to all.

[00:46:37]

Tacey Ann Rosolowski, PhD

[00:46:38]

Now, let me ask you, were you already thinking about a career in academic medicine at the time?

I mean, where's private practice in all that? What was your thinking?

[00:46:46]

Michael Fisch, MD

[00:46:47]

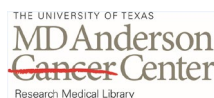
Yeah, never considered private practice.

[00:46:48]

Tacey Ann Rosolowski, PhD

[00:46:48]

Really?



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[00:46:48]

Michael Fisch, MD

[00:46:49]

Never even came close to thinking about that.

[00:46:51]

Tacey Ann Rosolowski, PhD

[00:46:51]

Why is that?

[00:46:52]

Michael Fisch, MD

[00:46:53]

You know, I don't know. I was so hungry to learn, and the environment of learning seemed so much in the academic world of asking questions, doing research, being around other people who were super curious, who were trying to change the way care was delivered or find new approaches new therapies. So the whole environment was all that I want. I mean, that was always what I wanted.

[00:47:20]

Tacey Ann Rosolowski, PhD

[00:47:20]

That makes sense.

[00:47:21]

Michael Fisch, MD

[00:47:21]

And I really never wavered from that. I had done that retrospective chart review study and then the next summer, the summer after my first year in med school, I got involved with a prospective study where I got to—well, the study involved a silver-impregnated catheter, like a catheter cuff, that when you're putting in a central venous catheter, the cuff would expand and the silver ion would have this antimicrobial effect. The whole idea was to reduce catheter-related infections. So the study was a randomized trial of the silver-impregnated cuff—they called it VitaCuff—versus an ordinary catheter.

And my job was to randomize the patients when they were getting these things put in and to collect some clinical data at the time of the insertion of the catheter. So I got to carry a pager around, which at the time was a big thrill, for a whole summer. I'm on call the whole summer, and if somebody needed a catheter put in at two a.m. in the ICU, then I showed up at the ICU and did the randomization assignment and took down the clinical data. So that was sort of thrilling, but it was also, as I found out, pretty disruptive. Maybe it's a late afternoon on a week night and I'd be trying to play some golf before it got dark, and then my pager would go off and I'd have to haul off the golf course, drive in to the ICU, and get ready to do that. So I learned the sacrifice of what being on call really does.

I remember going on a date with my wife, who is now my wife, and I remember I had a dinner date and I was making—the only thing I knew how to make, I think, was spaghetti. And I was having over for spaghetti and some bread in the oven. (laughs) Totally lame. But I think I got paged in to do the VitaCuff before she even showed up, so like at the time that she was supposed to come over, I was gone. (laughs)

[00:49:38]

Tacey Ann Rosolowski, PhD

[00:49:39]

She still married you?

[00:49:40]

Michael Fisch, MD

[00:49:40]

Yeah, yeah. But this was not a time where you just text and say, "I've got to go." I mean, it wasn't exactly as easy to sort of not be there.

But that's the kind of thing that that study was. But that was a prospective study.

[00:49:53]

[telephone interruption]

Tacey Ann Rosolowski, PhD

[00:50:10]

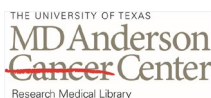
So tell me how your work with Dr. Farr—or did you kind of shift mentors as your research focus shifted in medical school?

[00:50:22]

Michael Fisch, MD

[00:50:23]

Yes.



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[00:50:24]

Tacey Ann Rosolowski, PhD

[00:50:24]

Then what happened after?

[00:50:25]

Michael Fisch, MD

[00:50:25]

Right. So, no, I didn't really shift mentors, so he remained my mentor. And I didn't really do research related to hem/onc while in med school. I didn't shift. Med school was just getting through med school, and my research experience was in the summers of my first year. Then after that, it was—you know, I don't really remember much specific research, just digging through all the other things you had to learn and do in medical school. And then I went into internal medicine training at UVA, so I went from undergrad to med school to internal medicine, all at UVA.

[00:51:09]

Tacey Ann Rosolowski, PhD

[00:51:10]

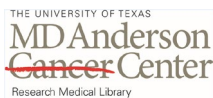
And you did your residency in 1993.

[00:51:12]

Michael Fisch, MD

[00:51:13]

Right. It was '90 to '93 was my residency, yeah. And so during that period of time, I started to—again, totally absorbing just to do internal medicine residency, but we did publish a paper in the *Annals of Internal Medicine* related to our pneumococcal bacteremia study, so we were following through on that work, and it kind of came out while I was in residency. I remember that my colleagues were impressed that I had a publication during residency. It was really the fruition of something that started earlier. And our catheter study got published in *JAMA*, so those kind of things were exciting. And I got involved in the kind of things that internal medicine residents get involved in, just little projects, case reports at the local chapters of our Medical Society chapters, and, you know, just little academic things that you can do as a resident, talk about, publish a case report of a weird infective endocarditis or this or that, you know, that sort of thing. If you look on my CV, you'll see little dabbles of the kind of things you might expect residents to be able to get involved with.



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I wasn't one of those folks who was on an MD/PhD track, a physician/scientist track. Now, as I interview people who want to go into fellowship here and I realize just how incredibly accomplished they are, I mean, the fellowship candidates for this program are way more accomplished than I was at that time. They have something more to say than a case report, generally speaking. They have some of the similar things, that they like what they're doing, they're hardworking, their colleagues respect how they're functioning in their role, they have potential, but there are people who come to our fellowship who are quite scientifically accomplished and have been doing lots of lab work and are physician/scientists ready to conquer the world. But I was a clinician, clinical researcher.

[00:53:23]

Chapter 06

A: The Researcher;

Entering the New Field of Symptom Experience

Story Codes

A: The Researcher;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

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

D: The History of Health Care, Patient Care;

Tacey Ann Rosolowski, PhD

[00:53:25]

So you made the decision to do the fellowship in hematology and oncology and general internal medicine, so tell me about that shift from the residency to the fellowship.

[00:53:34]

Michael Fisch, MD

[00:53:36]

So when I was interviewing for fellowships, I think I looked at Duke and University of North Carolina, and I even interviewed at the Food and Drug Administration. Then one of my colleagues, a guy named Steve Stevenson [phonetic], he said, "Well, I'm going to look at Indiana University." We'd heard good things about Indiana University because Dr. Lawrence Einhorn was very famous at that time for having developed a curative regimen for testicular cancer, so he was sort of a legend even—this is sort of the pinnacle of his sort of stature as a groundbreaking oncologist and was making Indiana University famous for that series of work. And one of my attendings, a guy named Mark Stewart at UVA, had trained with them at IU and was part of that sort of alumnus family and had spoken highly.

So I decided to go with Steve just to look at it. I couldn't imagine that my wife would ever want to be in Indiana. It was too far from home. It seemed implausible. But I thought, you know, it'd be a good experience for me to go out there and just round out my look, and so I tagged along with Steve at the last moment and ended up interviewing with them. You know, I think when I first got there, I think they thought I was a patient. I think they were giving me patient forms, and I don't think they understood why I was there at first. But we came to tell them I was there to interview, and they let me interview. Then I loved it after I talked to the chairman. It wasn't Dr. Einhorn who was the chairman. It was another hematologist who was well known. But I loved it, and I called my wife and said, "You know, you've got to come to Indianapolis. This is awesome." She was a cardio transplant coordinator, so she could hardly just up and fly to Indianapolis to look at it right then.

Commented [T6]:

In this segment, Dr. Fisch explains how his career path evolved once he decided, during the second year of his fellowship, to focus on symptom experience. He was involved in a research project on cisplatin adducts when he decided to focus on quality of life research and realized he needed additional training to work in this new field. He took another fellowship in general internal medicine and worked with Dr. Robert Diddis, who advised him to do a Masters in Public Health (Indiana University, Bloomington, Indiana; MPH conferred in 1997). He explains how this training benefited his approach to quality of life problems.

But I decided, “This is great. I want to come here,” and that turned out to be a really good decision. It was a great place to get trained, and had wonderful mentors there. It was one of those experiences where I couldn’t figure out in real time, it wasn’t obvious to me, but all these people who were around me then were extremely talented and were on their way to becoming extremely well known; they just weren’t well known to me at the time. They were just kind of like these are just your family, these are just the dudes who are training you. (laughs) But a whole set of them, they were talented and became known for their extraordinary talent. So a whole set of people had exceptional careers.

When you look back, it’s like you see in sports sometimes, you’re like, you know, those guys in high school, they all became pros. That was quite a concoction of people. You just couldn’t tell at the time. They seemed ordinary then, but they were really extraordinary people, and I had that feeling of appreciation as the years have gone by for just who I was around during that training.
[00:56:56]

Tacey Ann Rosolowski, PhD

[00:56:57]

So how did that training change you?

[00:56:58]

Michael Fisch, MD

[00:56:58]

Well, how did it change me? The main thing that it changed me, I became interested in the things that happen to cancer patients that we weren’t talking about. So I remember thinking in my continuity clinic at the V.A. Hospital, a fellows clinic, that I’m spending all my time thinking about these treatment decisions, like this man has colon cancer and he’s already been treated with this, and now what should we do with the next treatment. Or what are the most recent studies that inform me about how to treat lung cancer? So I was thinking about that, reading about that. In case conferences, we were all debating and learning about those things. But then in the course of a clinic day, there would be one or two or three times when any of that mattered, and all the rest of the things that were happening, I hadn’t been thinking about, didn’t have articles to read, and nobody was talking about. And I thought in the interstition of care are a million questions that totally matter that nobody is talking about.

[00:58:24]

Tacey Ann Rosolowski, PhD

[00:58:25]

Such as?

[00:58:25]

Michael Fisch, MD

[00:58:26]

So one example would be this one man with colon cancer who had been on a clinical trial for advanced cancer, and he had progressed, and I think he was on Hospice at this point, but he was still coming to the V.A. and seeing me in follow-up. And I'm getting ready to see him, and his wife and his sister sort of confront me in the hallway before I step in the room, and the sister says, "His Hospice nurse wanted us to ask you about this." She has a piece of paper, and the word "Paxil" is written on it.

I looked at it and I said, "Oh, I know what that is. That's an antidepressant. Do you think he's depressed?"

"Oh, absolutely. He's totally depressed."

I said, "Okay. I'll talk to him about that."

So I talked to him and I said, "Your family is really concerned that you're depressed. Are you depressed?"

He said, "No."

And I asked him to tell me a little bit about, you know, "Take me through your day and what sort of things are you doing."

He's like, "Well, I like to go upstairs and work on the computer, and I like to be a little bit by myself, and that's how I feel most comfortable at the moment."

And I thought, "I don't think I can solve this with a prescription or a pill. I don't think he's really depressed."

But the sister and the wife are like, "No, he's depressed."

I thought, "Well, I don't know how to go forward from here." (laughs)

So I went and asked my attending physician who was staffing clinic, who was the director of the Cancer Center, Steve Williams [phonetic], wonderful, wise oncologist. Talked to Dr. Williams about this, he comes and talks to the patient, goes through some of the same things. We go back out of the room. I'm like, "Dr. Williams, do you think he's depressed?"

He's like, "I don't know. We should call Psych. Call Psych."

All right. So consult the psychiatry team, keep going and seeing the other patients in clinic so I don't get too far behind. Psychiatrist comes down, spends it seems like forever in the room talking to the patient and family, and then we come back. "Okay. So do you think he's depressed?"

"I don't know. We could give him an antidepressant, I guess."

I'm like, "That's where we started. Nobody knows? Does nobody know whether somebody's depressed or not? Is there no way to know?"

Then you look up the literature about that, started to read about it, and then I presented it at a case conference with all these famous and brilliant experienced faculty. Their attitudes and opinions about this were all over the map, ranging from, "This is not really our job. If I think they might be depressed, I get Psych and Psych just sort of takes the ball and runs with it," to Dr. Einhorn, who said, "You know, I think that Lilly, when they studied Gemcitabine," a chemotherapy agent for the treatment of pancreatic cancer, "compared to 5-FU," another chemo agent, "that was an unfair fight. They should have squared Gemcitabine up against a different Lilly drug, Prozac. That would have been a fairer fight."

So I thought, "Well, that's a striking comment." But they didn't seem to know, but it seemed to matter. And the literature was very underdeveloped. I was underwhelmed with what anybody seemed to know about that, and so I thought, "You know, I'm going to get into that stuff."

I was also interested when I did my bone marrow transplant rotations, we had way too much bone marrow transplant rotation. We were like slave laborers, and the inpatient part of it was a lot of service. But in Transplant, I became really fascinated with how well informed the people who were getting transplants were about what their disease was, what Transplant's goals were, what the data was, I mean just their general sense of what was happening, and I was mostly taken aback about how poorly informed they were, even though they were smart. It's not like they were uninformed. They were just often, seeming to me, uninformed. Then I was trying to figure out is it because nobody's trying to tell them anything or because they're telling them in ways they don't understand, or is it because they're telling them in ways they could understand, but they choose not to understand it. It was sort of complicated.

I put together a project about informed consent and how it affected people's sort of reactions, their emotions. In our project, we kind of figured out in my project that information had a dampening effect on emotions, that it tended to trim off the edges, make people who are very at ease and confident feel less confident and people who are very ill at ease and out of sorts feel less out of sorts. So information had a dampening effect. That seemed to be the result of the project.

But the cool thing about that was I was curious, I had a question, I wrote a small grant, and I got like a \$5,000 grant to do that informed consent preferences project, and, again, that was like the same feeling I got when I first saw my name in microprint in an abstract in an infectious disease meeting, and that is the thrill of getting a grant. Somebody's giving me money to address a question that I laid out, why this is a good question. Then I get to put together a team and spend some money to make it all happen, and then I get to travel to a meeting to present it, and all that stuff.

But, again, that was not like the biology of leukemia cells and how to conquer them. This is about the experience of bone marrow transplant patients, and I was interested in the experience of a solid tumor patient with respect to depression, and their family's experience about their depression. So this was the symptom experience in patient and family events in the midst of cancer care. I became super interested, so I decided during fellowship, "That's what's my fascination." My job is to understand cancer and apply that knowledge, but what I could create is hypotheses and collecting data that inform this patient experience, this patient and family experience piece, and symptom research is what I wanted to do.

[01:05:28]

Tacey Ann Rosolowski, PhD

[01:05:28]

So I was actually confused. (laughs) Now, did you continue with your hematology research? Because it seems like there was sort of [unclear].

[01:05:44]

Michael Fisch, MD

[01:05:43]

So I was doing hem/onc fellowship, but I became interested again in research, which would seem like bone marrow transplant research, but it's not really about the transplant or about the disease, but people.

[01:05:54]

Tacey Ann Rosolowski, PhD

[01:05:55]

So your focus really shifted during that period.

[01:05:58]

Michael Fisch, MD

[01:05:58]

So I started to get interested in that, and then I decided, “Well, I want to have an academic career and I want to be a clinical researcher.” I had the sense in my second year—after the first year of fellowship, I did this, started this informed consent project in Transplant, and the rest of it, it was just unbelievably hard work, I mean just clinically fully subscribed.

In the second year and third year, you had some time to work on some research projects. It was expected that that would be part of your fellowship. So you had to sort of identify what you were going to do, and I was going to go into George Sledge’s lab and work with nude mice, injecting nude mice with different tumors. George was an amazing clinician and also had his lab where he was doing these kind of experiments, so he was just a tremendous role model for a physician who was a clinical researcher, clinical trialist, but also a lab researcher. He was sort of a Renaissance man, you know, amazing guy, and so fun to work with him clinic, I thought it would be great to work with him in a lab.

In fact, we’d also published with him another project on cisplatin adducts, and that was a project where I basically got involved with a project in progress and had a chance to learn it and write it up and had another thrill of writing that up. But I didn’t conceptualize it and I didn’t do the experiments, but I just got involved in flow. But I was working with Dr. Sledge and Einhorn on that, and so I was geared up to—I was willing to work endlessly in the clinic and then put even more time into these other projects. So I had a lot of “want to.” Like many people in this field of medicine at any level, and certainly in hem/onc, are full of people with sort of a freakish desire to work towards the craft. No different than in sports, right? You talk to professional athletes, and it’s not like they’re not freakishly interested in trying to get good at what they do. They’ll say they shot a thousand free throws in a summer or whatever, or a certain number per day, and it’s like, wow, that’s crazy. But these are crazy things that people in this sector will do to try to achieve things.

[01:08:22]

Tacey Ann Rosolowski, PhD

[01:08:22]

Well, it’s also asking speculative questions, too, though, which seems something that’s a little different in the cancer field. I mean the “what if” questions.

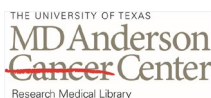
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Michael Fisch, MD

[01:08:34]

Right.

[01:08:34]



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Tacey Ann Rosolowski, PhD

[01:08:37]

I mean, in sports, it's like, well, what if I could bat whatever, but in cancer, it's like what if you do something entirely new.

[01:08:48]

Michael Fisch, MD

[01:08:48]

Yes. You could try things that are really unusual or things that would say, "Let me tell you why that won't work."

But anyway, I was going to go into Dr. Sledge's lab, but then I decided I wanted to do a clinical research and I wanted to do it in this other realm of sort of patient-related stuff. Quality-of-life stuff is what the label was. I want to do quality-of-life-type research. And I sort of realized that I wasn't going to be able to do that just because I sort of self-declared that was going to be my expertise. My mentors had become expert by just being who they are and just doing experiments, but I sort of realized that my pathway couldn't be the same as theirs. The world was changing so that it seemed like you'd have to get additional training to be able to do what they do, even though they didn't get trained, but I would have to get trained. I couldn't reproduce their path.

So one thing I did is I went to Dr. Sledge and I told him I wanted to learn more about quality of life and asked for permission to basically take this other fellowship and work on this master's degree. And he was wonderful and gracious, and he's still a great mentor. But I remember him saying, "You know, that's great. Pursue that. But, you know, Mike, you're never going to cure cancer doing that," and he was right. I have not cured cancer and I'm not on my way to curing cancer. But that was sort of what everybody was trying to do, so it was sort of like declaring that I'm not even going to try to do what everybody seemed to be wanting to do. I'm never going to cure cancer doing that. You know, think about MD Anderson. The mission of MD Anderson is to eliminate cancer in Texas and the nation and the world. That is a big, bold, wonderful statement that drives this place, and I'm very proud of it, but it doesn't have any notion of the person.

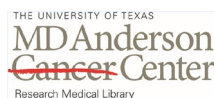
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Tacey Ann Rosolowski, PhD

[01:10:50]

Mm-hmm. Exactly.

[01:10:51]



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Michael Fisch, MD

[01:10:51]

You eliminate cancer in Texas, the nation, and the world. You're never going to cure cancer doing what I do.

[01:10:57]

Tacey Ann Rosolowski, PhD

[01:10:58]

How do you reduce the suffering of people before that happens?

[01:11:00]

Michael Fisch, MD

[01:11:00]

Yeah. That's not part of that statement. You have to decide that you're going to fold that in, but it's not sort of inherent to that statement.

So he was very gracious about that, but I wasn't even sure what needed to be done. I talked to some people in hem/onc, and they said, "You know, if you want to learn how to be a clinical trialist, you might want to talk to Bob Dittus. He was the head of General Internal Medicine at the Regenstrief Institute, which is associated with the Wishard Hospital, which is right in the same complex at IU. There was IU University Hospitals in Indiana, in Indianapolis, the Wishard Hospital's like the public safety net system, and then the V.A. Hospital. So there's basically three different health systems in one little complex.

[01:11:46]

Tacey Ann Rosolowski, PhD

[01:11:47]

Can I ask you a question? Was there a name for what you wanted to do at the time? Or was this really—

[01:11:53]

Michael Fisch, MD

[01:11:53]

Quality-of-life stuff.

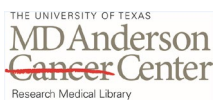
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Tacey Ann Rosolowski, PhD

[01:11:55]

Right. But, I mean, had it been formalized as a field?

[01:11:57]



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Michael Fisch, MD

[01:11:58]

No.

[01:11:59]

Tacey Ann Rosolowski, PhD

[01:11:59]

Which is the problem.

[01:11:59]

Michael Fisch, MD

[01:11:59]

There's no field. So it didn't make any sense.

[01:12:01]

Tacey Ann Rosolowski, PhD

[01:12:02]

Yeah, right.

[01:12:03]

Michael Fisch, MD

[01:12:03]

You're never going to cure cancer doing that. What are you talking about?

[01:12:05]

Tacey Ann Rosolowski, PhD

[01:12:05]

Well, right. But, I mean, that's sort of the systemic problem. You were working with a paradigm nobody else—I mean—

[01:12:11]

Michael Fisch, MD

[01:12:10]

Yeah, [unclear].

[01:12:12]

Tacey Ann Rosolowski, PhD

[01:12:12]

You didn't even really know. You were saying, the way you started it earlier, "I was interested in questions that nobody was talking about, the issues that nobody was talking about."

[01:12:20]

Michael Fisch, MD

[01:12:21]

Right. And maybe there were people talking about it, but they weren't these kind of people. There weren't oncologists talking about it. You could read an occasional article. It's not like the phrase "quality of life" didn't exist. There were some quality-of-life stuff, but it was very nascent and not well formulated, and there were not role models in oncology who were like the quality-of-life oncologist people. I mean, I didn't know who those people would be.

But when I wanted to become a trialist and learn more about this, they sent me to Dr. Dittus, and he started to describe, "Yes, you can come and you'll do a general medicine fellowship, you'll get a master's in public health, you're learn biostatistics and epidemiology, clinical decision-making. You'll be taking some courses in Bloomington. You'll have to drive to Bloomington. You'll take some stuff here in the Regenstrief Institute. We'll get you involved with research projects." So that was going to take two years, so it would overlap my third year of fellowship, and then I'd have to stay one additional year to finish that thing. But then the way he described it, that wouldn't be over. It's like then you'd be just barely read to learn. I mean, that just sort of gets your hand stamped, but you're going to need to be mentored in it. So he was describing a whole pathway that was, like, beyond my scope. Like I kind of thought that maybe there'd be a class to take, you know, a series of seminars, but two years, another degree, and then just a whole other pathway to launch into this, I was shocked, I mean truly shocked. But I said, "Okay, let's do that." (laughs)

It was a long rabbit hole, but I thought, "If that's the rabbit hole, let's do that. Let's go there." So, you know, I did that. I started to work on that master's while I was still in fellowship and then stayed an additional year, kept my clinic, basically just did four years of fellowship for the price of—well, they found another little stipend, so they could at least pay me my fellowship salary a little bit longer, and I did all that.

[01:14:29]

Tacey Ann Rosolowski, PhD

[01:14:30]

So you got your master's in public health in '97.

[01:14:32]



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Michael Fisch, MD

[01:14:33]

Yeah. So instead of being a fellow from '93 to '96, I was there from '93 to '97, got that MPH. But that was not a path that many people were doing. That was not like, "Who here wants to do clinical research and get a master's?" Now that's part of the menu of options. That's part of what people knew. At that time, that was, like, made up. We just sort of made it up by accidentally finding somebody who felt that was what you needed to do and then doing it.

[01:15:00]

Tacey Ann Rosolowski, PhD

[01:15:01]

Well, you were lucky.

[01:15:02]

Michael Fisch, MD

[01:15:02]

I was lucky. I have many, many people to be grateful towards and lots of just good fortune, but I got lucky enough to sort of put that investment of thinking, because the background, particularly behavioral change theory, some of the conceptual stuff about basically health education-type stuff and behavioral change work in the biostats, you needed time to just wax with that and spend figuring it out and taking courses that taught me how to use Stata, one of the statistical programs that would enable me to function a little bit the rest of my career in the world of statistics. I mean, it's just hard to learn that little bits at a time. You need to sort of invest and get up to speed at a certain level.

[01:15:57]

Chapter 07

A: Joining MD Anderson/Coming to Texas;

Coming to MD Anderson to Learn Palliative Care on the Job

Story Codes

A: Joining MD Anderson;

A: Professional Path;

Tacey Ann Rosolowski, PhD

[01:15:58]

So what opportunities did that all open up? I mean, this was like a watershed moment.

[01:16:02]

Michael Fisch, MD

[01:16:02]

Yeah, so that's a watershed moment, and it did two things. One, so I took my first job back at the University of Virginia. My strength of my clinical training was genitourinary medical oncology, which is the strength of IU's work. Then I also had a combined appointment in the Department of Health Evaluation Sciences. A guy named Bill Knauss [phonetic] and Al Connors [phonetic] was there, and these were very highly regarded health services researchers. Bill Knauss had led the support study, a big famous study at the time. Anyway, I had great mentors.

And I had two offices. So I had a combined appointment. I had an office in this place and then I had an office in Hem/Onc, and I had this tremendously busy clinical life doing all the GU cancer care. But also it's like living two lives. Then I'd try to be a health services researcher in between the lines. So you can't imagine how much work that is. It was just playing two career hands at the same time, but you can do that in the first—you know. You're young. You're fired up.

I wrote an R01. I didn't know any better, so I wrote an R01 and a P30 grant and an ASCO Young Investigator Award. I mean, in the first two years I was there, I was building a practice, I was working as a clinical trialist with ECOG, and I wrote a trial there. In fact, I started to work on a trial that I'd gotten going during my fellowship, a Prozac vs. placebo for advanced cancer patients, coming basically out of that question from that V.A. patient. That V.A. patient question led to a retrospective chart review study that I did as part of my MPH about how frequently antidepressants were being prescribed in cancer patients. So I figured out how to use the electronic record and do that project as part of the MPH.

Then we formulated this prospective trial with the Hoosier Oncology Group, which was a consortium that my IU colleagues were leaders in, and they helped mentor me to put that study together. So I was running that trial now at UVA and being a trialist and writing this health services research stuff and just working hard.

Commented [T7]:

In this segment, Dr. Fisch explains how he moved to MD Anderson from a position as Assistant Professor at the University of Virginia Health Science Center in Charlottesville. He recalls management issues in Charlottesville that helped convince him to take another position. He talks about presenting a paper on cancer and depression at a conference held by the American Society of Clinical Oncology. There he met Dr. Eduardo Bruera, who had been recruited to set up a palliative care program at MD Anderson. Dr. Fisch describes the advantages of the offer he was made to join MD Anderson to help establish that program, working from the Department of Critical Care and Anesthesiology.

What happened there in my first two years is that UVA seemed to have some resource constraints and, I think, really conceptual restraints about how to value oncologists ultimately. I was sharing with the thoracic expert a nurse and we were sharing one secretary, so I had a half nurse and a half secretary. And then our nurse started to be asked by the administrators to do certain night shifts so that she wasn't always available to us in clinic, so it was really less than half a nurse. And then our secretary took another job somewhere else in the institution, and they decided not to replace this secretary. And I thought, you know, if I can't have a half nurse and a half secretary—I mean, we were borrowing other people's secretary with no intent to fill that. I thought, "This is not going to work. This is not possible."

[01:19:26]

Tacey Ann Rosolowski, PhD

[01:19:30]

Was that some weird political vote on—

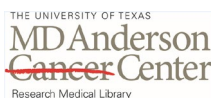
[01:19:32]

Michael Fisch, MD

[01:19:33]

You know, I think it had to do with the attribution of value of oncologists, because if you look at oncologists and only credit them for the evaluation and management of the patients and the billing that goes with that, then they're just like expensive, needy rheumatologists. They need a lot of resources and support to do a cognitive discipline. But in truth, oncology was lucrative because lab and path and imaging and chemotherapy was driving lots of revenue, and so that's true here and it was true there. But the revenue was not being attributed to the oncologists; it was being attributed to the Cancer Center. So if you didn't really know the business of oncology, you might have the misperception that the pharmacist in the Cancer Center is the world's most valuable individual who should have gold-lined walls and marble sink, and the oncologists are worthless and you can't even afford a half secretary for those worthless individuals.

So I think it just got misunderstood, and in a matrix hospital like that, it seemed to me—this is just my naïve view at that time, but it seemed like they understood the business of how do you make a Heart Center work and what's the business of cardiovascular care and what's the business of orthopedics care, but the business of cancer care was different, the model was different, and it was conceptually not well understood by everybody. It was understood by some people. But it was possible to kind of get off kilter in how you thought about how to attribute value. They were paying me \$91,000 a year to work very, very hard, and I probably would still be there if they would give me, you know, a half secretary, a half nurse, and about 2 percent increase per year, but they didn't. (laughs)



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So I became open-minded to what other options there might be, and that's where MD Anderson came in because I presented a poster about some of this depression work, some other depression project that I had going on at UVA that I'd started in those two years in my health evaluation sciences realm. And I presented at ASCO in the spring of '99, and Dr. Bruera, who was in Edmonton at the time, but he'd been recruited to start Palliative Care at MD Anderson, and he was looking to build his faculty, he saw my work and talked to me at ASCO and basically offered me a chance to come work for him.

It turned out that that would be a chance to work with a very famous, brilliant guy who's a specialist in palliative care. I had nobody to sort of teach me quality-of-life stuff at UVA, and was just a self-declared interest guy, but I didn't have a way to learn it other than by myself. But here's somebody who was established in that field, could teach me, who'd build a department. And I'd get an 80 percent raise and I'd get some basic resources. I thought, "I'll try that." There's no fellowships in Palliative Care at the time, right? So you could just declare yourself Palliative Care faculty, self-declared, "All right, I'm that now," and I'll learn on the job, and they'll pay me on the job to learn palliative care.

I remember telling my family, who were very upset to leave central Virginia, because Charlottesville is kind of right in between where my parents and my wife's parents were, so it was a perfect situation for us, but professionally it wasn't perfect. So go all the way to Texas for what? But I thought, "You know, I'll come here for a few years, and I'm very interested in learning this stuff, and if I don't like it, I'll go back and do what I do. But, you know, nothing bad could happen here. I don't see what bad comes out of coming to MD Anderson, working with this kind of person in this environment. The narrative of my career will not be ruined by this move." (laughs)

Chapter 08

B: Building the Institution;

Building a Palliative Care Program at MD Anderson

Story Codes

B: MD Anderson History;

B: MD Anderson Culture;

A: Overview;

A: Definitions, Explanations, Translations;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: Obstacles, Challenges;

C: Professional Practice;

C: The Professional at Work;

Michael Fisch, MD

[01:19:33]+

So I came, and it was the most strange experience, because I leave the common world of Internal Medicine Division and Department of Hematology/Oncology, and then I come here, and Tom Feeley was my first chair. He's the head of Critical Care and Anesthesia. So I'm in the Division of Critical Care and Anesthesia. That's where Palliative Care and Rehab sat. Eduardo [Bruera] had come in July, by July he showed up, so it was July of '99 he starts. By November of '99 I'm here. I gave them seven weeks' notice at UVA. In hindsight, I should have given them longer. I didn't know how to properly transition from one place to another. But they seemed to want me to come here fast, and so I did. (laughs)

But then I'm working. The initial sort of culture, the natives who are already here were anesthesiology-trained cancer specialists, so these were not Internal Medicine. These were people who were not acculturated the way I am. They're not from my tribe. (laughs) They're not oncologists. They're not even internists. They're anesthesia pain people who do a lot of procedures.

Commented [T8]:

In this segment, Dr. Fisch talks about the challenges faced as he and others set up palliative care program at MD Anderson from scratch. He defines palliative care, which he stresses is much broader than pain management. He also explains how the culture of MD Anderson worked against acceptance of palliative care. Dr. Fisch notes that the palliative care program stressed quality of life and that a decision was made to change the name to the Supportive Care Center to help overcome resistance. He gives examples of how he and other palliative care providers would figure out how to "create an interface" with treating oncologists, so they would integrate a palliative care provider into the team.

Dr. Bruera's goal was to recruit medical experts like me and other palliative care experts, and he recruited Donna Zukhovsky and Paul Walker [phonetic]. Suresh Reddy [phonetic] was an anesthesia-trained person who was there at the time. Larry Driver [phonetic] was there at the time. So those faculty, Suresh Reddy, Larry Driver, Donna Zukhovsky, Paul Walker, were already professionalized in this realm, and they were not tabula rasa, learning on the job. They were recruited because they know what they're doing. I was recruited because I was willing to learn. (laughs) But anyway, they were great people and I was able to learn from them. And as we were building from scratch, we weren't super busy at first, right? We had to sort of show up, and

people had to figure out how to ask us to do anything. So it was very disconcerting at first, it was so unusual.

[01:26:00]

Tacey Ann Rosolowski, PhD

[01:26:00]

What was going on at the institution at that time that motivated the creation of this department, Palliative Care?

[01:26:09]

Michael Fisch, MD

[01:26:09]

Yeah, that's a good question, because that's a backstory that I—you know, the part of the frontstory was Eduardo had a job to give and had a lot of charisma and had a lot of ability and—

[01:26:18]

Tacey Ann Rosolowski, PhD

[01:26:19]

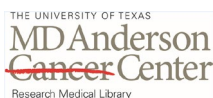
And Eduardo is Dr. Bruera?

[01:26:20]

Michael Fisch, MD

[01:26:20]

Yeah, Dr. Eduardo Bruera, the chair of that department. He's the most famous person in the field now, and he was pretty much the most famous person in the field then, prolific and brilliant. So it was easy to want to come work for him. He has since built an incredible department that has twenty-plus faculty, but I was one of the very first. I think I was the first externally recruited person to arrive, at least to show up and be in the office. It was a fabulous, interesting experience. But what was happening in the institution at the time is hard for me to know, because, in a sense, I was not privy to all that. But I think there was interest in pain—I think they'd had a pain team. They'd had some other people before Eduardo who were more like pain specialists.



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[01:27:23]

Tacey Ann Rosolowski, PhD

[01:27:24]

Yeah, like C. Stratton Hill had—

[01:27:25]

Michael Fisch, MD

[01:27:25]

C. Stratton Hill and—

[01:27:26]

Tacey Ann Rosolowski, PhD

[01:27:27]

—who I interviewed.

[01:27:28]

Michael Fisch, MD

[01:27:28]

So they had sort of a Pain Clinic story. But Eduardo was being recruited to get beyond pain, a bigger model, and Palliative Care was not nonexistent. It was existent at that time, but nascent and not really integral to oncology thinking.

[01:27:47]

Tacey Ann Rosolowski, PhD

[01:27:47]

Could you define for me “palliative care”?

[01:27:49]

Michael Fisch, MD

[01:27:50]

That’s a fabulous question. One of my earliest experiences coming here was—so I show up here, and I’ve got “Palliative Care and Rehab” on my name badge, and I’m on the elevator, and you can tell that people are looking at you, trying to figure out—you’re a new face, and looking at your name badge. I remember on one elevator ride, one of the faculty there—I can’t remember who it was, but an older established MD Anderson faculty, goes, “Oh, you’re with the body bag service.”

And I was taken aback by that, and I started to try to explain what palliative care was, and I don't remember what I was saying, but it sounded a lot like a lot of babble. This was the classic elevator speech, right? Either you've got something ready to explain about what is palliative care on an elevator, because you're on an elevator, or you don't. And it's the body bag service until you explain otherwise. And my first experience with that was a fail of some sort.

So I went back to my office and I found a definition that I was going to be able to use, and it was one written by Andrew Billings, who was at, I think, Mass General at the time. So palliative care, the way I decided I was going to explain it, is comprehensive interdisciplinary care focused on patients and their families when the patient's living with a serious chronic illness, and the goals of care include improving quality of life and reducing suffering. So more or less those kind of five bullet points kind of come to mind for the elevator spiel. At least that made me feel like I was qualified to have that on my name badge.

And then I found that very useful, right, because referring doctors wanted to know. Patients and families, "Why am I being referred to—why am I seeing you? You're what? What's palliative care?" So that question was a quite useful question. If you can't make any sense out of that, things aren't going to work.

[01:29:52]

Tacey Ann Rosolowski, PhD

[01:29:53]

It's interesting, when I was interviewing, I think it was C. Stratton Hill who told me this, because there was the whole issue of when or how did MD Anderson get connected up with Hospice, and apparently there was a resistance when, I mean, R. Lee Clark was, like, adamant, "No, we're not going to get connected up with Hospice, because Hospice is about dying, and MD Anderson is not about dying."

[01:30:17]

Michael Fisch, MD

[01:30:18]

Well, that's exactly right, and that actual reluctance has been present here and present everywhere in cancer medicine, you know, globally, that avoidance of the association. You're either coming to our Cancer Center for hope and life and cure. Nobody comes here so they can die better. If we make dying better, dying easier, quality of life our emphasis, then people are going to reject us and they're going to go to our more hopeful competition. So it's been hard. I mean, it's been a fear fest in that sense.

The question is how do you bring both? How do you strive for novel treatments, hope, curative therapy, aggressive care, if that's what people want and when it's appropriate, you know, how do you pull that off without enhancing the suffering or reducing opportunities to mitigate suffering, and how do you do that. So it's been puzzling, and we struggle with that. So we found that talking about palliative care was always associated with Hospice. It's sort of just a mental association, and palliative care linked to Hospice, linked to dying. "I don't want that." So we started to talk about our work as emphasizing the quality-of-life stuff. We're the quality-of-life guys, you know, like the car guys. We're the quality-of-life guys.

Then we started talking about we probably should change our name badge. We should call ourselves something else. (laughs) And that was debated for a number of years and eventually—this is after I left Palliative Care to get into General Oncology, but eventually they did that and changed the name from Palliative Care Center to the Supportive Care Center and have actually published about what that name change has meant. So that work has been done, but before that change and the subsequent publications was a lot of dialogue and a lot of resistance, because in the field the issue was—and I always felt that our department was more or less palliative care centrists, so true palliative care, and what they wanted to do is just get everybody on the right page about what true palliative care is, why it's important, what people need, and how to understand it properly. And they were seemingly a little bit more suspicious of things on the edge of palliative care, like, to me, sort of a bubble of palliative care in oncology and at the interface is what I was interested in. But at the interface is where things are most different from centrist palliative care. So the centrists were not always happy with the palliative care at the edge of oncology.

[01:33:25]

Tacey Ann Rosolowski, PhD

[01:33:26]

And what are some of those things at the edge?

[01:33:27]

Michael Fisch, MD

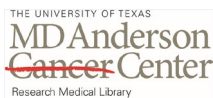
[01:33:27]

Well, one might describe it as the sort of things where you sort of holding your nose while people do things that you might not want to see them doing, you know, giving extra chemotherapy while you're trying to work on symptom management, or, you know, it's basically a negotiated version. Like in order to have the privilege to get involved with care, you can't have a non-negotiable style about what's going to happen. Who's going to be talking about prognosis and what's the story? You can't have a counterstory to the treating oncologist, because that doesn't have a favorable effect on patients and families. They just realize, "These people aren't on the same page. They're confusing me. Which is it?" So unless you want to make people suffer, you've got to figure out how to influence care by harmonizing with the treating oncologist, and that means they might do things that you might not always agree with.

Or, for example, if you want to start morphine or if you want to use methadone because the morphine that's being given to the patient is not being well metabolized and it's making them confused or twitchy or delirious, and you want to switch the patient to methadone, which you think in a sense will burn cleaner and be a better way of achieving the goals, well, what if the oncologist doesn't want to do that because they don't like methadone, because they associate that with addicts or they think it's dangerous or they're just unfamiliar, they're just not going to do it? Well, you need to come up with some other idea. You've got to switch to something else that they're willing to do, or maybe you'll get involved with helping in ways that they're willing to let you help. So maybe they don't want to switch the morphine at all, even though you think it's a good idea, but maybe you can talk to the patient about working on their bowels or helping them get hydrated.

So in a sense, if the clinical problem is opioid toxicity and you actually feel like you can solve it by switching the opioid but that's not comfortable enough for the treating oncologist, then try to switch it by improving the patient's renal function by hydrating them, by solving their constipation problem, by making yourself useful in some other ways. Do something useful that you're allowed to do, and over time you'll gain some credibility, and maybe they'll see some other people get opioid rotations or get switched to methadone, have things go nifty, and begin to have more confidence in you. But you've got to be willing to sort of start with whatever role you're given, being the water boy, being sort of the water boy on the team. You have to be very humble and, of course, it's easy for me to be humble because I was just learning this stuff anyway. But I think it's harder if you're a palliative care centrist and you know how to do things, and you come to a place where people are not respecting what you know how to do or even let you exercise your skills to help patients. It takes a certain resilience to put up with that.

[01:36:39]



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Tacey Ann Rosolowski, PhD

[01:36:40]

But I tell you I've had so many conversations with people along these same lines, you know, basically have come up with a new idea, and basically having to prove literally case by case that what they have to offer is legitimate, and then building a constituency and a demand for their services through that step-by-step process.

[01:37:03]

Michael Fisch, MD

[01:37:03]

Yes. So probably this entire story of the seeding of Palliative Care at MD Anderson is not very different than the seeding of any innovative new thing.

[01:37:11]

Tacey Ann Rosolowski, PhD

[01:37:11]

Basically.

[01:37:12]

Michael Fisch, MD

[01:37:12]

It's the same formula.

[01:37:13]

Tacey Ann Rosolowski, PhD

[01:37:13]

Particularly when it involves multidisciplinary interactions like that.

[01:37:16]

Michael Fisch, MD

[01:37:17]

Yeah, it's the same on the—

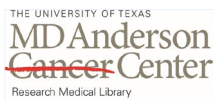
[01:37:19]

Tacey Ann Rosolowski, PhD

[01:37:19]

Not to diminish your pain. (laughs)

[01:37:20]



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Michael Fisch, MD

[01:37:21]

No, but, I mean, we only live one story, so it's the only story we know. But I think probably true that it's a very general thing.

[01:37:31]

Chapter 09

B: An Institutional Unit;

A Precarious Time for the Palliative Care Program

Story Codes

B: MD Anderson History;

B: Obstacles, Challenges;

B: Institutional Politics;

B: Controversy;

Tacey Ann Rosolowski, PhD

[01:37:31]

So about how long—I mean, what was the arc of acceptance, do you think? I mean, you came in '99. When did you begin to feel as though there was sort of a critical mass of people who could hear the message?

[01:37:43]

Michael Fisch, MD

[01:37:43]

Well, you know, it's a long arc, so we didn't come and conquer very quickly. In fact, we came and it seemed like we were failing. It seemed like it was frustrating, and they started to sort of unbuild us. By the middle of 2000 or 2001, it seemed like they had delivered kind of a political insult to Dr. Bruera. I remember they were splitting off a cancer pain group. The anesthesia, we were sort of owned and managed by anesthesiologists, so anesthesia had some change of leadership and they were kind of interviewing us and sort of measuring our human worth. I feel like I was getting a human-worth biopsy in a roomful of my colleagues. "What do you do? What's your training?" And it was sort of like, dud, not anesthesia.

And then Dr. Bruera's clinic, instead of being completely in charge, it seemed like he had taken sort of a political setback of some sort. I'm not sure what the reason for it was. I can't remember. But we were sort of taken aback, and I remember wondering whether this was going to last. Eduardo was beginning to interview for some other jobs, so he was on the market. I remember wondering whether I—you know, time to leave. I started interviewing in private-practice jobs in central Virginia. In fact, I remember cold-calling some people in Lynchburg, saying, "I'm a faculty member at MD Anderson. I'm an oncologist. Do you have any jobs in Lynchburg?" Just cold-calling these people.

And they're like, "No."

Commented [T9]:

In this segment, Dr. Fisch talks about a period when the Palliative Care Program seemed less valued than anesthesiology and the administration was splitting off groups from the department of Anesthesiology and Critical Care. He recalls that Dr. Bruera interviewed for a new job and he himself began calling about positions in Virginia. He tells an anecdote about where he was on 11 September 2001. He explains why he remained at MD Anderson and how, after a meeting with leaders, the situation for the department and program seemed to improve.

Then I went and interviewed in Roanoke and would have taken a job there, but it wasn't quite ready, the dude who would have to retire before the next job would be available. So they kind of were interested in me, but they weren't quite ripe.

Then the time between that—in fact, September 11th, 2001, that day, 9/11, I was at the Medical College of Virginia with Tom Smith, who will be here tomorrow giving grand rounds or giving the plenary talk at a medical issues and cancer survivor—so I'm going to meet with Tom tomorrow. Dr. Bruera and I will meet with Tom Smith tomorrow. But Tom Smith was hearing me talk about depression and cancer on September 11th, and it was a job talk. I was looking to leave on September 11th. And as I was talking to one faculty after another, I got a vague sense that there was something happening. Like 9/11, I missed it, and I couldn't quite—because you're so overscheduled, you just go in one place to another and talking to people the whole time. So I didn't have a chance to just look up and try to understand what was going on. And I remember at one point I was talking like this, and somebody knocked on the door and say, "Yeah, I just wanted to let you know that some plane hit the World Trade Center."

We're like, "Oh, huh. Awful." Okay, right back to our conversation, like couldn't quite grasp what he was trying to tell us. Sort of a strange experience. Then I got stuck in Virginia. I was at Tom Smith's house for a number of days, so he and I shared that experience.

[01:40:59]

Tacey Ann Rosolowski, PhD

[01:40:59]

Everything was shut down.

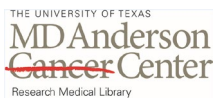
[01:40:59]

Michael Fisch, MD

[01:41:00]

Yeah, the whole scene. But I actually gave my talk on depression and cancer at MCV that afternoon at, like, four o'clock, and people came. Not very many, but some people actually showed up to that conference. I think people—you know. Other freakish medical people who hadn't been able to completely tune in to the gravity of what had happened to the world were still showing up to the kind of things that you might show up to at four o'clock.

But, anyway, the point of that story is that's where I was at. I was, like, ready to leave as the whole thing seemed like it hadn't taken root, like this wasn't going to go anywhere. But I didn't. The MCV job wasn't exactly in the right location for my family, and they decided they didn't want me to go to that. The Roanoke job wasn't ready, and Lynchburg didn't have a job, so I was sort of forced to hang around a little bit longer. And in so hanging around, we found a better groove. Things got a little better.



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I remember at some point there was a meeting with some institution leaders where it seemed like it was a classic—they were sort of trying to make us feel better. They were making repairs with Dr. Bruera and the faculty. They decided that they weren't ready to blow us apart. I remember Dr. Callender and who was the physician-in-chief, David Callender, and then maybe some other leader whose name I can't remember, but I remember us eating in this little conference room and them pouring us tea. So the whole idea of junior faculty and all of us, and them pouring us tea in this sort of classic making repairs kind of mode. And I remember Dr. Bruera talking about so what it had felt like for all of us to be, in a sense, treated the way this group was being treated around that time.

Chapter 10

B: An Institutional Unit;

Building the Reputation of Palliative Care

Story Codes

C: Patients;;

C: Patients, Treatment, Survivors;

C: Discovery and Success;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

C: Professional Practice;

C: The Professional at Work;

Michael Fisch, MD

[01:41:00]+

So it got repaired and we had a talented group. I mean, these people knew what they were doing. Eduardo and his team know how to take care of patients. He had great ideas, we were doing good things, and gradually that sort of got noticed. Really, there was just a very small number of faculty who would refer to us. I mean, we seeded the whole thing, more or less, it seemed like, on the power of referrals from like maybe three or four people in the whole place, but they could hand us enough patients to keep us afloat, and then our work could seed and spread a little bit. But Cathy Pisters was one of the main ones, Katherine Pisters in Thoracic, got to know her and come to be such an admirer of her and her friend. But if it weren't for Kathy Pisters, and Bob Wolff was another, and just a few other people who let us in and let us do our thing.

Then the other thing I remember is sometimes we'd do things—you know, because I was learning the field, but we would switch medicines around, rotate the opioids, and address constipation and address psychosocial distress and spiritual well-being, and sort of deliver a package of palliative care that was pretty cool, and sometimes people would go from literally being what seemed like in a complete heap, just—you know, I remember one patient with an eye patch, nauseated, constipated, couldn't walk, everything was miserable, and he has a young family, and then we kind of do what we do, and literally within a week, he's *way* better. He can walk, he can eat, he can think, and then their family got ready. They were so uplifted, and then they went on this great beach trip, and it was just fantastic.

But I remember it's sort of like spiking the ball after a touchdown. You just get so excited. But sometimes we would succeed so dramatically that it was a little bit off-putting to a referring doctor. Imagine if you're in that kind of heap, and then you see somebody and they fix it, you're like super thrilled, but you're also thinking, "How did I get like this and how long was I like this until I met you?" And you feel a little bit bad about these people who didn't know how to solve

Commented [T10]:

In this segment, Dr. Fisch sketches how the talented team in palliative care was successful in securing regular referrals from a few oncologists, building the program's reputation. He tells anecdotes about the surprising and positive results they would get from integrating palliative approaches into treatment protocols.

At the end of this segment, Dr. Fisch shares lessons he learned about how to interact successfully with oncologists to ensure they would call on him as a palliative care providers.

Page Break

this problem or didn't know how to refer sooner. So there's sort of a good news/bad news effect. The good news is it feels good for us, like we're the heroes. Feels bad for the referring doctor. Rule number one, don't succeed in a way that's painful for the referring doctors if you like referrals. So we learned how to—and maybe they already knew this, but I learned at least how to be a very quiet, humble solver and how to have these, in a sense, sort of like score a touchdown and just hand the ball to the referee. Don't have a big celebration. That celebration does not do you any good. Let you be understated in solving these problems.

And also sometimes I would get used to solving these problems and it would seem too easy. I could see it. It's like seeing you're going to score, and I'd say, "We can fix this. You watch what we can do. We're going to do this." Then, you know, medicine humbles you and life humbles you, and some of the solutions couldn't be always reproduced because their life is complicated. So learn to be much more measured about what I thought we could always achieve and quiet about it when we did achieve it. That's sort of in the comeuppance of—again, maybe that's Consult 101, you know, whether you're putting in stents in a biliary tract or doing palliative care. Wow people quietly, not loudly. But that was all part of the experience.

[01:46:56]

Tacey Ann Rosolowski, PhD

[01:46:58]

Well, we're at noon. Shall we leave it here for today?

[01:47:00]

Michael Fisch, MD

[01:47:00]

Yes, yes. I didn't realize we were already at noon. I've got to show up to another meeting real quick.

[01:47:04]

Tacey Ann Rosolowski, PhD

[01:47:05]

Well, I look forward to talking to you next week.

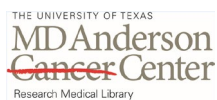
[01:47:06]

Michael Fisch, MD

[01:47:07]

Thanks so much for your time, and I look forward to talking to you some more. I'll run off to my meeting.

[01:47:11]



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Tacey Ann Rosolowski, PhD

[01:47:12]

All right. I'm turning off the recorder at noon.

[01:47:14]



II – MDA-RML_Fisch_Michael Session 2 – February 13, 2015

Chapter 00B ***Interview Identifier*** [00:00:00]

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

All right. Okay. Well, our counter is moving, and it is about nine minutes after ten on the 13th of February, Friday the 13th, 2015, and I am on the twelfth floor of the Faculty Center in the Department of General Oncology. Today I'm having my second session with Dr. Michael J. Fisch.

So thank you again for making time for this session.
[00:00:27]

Michael Fisch, MD
[00:00:27]
My pleasure.
[00:00:28]

Chapter 11

A: Overview;

Defining the Scope of General Medical Oncology

Story Codes

A: Joining MD Anderson;

A: Overview;

A: Definitions, Explanations, Translations;

A: The Researcher;

A: The Clinician;

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

D: The History of Health Care, Patient Care;

C: Controversies;

Tacey Ann Rosolowski, PhD

[00:00:28]

Well, we strategized a little bit before the counter went on, or before the recorder went on, and I wanted to ask you about a series of terms that have come up in my background research, because it's just interesting. You've been involved in this particular field of medical practice at the time when an entirely new perspectives on cancer treatment is emerging, and so I have a feeling we're in need of some definitions here. So let me give you the list, and then we can kind of see how they overlap and what they all mean. The first one, of course, is Medical Oncology, which is the name of the department of which you are now a part and, I believe, the department which you helped to build here at MD Anderson.

[00:01:15]

Michael Fisch, MD

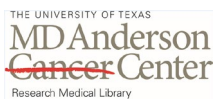
[00:01:16]

Yeah. My department's name is the Department of General Oncology, but it's in the discipline of Medical Oncology and in the Division of Cancer Medicine, which is the operational and intellectual home of the medical oncologists within the institution, who are numerous and what seems like maybe the world's biggest group of medical oncologists. So that's interesting in its own right to the extent that I wasn't hired into a home of medical oncologists. I came into the Division of Critical Care and Anesthesia, where the Department of Palliative Care and Rehab was initially placed, and so that was very unsettling to not be in a homeland of other people within my discipline. I felt like a refugee in a certain sense, and I felt much, much better doing the same work when the department was moved into the Division of Cancer Medicine.

Commented [T11]:

Dr. Fisch begins with an explanation of why he felt like a disciplinary "refugee" when he arrived at MD Anderson and joined the Department of Critical Care and Anesthesiology.

He then defines the purpose and scope of General Medical Oncology as a practice: the long-term care of patients with cancer when overall care is the focus, including delivery of pharmaceuticals and injections and after care following surgery, radiation or chemotherapy. The GMO clinician work with a patient over a lifetime. He notes some controversy in the field over when the GMO clinician "lets go" of a patient who is transitioning to survivorship.



Making Cancer History®

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[00:02:21]

Tacey Ann Rosolowski, PhD

[00:02:21]

Interesting.

[00:02:21]

Michael Fisch, MD

[00:02:21]

I felt like somebody who had been repatriated.

[00:02:24]

Tacey Ann Rosolowski, PhD

[00:02:24]

What was the disconnect when you were in Anesthesiology?

[00:02:28]

Michael Fisch, MD

[00:02:29]

Well, again, I guess it gets to what it means to be in a certain discipline, sort of what is a discipline. It's a body of knowledge about a particular area. It has a certain perspective on that area. It has a certain history. It has sort of its own founding fathers, its own stories, and its own culture. There's a bit of a culture. The culture of Medical Oncology and the culture of Radiation Oncology and the culture of Surgical Oncology are not precisely the same, although they have lots of overlap in content. So, again, it's like living overseas for a long time. People are people and things are things, but you feel some bereft of some acculturation there, of connection to the people.

[00:03:28]

Tacey Ann Rosolowski, PhD

[00:03:28]

What exactly is general medical oncology?

[00:03:32]

Michael Fisch, MD

[00:03:33]

The department, you mean?

[00:03:34]

Tacey Ann Rosolowski, PhD

[00:03:34]

Just the field.

[00:03:35]

Michael Fisch, MD

[00:03:36]

Right. So one way I would tell it is sometimes I think about things like, you know, “Tell it to me like you would tell your grandmother.” (laughs) “Grandma, ask me what medical oncology is.” I guess its root is the care of patients with cancer when the overall care of the patient is the focus and particularly when using pills or injectional therapies is really central to getting the best results. So if somebody just needs a tumor taken out, people say, “Can you do that?” and the answer is, no, I don’t have the skill set, the training, the capability of fulfilling that kind of care. Or if I need to use radiation, then that’s not what I do. But if I need to take care of giving chemotherapy, that’s sort of the procedure that belongs to Medical Oncology, but also everything in between. The care of a patient after radiation when they’ve also had surgery or comprehensive multidisciplinary treatment planning, medical oncologists are pretty much always invited to the mix because they tend not to come in and provide episodic care. These other specialties may kind of, in a sense, come and go. When you had your tumor and we saw it and we biopsied it and then we took it out, and then there may be ten years where there’s no reason to talk to a surgical oncologist. There’s no special added value. They came and did what they needed to, and they maybe were involved a little bit in the planning, pre-surgery, and a little bit post-surgery, but then after that, that’s not where their value is.

And the same with radiation oncology. They come for a stretch of the road. I’ve often used the metaphor of a hitchhiker. You know, patients living with cancer are a risk of cancer or risk of cancer recurrence, they wish the whole specter of cancer could be just disappeared, something that is gone and extinguished from their lives, but so often that’s not really what happens. They’re either living literally with cancer or they’re being surveyed and living with the cancer story being part of their medical problem list that needs careful thinking and things need to be done.

I think of it like hitchhiking, like, you know, if you wanted to go from, say, Houston to Seattle, you’d like to fly there and get there directly and then you’d be there. But if somebody said, “Well, I’m afraid there’s no way to fly to Seattle,” and you still wanted to go, and let’s imagine there’s no other sort of direct transportation, you might have to just try to hitchhike there. And that process, metaphorically, would be, well, you’d want to choose a ride that was safe and comfortable enough and heading in the right direction, and then you would want to monitor that

ride to make sure it remained safe and comfortable enough, continue to head in the right direction, and be able to, in a sense, jump off when those things weren't true anymore and then look for a new ride that was safe and comfortable enough and heading in the right direction, and the process of doing that would get you toward Seattle and hopefully eventually in Seattle, right?

So medical oncologists are basically hitchhiker guides throughout the whole trajectory, where surgical oncologists and radiation oncologists and cardiologists and geriatricians and all kinds of people involved, but they are often there for portions of the ride, they are highly specialized for portions of the ride, where the medical oncologist really has something to say about the entire journey.

[00:08:04]

Tacey Ann Rosolowski, PhD

[00:08:05]

Interesting.

[00:08:07]

Michael Fisch, MD

[00:08:09]

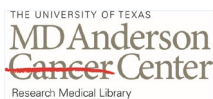
So I'm not sure everybody would share that view, and maybe I have this sort of discipline-specific sort of ethnocentrism about it, you know, but that's sort of my grandiose view of medical oncologists, and I think other oncologists feel the same way. In fact, that actually creates a certain kind of dilemma, a certain controversy, and that is how do we transition people into survivorship programs. Like when are medical oncologists supposed to let go? Are we sure that medical oncologists should be involved in the entire ride? That's a little bit inefficient. There's not enough medical oncologists. Maybe they're actually only good at some parts of the ride. They're really good at some parts of the ride. That's what they always focus and talk about. And then the sort of post-treatment survivorship portion of the ride, they're still on board but they're not paying as much attention and they don't navigate it perfectly well. And shouldn't somebody else be able to help navigate? What's our plan for either getting the oncologist more interested in doing that well or getting the oncologist interested in relinquishing or sharing the role of hitchhiker guide during that survivorship portion of the ride?

[00:09:29]

Tacey Ann Rosolowski, PhD

[00:09:30]

Now, is this controversy—I mean, it just seems to me that it might be fallout from the fact that, (a), survivorship is a relatively new phenomenon and long-term survivors are a relatively new phenomenon, and, (b), that medical oncology itself is a fairly young science, and so those two things together, it's like figuring out a whole new territory.



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[00:09:57]

Michael Fisch, MD

[00:09:57]

Well, you're right. Survivorship is a problem emanating from our successes, right? If people live seven to ten months and die, then you don't have a big survivorship problem. Just in my career span, when I was a fellow taking care of a V.A. patient being treated for colorectal cancer in the mid-nineties, people lived with colorectal cancer seven to ten months when they had advanced disease. Now the median survival of a patient with metastatic colorectal cancer is more like twenty-five months' median, and it turns out that 5 or 10 percent of those people are living three times more than the median. So there are people hanging around on this—the journey has changed and the span to be navigated by oncologists has changed. That's colorectal cancer. This is happening in other diseases, head and neck cancer, and it's a great joy to see these things happening.

Chapter 12

A: Overview;

Reimbursement for General Medical Oncology; the Value of Generalists in a Field of Subspecialties

Story Codes

D: Fiscal Realities in Healthcare;

D: The Healthcare Industry;

A: Overview;

A: Definitions, Explanations, Translations;

A: The Researcher ;

A: The Clinician;

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

D: The History of Health Care, Patient Care;

C: Controversies;

C: Patients;

C: Patients, Treatment, Survivors;

Michael Fisch, MD

[00:09:57]+

But you're right, it creates sort of a new field and it creates some other dilemmas that are also financial dilemmas. So to the extent that medical oncologists get paid for what they do, they do not get paid in the same way. Or let's just say their keepers, you know, the systems that hire them, either them individually or their groups or their organizations, are not being paid a flat rate for all their navigation, so they get best reimbursed or their systems are being most reimbursed during the part of the journey that involves initial treatment planning, lots of use of laboratory and diagnostic tests and multidisciplinary planning, and then the giving of the treatment. In fact, the pay is tied to the treatment itself, which is a bit of a problem that people are trying to figure out how to reform.

But in this post-treatment part of the ride, there's often a fair amount of complexity but not much reimbursement, and so that becomes a problem. People who know more than I do about administering cancer care from the financial administrative point of view will sort of point out that, in a sense, the margins become negative after a certain part of the ride, so that there becomes an organizational incentive to say, "Why don't we do this part, and then why don't we see if somebody else will do the part that's margin-negative for how we're structured and how our costs are put together and such." And the problem there is that part of the ride's not margin-positive for anybody, so you don't sort of create an industry around that. You have to figure out how that's going to happen.

Commented [T12]:

Dr. Fisch begins this segment by explaining the challenges of arranging insurance reimbursement for the contributions that general medical oncologists make to patient care. He explains that reimbursement margins during post-treatment care become negative after a certain point. He also notes that losing connection with the GMO clinician can be very setting for a patient, and he gives examples of problems that can arise.

Dr. Fisch also explains that "people's health stories are not completely oncology." They often have co-morbidities and challenges can arise in bringing together specialists to fully treat a patient. In a fragmented system organized by subspecializations, often the patient must serve as "project manager" of his or her own care.

Next Dr. Fisch talks about the value of having a generalist perspective in this situation. He then talks about LBJ Hospital. He comments that eventually generalists will define the pathways into a patient's care and then specialists will take over.

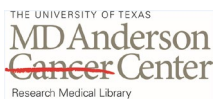
From the patient experience of that entire ride, it can be very unsettling to realize that as time goes by that there can be gaps. Sometimes there are significant post-treatment problems, things that started during treatment and never went away. The jargon around that is to call them chronic effects. Might be painful numbness and tingling from nerve damage due to treatments that started during the treatment and never disappeared, or they may be late effects, which are more or less—a late effect is like a little time bomb that goes off later. So if you develop a leukemia as a consequence of treatment that pops up three or five or seven years down the road, that's kind of a late effect. Or emerging heart failure or ischemic heart disease some years after the treatment, maybe it was a little bit chronic in terms if it was theoretically detectable, the biology, the damage was already there on a chronic basis, but the late effect of the worsening of it or the clinical emergence of it to where you notice it, you know, it was a sort of submerged problem that surfaces years down the road. So there's some complexity in there, some subtleties in there.

And the other thing is, you know, people's health stories are not purely oncology, right? We tend to put on our oncology-colored lenses and we look at the patient as a colorectal cancer patient, pre-treatment, during treatment, post-treatment, but that person is a person who has many dimensions, including other health problems. They are also a person with diabetes, a person with arthritis, a person about to acquire other comorbidities, memory loss or what have you, and the cancer part of the story is one piece of it.

So then the issue is, well, how is this all integrated in terms of caring for that person? Do the oncologists stay with oncology-colored lenses and then ask a primary care doctor to coordinate all this stuff? Or how do you bring it all together? I think our system has been very fragmented. It rewards subspecialization, and people are really attracted to subspecialists, right? My doctor knows more about the heart than anything else, and I have a heart problem, I want to see somebody who knows a lot about that. Or same idea for any kind of specialty, including cancer.

But that has been problematic in this country with respect to coordination of care, fragmentation of care, and more burden being shifted onto patients and families to sort of be a stronger member of their own healthcare team and really the project manager of their own healthcare. They're having trouble delegating that project management piece, but that project management piece takes medical knowledge oftentimes, and quite a lot of time, and there are consequences to getting that part not right.

But anyway, these are the sort of things. So even within the field of oncology, you know, people are very attracted to subspecialty care. So I have breast cancer, I want somebody who does breast cancer all day long and knows everything about breast cancer and talks about every little thing that's happening in breast cancer. I only feel safe if that's the way it is. And there's something appealing to subspecialty care like that, but there are some limitations there as well. So it is



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useful to have a broader perspective on cancer care to be able to connect the dots about trends in patient care and supportive care and the biology of cancers that cut across disease. So being super narrow is appealing only but so much.

So in my department, the Department of General Oncology, we developed out of an appreciation for having some flexible and versatile oncologists who are needed in settings where there's a case mix, so to speak, people with different diseases coming to the same clinic. If you're in one clinic at Lyndon B. Johnson General Hospital in Houston, a county safety net hospital, now called the Harris Health System, you don't have sort of the Breast Cancer Clinic, the Colorectal Clinic, etc. You have the Oncology Clinic, and flowing through there are people with different diseases. So unless you're going to have a bunch of specialists just trying to pick off the specific little case mix, which is sort of their specific area, that's very inefficient. It's more efficient to have people who are able to see whatever those patients are. Or if you are in a practice in Lynchburg, Virginia, you don't need a colorectal specialist. You need general oncologists who may be in touch with colorectal specialists when they're learning about how to apply themselves or following pathways that have been constructed by specialists.

So I think we're getting to a world where you need fewer specialists who are creating highways that are navigable by general oncologists, but there's controversy around that, so it depends what you're trying to do. Some people just find that sort of efficient and sensible at some level, but it doesn't work for the marketing department, you know, and to differentiate yourself from the other generalist pack, you try to be more specialized and appeal to people who are attracted to the super specialist models.

[00:19:43]

Chapter 13

B: Building the Institution;

The Community Clinical Oncology Program (CCOP)

Story Codes

A: The Researcher;

A: The Clinician;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

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

D: The History of Health Care, Patient Care;

C: Research, Care, and Education;

B: Beyond the Institution;

B: MD Anderson Culture;

B: The MD Anderson Brand, Reputation;

Tacey Ann Rosolowski, PhD

[00:19:45]

You know, we had talked at the beginning about how we were going to focus on your research today, but given what you've been saying about medical oncology, maybe it would be better, since you've set that context, to talk about the creation of the department here. Would that make sense?

[00:19:59]

Michael Fisch, MD

[00:20:00]

Sure.

[00:20:00]

Tacey Ann Rosolowski, PhD

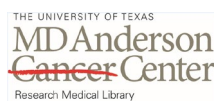
[00:20:02]

Because I have a feeling that—well, I will let you tell the story. (laughs) So as I understand, the department was formally created in 2008, but it grew out of, if I'm correct, the Community Clinical Oncology Program. Is that correct?

Commented [T13]:

In this segment, Dr. Fisch talks about the history of the Community Clinical Oncology Program (CCOP). (He has served as Medical Director since 2004.) He notes NCI involvement providing funds for community based initiatives and explains the purpose: to develop clinical trials linked to the community contexts where eighty percent of patients are treated. He characterizes MD Anderson's reputation as a "solution shop" driving treatment, with the CCOP's different approach to treatment and research, including that community practice has something to teach about treatment.

He then notes that, as Medical Director, he served as a facilitator and broker for trials. He talks about how CCOP trials and research worked at MD Anderson, including how biases against randomized trials worked into the planning process, with efficacy trials conducted with MD Anderson patients and Phase 3 trials conducted in the community. He gives an example.



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[00:20:24]

Michael Fisch, MD

[00:20:24]

Right.

[00:20:25]

Tacey Ann Rosolowski, PhD

[00:20:26]

And you were medical director of that, just so I have the note on the recorder, from 2004 until the present.

[00:20:36]

Michael Fisch, MD

[00:20:36]

Right.

[00:20:36]

Tacey Ann Rosolowski, PhD

[00:20:36]

Okay. So tell me about that Clinical Oncology Program and then how it gave rise to—

[00:20:43]

Michael Fisch, MD

[00:20:43]

Yeah, so that program is one way to tell the whole story of how these things come together, symptom management and general oncology and the discipline of oncology, to the extent that this is a program funded by the National Cancer Institute. I think the program dates back to, say, probably 1983, I believe. MD Anderson has had a grant with that program that began in 1987, and then I was intersecting with it really after I first got here. I interviewed with Roger Winn, who was the head of the CCOP. When I interviewed—

[00:21:24]

Tacey Ann Rosolowski, PhD

[00:21:24]

CCOP?

[00:21:24]

Michael Fisch, MD

[00:21:25]

Yeah. He was the P.I. of this program.



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[00:21:27]

Tacey Ann Rosolowski, PhD

[00:21:27]

Oh, that's the Community Clinical Oncology—okay.

[00:21:27]

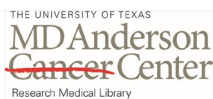
Michael Fisch, MD

[00:21:27]

—that MD Anderson had had since 1987. So when I talked to Dr. Winn in the HMB Building, where my initial offices were and where the CCOP was, I was interested in that because it is a venue for clinical trials research that's a multi-site research, and the whole idea is to connect academic centers that are kind of like the hubs, the research bases, to the spokes that are community practicing sites, oncologists in the rest of the world. And that's where 80 percent of the care is delivered in the rest of the world. So if you want to have innovations that are meaningful and start to apply to patients in the world at large, you have to have some connection to them. So it wasn't really how MD Anderson was scoring its points as an institution. We were more like a solution shop where people from all over the world would come to the solution shop for highly specialized care and special equipment and techniques to get the best results. That was the attraction.

But the question would be what about people who don't want to come here, or should we only influence those who are willing to come to the solution shop. Is there anything that we could do to learn how to disseminate some ideas to the rest of the world, and maybe there are certain things that are good ideas in the community setting in the first place, that they don't necessarily—aren't the same sort of things you do in a solution shop, but there would be innovations that begin and progress that were specifically tailored to community practice, which makes the most sense. What makes the least sense is to try to put together ideas and programs of care that really only work in a solution shop and make the mistake of trying to do them in settings where that's not a good idea. (laughs)

So anyway, there's the Community Clinical Oncology Program, and at MD Anderson it was directed towards treatment trials, you know, new ways of treating this or that. Many times rarer disease would be what MD Anderson faculty might be interested in studying in the community, because even here there's not enough patients to study what you want. What would happen here is if you wanted to study a new way of giving 5-Fluorouracil and radiation to rectal cancer patients, you've got enough rectal cancer patients here, you get together with your group, you decide how you want to do it, you do it a certain number of patients, you present it, it becomes the MD Anderson experience, the MD Anderson way, the MD Anderson data, what we look at,



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what we're doing. They'd wonder, "Ah, that's MD Anderson, where they selected patients at their own solution shop. I'm not sure what that means to us."

But you could do that and publish papers and make a career and get tenure until the end of time here, and you can do that for all the diseases for which you had enough patients, but if you're studying a rarer disease, I don't want to make something up, but peripheral T-cell lymphomas or something where it's a little tough to get even enough patients here, you might think, "Well, those patients, there's a lot of them out there. They're not all coming here. So maybe if we had a trial where we would enroll the ones here and the ones there, we would learn things faster." So we like to go to the community oncologists and try to get them to participate in those kind of studies.

[00:25:21]

Tacey Ann Rosolowski, PhD

[00:25:22]

So what were some of the studies that you first did, and were you conducting the studies yourself through this group—

[00:25:27]

Michael Fisch, MD

[00:25:28]

Right, right.

[00:25:29]

Tacey Ann Rosolowski, PhD

[00:25:29]

—or administering other people? How did that work?

[00:25:31]

Michael Fisch, MD

[00:25:31]

Right. So I was really a facilitator of that stuff, so I guess my special angle was I felt identified as an oncologist and really sort of understood what oncologists were trying to do and had a license to think broadly in oncology, being a general oncologist, not just somebody who came out of one disease area. But I wasn't the guy who was going to be creative across all diseases, so my job was to sort of be a broker for trials. So I would be trying to help my colleagues in different departments understand what the CCOP was, how the network worked, the terms of doing research in this setting, what we could and couldn't do, and then find trials and implement them. So I would sort of connect the dots between our G.U. medical oncologists and the community doctors.

So an example would be maybe our G.U. medical oncologists were figuring out that they could combine a radio nucleotide like strontium for patients with bone metastases in prostate cancer with chemotherapy, whereas maybe the world at large thought that that would be impossible or too toxic and were struggling enough to figure out where they could safely give strontium ever, like where would strontium's role ever be, how do they figure out how and when to use it. But in our experience here, they'd figured out how to safely use strontium in chemotherapy, felt like the results were pretty good, and so would want to formulate a clinical trial of chemotherapy, with or without strontium, in prostate cancer.

And maybe here they would think, "I don't want to randomly assign patients here, because we think patients don't come here to be randomly assigned." That's a concern, right? They come here because the doctors know what the leading edge is, and they say, "I want the leading edge. Don't randomly assign me to the leading edge that you're hopeful about versus conventional care. If I wanted conventional care, I'd go to the community and get conventional care. I don't want to have you play games with me in some random assignment." So there's some perceived barriers to random trials here.

So people like to do essentially what's called Phase 2 trials, efficacy trials, where they would look at the new innovation and just enroll a series of people in a new thing and say, "This is the standard of care, this is an acceptable new way of doing things, and we won't randomly assign you, but will just collect data on how this goes for you. So that was appealing.

So they would do the Phase 2 work here, say this is feasible, this is promising. But then that doesn't change practice because they don't know if it's better than standard of care. Say, "Okay, now we'd like you to enroll your patients." And the sell in the community would be, "We could just give you chemotherapy or we could give you strontium alone, but there's some promising data from MD Anderson that these things can be combined. But we're not sure if it's better or if it's worse, so would you be interested in enrolling in a trial but where we would randomly assign you to the combination versus just chemotherapy like this?"

So the value proposition for the random assignment of the possibility of a new, promising, but not proven to be better treatment, where the oncologist and maybe the patients are in equipoise around which is really the best thing, that would be the whole idea.

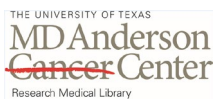
[00:29:39]

Tacey Ann Rosolowski, PhD

[00:29:39]

Interesting.

[00:29:40]



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Michael Fisch, MD

[00:29:40]

So that would be an example. Or taking a patient with advanced pancreatic cancer and saying, "We're going to give you chemotherapy plus Celebrex versus chemotherapy alone to see if Celebrex would help you have fewer symptoms from the chemotherapy." It may be also better results. There might be plausible reasons why it might even work better. There's plausible reasons to think it could just add toxicities, too, or side effects or problems. So you do those kind of trials.

So I'm trying to find faculty who are interested, trying to connect them to this, and then also trying to help the community oncologists, first of all, understand what are they seeing, what are they interested in, how are they treating their patients, what are their viewpoints about these ideas, and they have strong views that strontium can't be given or we can't get it paid for, or we can't find the nuclear medicine experts to collect the data to help us conduct the trial, you know, you have to figure out how they function. Sometimes the way we can function at our own solution shop and the way we team up with different disciplines is quite a bit different than every community where they're not vertically integrated and it's just a different story, and it's sometimes a story that you can't understand unless to go listen to them and talk to the ideas that you have and work through all that.

Chapter 14

B: Building the Institution;

The Community Clinical Oncology Program (CCOP); Transitioning to Research in Cancer Control and Prevention

Story Codes

A: The Researcher;

A: The Clinician;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

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

D: The History of Health Care, Patient Care;

C: Research, Care, and Education;

B: Beyond the Institution;

Michael Fisch, MD

[00:29:40]+

So, anyway, my job was to facilitate across these things, and this was also where the marriage—you know, it's a broad spectrum of conditions, right? The people in the community are seeing a case mix, so I needed to understand the case mix and then relate to various other departments here. But the people in the community are also highly interested in the experience of their patients, so they will say things like, "A lot of our patients getting aromatase inhibitors are getting muscle aches. Can we come up with a trial for that?" which is much tougher. I always found it much tougher to hear what the community wanted, what they're experiencing, and go try to solve their problem versus to tackle the things that we were already interested in or take solutions we already had and say, "Try that." (laughs) Again, it's much easier. It's much easier to try to ask people to do what you already have made. It's like, I don't know, you make a burger, you say, "Would you like to go sell those?" versus people who say they want certain kinds of dishes made a certain kind of way.

[00:32:25]

Tacey Ann Rosolowski, PhD

[00:32:26]

Sure. Project [unclear].

Commented [T14]:

In this segment, Dr. Fisch explains how research conducted via the CCOP transitioned from a focus on treatments to a focus on prevention, cancer control, and symptom management.

He first talks about his role as a facilitator setting structures for research collaborations. He notes that community settings offered a comprehensive view of patients, driving his own interest in symptom management. He talks about the overlap of different specialties whose borders are all debated. He illustrates with the example of pain management.

Next he sketches the factors that led to his decision to "sunset" the treatment focused trials. He was partnering with Dr. Blyer, who shared his vision. The NCI was also requiring that more research focus in these areas. Many regional research groups were putting together trials focused on prevention and control.



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[00:32:28]

Michael Fisch, MD

[00:32:28]

Sometimes you don't have the ingredients, you've never cooked it before, you don't know where you'd get those ingredients. Anyway, so we've had both kinds of experience.

[00:32:37]

Tacey Ann Rosolowski, PhD

[00:32:38]

Sometimes people don't even know the cuisine. I mean, it sounds like that's a totally different [unclear].

[00:32:41]

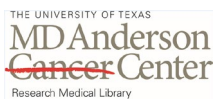
Michael Fisch, MD

[00:32:41]

That's right, they don't even understand the basis of the question. They may not even believe it, you know. "I don't think those muscle aches are really from the aromatase inhibitors. Maybe they are, but I think a lot of these women have arthritis." So the biology is not clear. But this sort of comprehensive view of people, that they are looking for the best treatment for their cancer, they are sometimes puzzled about how to attribute problems they have. Is this due to my treatment? Is this due to the cancer? Is this due to some other condition?

So attribution is confusing, and therein lies, I think, one reason why all these terms come up. What's supportive oncology? What's palliative care? What's symptom management? Maybe you think supportive oncology is things you do to mitigate the toxicities of cancer treatment. It's more toxicity oriented, where maybe you think symptom management is managing the symptoms due to the cancer, and maybe palliative care involves toxicity management, management of symptoms due to cancer, involves physical and psychological things, involves multidisciplinary comprehensive care and some other things too. So these things are all related.

But imagine a Venn diagram. Each bubble is highly debated. All the turf is being highly debated, both in those sort of conceptual ways around attribution of the problem, but also in discipline ways, right? So that's another issue. And sort of the story of my coming to MD Anderson in the Critical Care and Anesthesia Division was that cancer pain is cancer pain, but there's anesthesia-based cancer pain management and then there's medical-based cancer pain management, and different ways of tackling the problem, different assessment paradigms, and sometimes turf wars, in a sense. So the turf wars can be by attribution of the problem or by discipline. So it all gets sort of enmeshed.



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[00:35:11]

Tacey Ann Rosolowski, PhD

[00:35:13]

So tell me about the evolution of the story of the Community Clinical Oncology Program. It sounds like it began with some looks at agents, but did it eventually broaden to encompass these quality-of-life or symptom-management issues?

[00:35:30]

Michael Fisch, MD

[00:35:30]

Yes.

[00:35:30]

Tacey Ann Rosolowski, PhD

[00:35:31]

And what was that? Because that sounds like a culture shift.

[00:35:33]

Michael Fisch, MD

[00:35:34]

Yes. Yeah, there was a culture shift, and it was really a strategic move. So it seemed to me early on as I was working with Dr. Blyer, who's a pediatric oncologist and an expert in adolescent and young adult issues, but that was a very marginal part of MD Anderson and the community oncology. In fact, we're in the wrong crowd. Our constituents in the community were adult oncologists. Adult and pediatric oncologists are not roaming around together. They exist in separate universes. They don't talk to each other very often. You're either a pediatrician and you care for kids, or you're not, and very few people are med-peds trained, right? So the program is mostly adult oncologists and they may see some pediatric survivors or somebody who's eighteen years old who has Hodgkin's disease, and we could argue about which office they enter. There's all those issues.

But Dr. Blyer was a wonderful, effective oncologist and leader, but his content expertise was just a little askew of what was really the main place that these things could go. So I was a good partner for him towards the end of his career here.

But then once it was my job to have a vision for the CCOP, my vision was that we would start to deemphasize the treatment trials and start to expand the work that we're doing in cancer control and prevention and particularly in symptom management. That was sort of like a mandatory part of the program, so to speak, for the community oncologists. When the community oncologists received their own grants from the NCI, they would say, "We will enroll a certain number of patients on treatment trials," and then the NCI required that they had a certain proportion of patients on cancer control trials, too, so they didn't have the option of just saying, "We're not really into that stuff and we're not going to do it. We're just going to put our patients on treatment trials." That wasn't an option.

But many times they had trouble finding the supportive care, cancer control-type trials that would give them the credits that they had to produce; that is, enrollments on trials that were required. They had trouble finding good trials for that. There's more of an opportunity to try to craft some of those trials and compete to have that research prioritized and get those research questions answered.

[00:38:21]

Tacey Ann Rosolowski, PhD

[00:38:22]

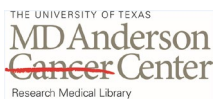
Was that kind of avant-garde of the NCI to be interested and supporting that kind of research at that time?

[00:38:28]

Michael Fisch, MD

[00:38:31]

I don't know how to answer that. I don't recall me being in the middle of that or really understanding how it all happened. So by the time I'm taking the lead of the CCOP around 2004, all that was part of the woodwork, so I wasn't sure how the woodwork got that way. I think it was a good idea, but how that idea emanated and took root, I don't really know. But I do know that it seemed to me that there were a number of cooperative groups, these other groups, putting together treatment trials, so there was ECOG and SWOG and SNABP and the NCCTG and the GOG, all these OGs, oncology groups are the OGs, whether it's Gynecologic Oncology Group, Southwest Oncology Group, Eastern Cooperative Oncology Group, all these big network groups where there would be five thousand or more total physicians in the network, large grant-funded groups, and they would have multiple committees, so they would have a Lymphoma Committee and a Brain Tumor Committee and a Sarcoma Committee and a Leukemia Committee, etc. They had all these tumor subtype committees.



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Interview Session: 02

Interview Date: February 13, 2015

So for the few Cancer Center-based research bases, these were sort of multi-institutional. There might be twenty academic institutions and a number of community oncologists that are part of these bigger groups, and then MD Anderson, the University of Rochester, for a while the Moffitt Cancer Center, and the University of Pennsylvania and the University of Michigan. There were some cancer center-based research bases.

But it seemed to me that the community oncology world did not need MD Anderson's Phase 2 trials in all these treatment areas, that there was plenty of good ideas bubbling up from these very big, mammoth groups that were really composites of other academic institutions. And MD Anderson was generally able to do a lot of the stuff they wanted to do here without us anyway, right, so MD Anderson didn't need us that much, and the world didn't need us that much on the treatment trial side. So I thought, "Why don't we go to where we're needed. Let's try to work on cancer control and try to find the rich resources for symptom management, cancer control-type things that are at MD Anderson, really smart people with good ideas, and see if that would be a good outlet."

So I sort of basically sunsetted the treatment trial part of our portfolio, tried to continue to conduct the ongoing trials but not start any new ones, and then completely start new ones in just this cancer control realm and turned it in, and that turned out to be a pretty good idea, because that's where the NCI was going to go anyway. So we sort of started heading down exactly the path that became the only available path after a while. It seemed like an obvious point that became increasingly obvious as a good idea.

Chapter 15

B: An Institutional Unit;

The Community Clinical Oncology Program (CCOP); Finances, Organization of Research, Some Examples

Story Codes

A: The Administrator;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Research, Care, and Education;
B: Beyond the Institution;
C: Patients;
C: Patients, Treatment, Survivors;
C: The Institution and Finances;
D: Business of Research;
C: Leadership;

Michael Fisch, MD

[00:38:31]+

So then you start figuring out, well, who are the experts around here? And it's not so much drug-oriented, but working with Palliative Care and Rehab, behavioral scientists, integrative medicine specialists, cancer pain people, anybody with these types of ideas. But the whole program was based around interventions, so it wasn't for just descriptive studies, it wasn't for health services research or cancer care delivery research or quality improvement things. It was more or less interventional research, and a lot of it was sort of empirical.

So somebody might say, a rehab physician here, Dr. Gwo [phonetic] and others, working with Art Forman [phonetic], a neurologist, might say, "We think that alpha lipoic acid would be able to prevent the neuropathy, or nerve damage, due to Cisplatin-based chemotherapy, and here's why we think that on some small observational bases and some theoretical bases. But it's not proven, and we'd like to do a trial where we look at using alpha lipoic acid compared to placebo to prevent platinum-related neuropathy." That would be an example, a neurologist, a rehab physician, an idea related to treatment. And then can we do that?

Commented [T15]:

Dr. Fisch begins this segment by noting that he began looking for experts to begin developing the new focus of the CCOP. He explains why MD Anderson physicians need community based patients.

He explains finances: the program pays for the infrastructure, not the drugs and other related costs. He discusses strategies researchers use to address this challenge. He gives an example of a trial run by Dr. Lorenzo Cohen comparing the impact of meditation versus relaxing music on patients' inflammation cascade. He discusses how to convince community physicians of the value of such studies.

Dr. Fisch notes his role as facilitator and stresses the importance of being respectful of the research issues that behavioral scientists confront. He gives some examples.

That's much easier to do in the community setting than it is to do here. The rehab specialists are not all seeing platinum-exposure patients. They're just getting referred patients. So they can't just wait in clinic for a flow of these people to come through into the trial. And none of them are in the setting where they can prevent. You know, the neurologist is getting referred people with neuropathy but is not seeing people at risk for neuropathy, so they can't enroll patients under their own practice to address this question. They need help. So the neurologist and rehab physician would be very knowledgeable, could work together, could write a study, but would need an oncologist to execute the study, and would need a setting, probably of general oncology, where multiple reasons to use Cisplatin would be there across diseases, and then you could conduct the study. So that's kind of a nice example of general oncology meets supportive care and supportive oncology, and in a cancer control type of study, having more to do with cancer control, meaning things that are not directly anti-disease, some aspect of care that's not directly disease-focused. So, yeah, that's an example.

So that's really where the program started to go, and then we started to not only work on—drug trials are tough because somebody has to pay for the drug. The program sort of pays for the infrastructure, the data management, the incentive to enroll patients, but they don't pay for the intervention themselves. So if you want to give 150 people alpha lipoic acid and 150 people placebo, you've got to come up with a drug and you've got to come up with a placebo. Who's going to make a placebo that looks the same? And then how are you going to distribute it to the sites? I mean, all these pieces of the puzzle are not funded, so you end up having to get other grants or work with companies that will help you do this, and generally speaking, if there's not an FDA approval and a market for what they're doing, then it can be hard to put these things together. So you can try, and we conducted the alpha lipoic acid trial with the help of a company. But in the end, the other thing you can do is start doing interventions that you don't have to pay for, or you don't have to pay for in such a discrete way. You don't have so much trouble distributing it. So it might be like a mindfulness relaxation technique versus relaxing music as a control to prevent chemotherapy-associated symptoms and ameliorate those.

[00:46:23]

Tacey Ann Rosolowski, PhD

[00:46:23]

Was that a real study?

[00:46:24]

Michael Fisch, MD

[00:46:24]

It's a real study.

[00:46:25]

Tacey Ann Rosolowski, PhD

[00:46:25]

What were the results of that study?

[00:46:26]

Michael Fisch, MD

[00:46:27]

Well, this study took a number of years. It's now complete and being analyzed, so I don't have the final punch line quite yet. This was a study led by Lorenzo Cohen, who's a fabulous researcher in integrative medicine, a professor whose background is behavioral science, and really a world leader in integrative medicine, collaborating with a physician in Toronto whose name is John Hunter [phonetic]. He was a psychiatrist and just a terrific thinker and a great partner. So a psychiatrist in Toronto and a Ph.D. behavioral scientist integrative medicine guru here, working with community practices whose patients experience a potpourri of symptoms during chemotherapy and thinking that a mind-body intervention could work for various reasons related to this sort of ideas about the inflammatory cascade and the mind-body relationships that are involved, and the neurohumoral access, you know, the connection between number of hormones and inflammation. So quite a nice body of science around that.

That study would involve empirically, like did the mindfulness relaxation group or the relaxing music group have better experience, but also collecting biological correlates to say did the slope of cortisol change seem more normal and physiologic in the group that got the intervention and was more blunted and abnormal in the group that didn't respond, the control group that maybe wouldn't respond as well.

So to do that sort of thing, first you have to explain to the community oncologists why this makes sense and what the biology and the background science is, and then you have to understand their workflow, like how would you do this, who's going to teach them mindfulness relaxation, where do people get chemotherapy, where is this intervention going to take place, how can you do it in a HIPPA-compliant manner, how can you do it without increasing the amount of chair time that they spend, because chair time is money in your practice as you try to run it efficiently. So, all kinds of logistical issues of trying to conduct the research.

Then it's not like these days where you might get on the web and try to get some interaction, but this particular study involved training the specific people who would be at that practice, because it's to deliver the intervention. So it might be if you were a nurse and you were working in Spartanburg, South Carolina, that we would train you about this intervention so you understood the basis of it, but then you would record a CD of your voice doing the intervention so that the patient would learn it from you but then would have a CD, would hear your voice reinforcing the intervention. So it was tailored, and that's an element of the trial.

But, anyway, all this stuff means travel time for the guys from Toronto to do the training, for making the CDs, and then sometimes staff turnover. What if the person you trained in Spartanburg got a new job? Does the study end there? Are you going to train more than one of them? Are you going to bring them back and make another recording? You'd have to have different sessions. So the logistics of doing any of this stuff is tricky.

But, again, in my role, I'm a facilitator of this type of research, to know what we need, to know what kind of expertise is involved, and very respectful of the fact that behavioral scientists, they encounter all kinds of research issues both at the conceptual level, how to write them, how to get them approved by the review committees to be conducted, because we don't get to just decide what we're going to do and do it. We decide what we want to do, and since this grant program is a cooperative agreement between us and the NCI, the NCI reviews and approves whether their grant funds will be used for what kind of research.

So you need behavioral scientists to have the ideas, to sell those ideas, to make sure they're tight and rigorous enough, and to have the professionalization to work through all the various pieces of the execution of these projects and then ultimately, also, the analysis of these things. How do you analyze these sort of data? These are things that are often tricky to find the right statistician. You can't just say, well, data analysis is a statistician issue. You need the right kind of statisticians interacting with, many times, behavioral scientists or whatever kind of scientists you're talking about who bring their perspective to that data, and the analysis is sort of a team effort in its own right. It's not just a commodity that you hand over to a statistician. The statisticians are actually involved in the construction of the project and often the execution of the project as they kind of learn what's going on with the data. So when done properly, that's very carefully coordinated over time.

So, behavioral science center, it could be exercise. We did mindfulness relaxation versus relaxing music. We've done an exercise intervention during the time that people are getting chemotherapy for colorectal cancer versus a control which was not as rigorous and that sort of thing.

[00:52:53]

Chapter 16

B: Building the Institution;

A New Department of General Medical Oncology

Story Codes

B: MD Anderson History;

B: Beyond the Institution;

D: On the Nature of Institutions;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

Tacey Ann Rosolowski, PhD

[00:52:54]

So can I ask how did the development of these studies—what was happening that made it clear that a Department of General Medical Oncology needed to be created from this?

[00:53:08]

Michael Fisch, MD

[00:53:09]

Right. So I would say that that became sort of the linchpin of the department. You have a grant-funded program that's taking advantage of a perspective of general oncology to connect community oncologists to experts of various types, but that by itself wasn't enough to departmentalize, because that's just a research program. It can stand alone. You have to say, where's this research program sit in the institution, and how's it piped in?

But really, the department came about because at that time that I was getting going there. By 2004 I moved out of Palliative Care as my sort of departmental home to the Department of GI Medical Oncology, and that's because they had, amongst the specific GI illnesses, disease-specific realms, they were the ones who saw cancer of unknown primary site, like cancers where we don't know where it came from, could be from anywhere, and that was sort of the closest thing to general oncology, like what if the cancer could come from anywhere, then it's nonspecific oncology in a sense. It's really sort of a given kind of chapter in textbook. Cancer of unknown primary site is like a site, it's just a certain way of looking at it. But anyway, that seemed to be the most generic sort of place to put somebody who is functioning in an unusually broad fashion.

Commented [T16]:

Dr. Fisch notes that the Community Clinical Oncology Program (CCOP) offered a platform to create a new Department of General Medical Oncology. He tells the history of how the department was formed. He explains how the program at LBJ Hospital was involved as well as Dr. James Cox's [Oral History Interview] mandate to expand radiation oncology services beyond MD Anderson proper.

Given this complexity, Dr. Fisch notes, it made sense to put all generalists together in a new department. He headed a General Oncology Program that operated from 2006 – 2008. In 2008, plans for departmentalization were made and he was named chair. He lists the functions included in the new department. He lists the functions included and talks about the challenges of creating cohesion in the diverse department.

But then we had other things that were happening at the same time in the sort of general oncology realm. The LBJ program, which had started in the mid-nineties with Vicente Valero's leadership and just a few people, was beginning to grow, where MD Anderson faculty were working with MD Anderson fellows in another health system with a broad case mix in both inpatient and outpatient setting, and as the number of patients there grew and a few more faculty had to get involved and more and more fellows were seeing patients out there, that became a bigger thing, and it was being managed like an executive-sponsored project within the Division of Cancer Medicine, so it didn't sort of belong to any of the department chairs. It then belongs to the division head and the fellowship program, and it's sort of a one-off thing that you manage right from the top office, from the corner office.

But things that are managed as executive-sponsored projects tend to have trouble getting bigger in scope and having a big vision. They have their ups and downs because you're borrowing time from everybody. There's nobody in charge. It's a small part of their job. It's a project that won't go away, but it's not really what they do. And as it gets more complicated, it just becomes a bit hard to deal with, right? So there is that happening.

Then at the same time in the institution, the radiation oncology world, under the leadership of Jim Cox, the division head at the time, had started to fulfill demand that people had for getting their radiation closer to home. So people didn't want to come to the solution shop for radiation if they could get it closer, and MD Anderson was not able to influence care for patients who wouldn't come here for their radiation. So under Dr. Cox's leadership, they started to build some radiation satellites and then they had some success with that and they were starting to think, as oncology became more and more interested in combining chemotherapy with radiation, then it was a bit of a hassle to have pure radiation satellites where there's only radiation oncologists in the satellites.

So they said, "We would like to hire an oncologist to give chemo-radiotherapy at our radiation satellite." Then the question to the division was, "Who would do that? I mean, why would you hire one oncologist just to give chemo and radiation? Why don't you hire—?" First of all, you can't hire one. You always have to have more than one, because they're not going to work every second. So you need more than one. You need at least two. And, sure, they'll give chemotherapy with radiation, but how about giving chemotherapy by itself? So how can we just start to have a more robust version of a satellite that had two medical oncologists and one radiation oncologist with some other rotating radiation oncologists backing him up. Why don't we try doing that?

Then the division was asked, "Should we do this and can we try this? We'll do this in the Bay Area as our first place." So then you started to say, well, that's another sort of executive-sponsored project that gets complexity, hire them and who's going to supervise them? How are we going to run this clinic? We have no experience running community outlying clinics. We've

never functioned that way. This wasn't an invention of the Division of Cancer Medicine. This was an executive idea, and Cancer Medicine was sort of asked to fulfill the cancer medicine part of this idea.

So then you started to have multiple things that were beginning to sort of build up the complexity surrounding the division office, and it made sense to just departmentalize these things, put them together, say, well, who's going to run the satellites and hire them and start thinking about all that, and that same general oncology department can tackle this LBJ program.

So then you have generalists in the Bay Area and you have a generalist in LBJ, and then you have the CCOP program, which is a bunch of generalists thinking across disease. And for that matter, we have our International Cancer Assessment Center, so people from all over the world who come with cancers where many times they haven't yet sorted out what cancer it is, so there's a portion of their experience that needs to start in a very general mode. So why don't we just sort of take these general oncology things and put them into a department, and then we can have a bigger vision and grow over time, and it will run more efficiently and effectively.

That was, I think, Dr. Hong's idea that didn't all come one fell swoop as Marty Raber, who was a special adviser, a beloved GI medical oncologist, senior person but very much known for his wisdom and his perspective, and Marty would say there was a lot of time planting seeds around some of these ideas, and sometimes over time you plant the seeds and the little water and sunshine and time, and some of them will sprout.

So between 2004 and 2006 or so, some of those seeds sprouted, and then it kind of became like a General Oncology Program between roughly 2006 and 2008. I mean sort of have a label where I would start coming to the Division of Cancer Medicine Executive Council meetings as the head of the General Oncology Program, and I would be speaking towards that particular collection of things and what was bubbling up in that realm. And then around 2008, the plan for departmentalizing it came forth, and I was the ad interim chair in 2008, and then I was named chair of the department by 2009.

So this was a process of putting these things together, and as the department came together, that's when the Integrative Medicine Program, which had been in Behavioral Science and then a little bit in Palliative Care, I think—exactly where it was, sometimes I'm finding the history of where it literally was a little puzzling, but it wasn't in General Oncology. It was somewhere else. And the patient care piece was being done in one room of the Palliative Care Clinic at the time, and a decision was made to move that program into General Oncology, and instead of having a sort of integrative medical specialist who wasn't a cancer specialist doing integrative medicine, to hire oncologists trained in palliative care to be the backbone of an Integrative Medicine Clinical Program.

So that was the vision for Integrative Medicine coming into General Oncology, and then we executed on that vision, hiring, first, Richard Lee from Northwestern, who finished his medical oncology fellowship and did a palliative care fellowship and then got recruited because he was highly interested in integrative medicine and had done some work in acupuncture and had an ASCO YIA grant about attitudes, about integrative medicine and practice. So he was sort of like the perfect person to come and fulfill this vision of an integrative medicine specialist with an intellectual home in general oncology to see that program.

Then, subsequently, we hired a Gabe Lopez, who's similarly trained, that is, medical oncology and palliative care, interested enough to come from, I think, the Medical University of South Carolina to join Richard and be the second similarly trained person working full-time in Integrative Medicine. And then pairing them up, the clinicians, with Lorenzo Cohen, who had a longstanding successful research program that was continuing to build momentum on the research side, a PhD researcher, and then a clinical program built around that. And we were sort of the home base for that.

Then the question was, how are you getting all these pieces of the puzzle together into some kind of cohesive department? Because Integrative Medicine is happening, International Center is a little different thing, some of the people are offsite at LBJ in the Bay Area, so how are they going to feel like they're part of the same family? So that wasn't always easy, and in the early years we were a band of a new department with a certain energy and we could get people together periodically at the main campus and also tune them in by teleconference. Then we also could cross-cover, so our Integrative Medicine guys would see some patients at LBJ, and sometimes I would cover weekends in the Bay Area, and sometimes any of us would help in the International Center. So we were flexible and versatile and doing all that. So that's how it got started, and it worked well.

Then as time went on, each of these things grew enormously in their own right, so the regional program blossomed so there were then sort of satellites in Katy and Sugarland and in The Woodlands, and then a regional administration came, so it wasn't sort of run and administered through the Division of Cancer Medicine. We became the academic home and the sort of content advisors, but it became more multidisciplinary, so they started to add surgery, got lab-path involved, and they became more like multidisciplinary centers and started to think of it more like a regionalized care of MD Anderson more so than satellite care. And that's a whole other story.

But the punch line, I guess, is that each segment of General Oncology began to grow in its own right, and then the possibility of cross-coverage became less and less, right? So as the Integrative Medicine is really growing rapidly, then getting those oncologists to come to the International Center would not seem like an especially great idea to them. Or the LBJ Program was also

growing significantly, and so each of them grew in their own rights and, over time, creating a challenge for the department to not feel like you have just separate silos that got big enough to where they could even cover themselves, but then they're resourced from one department, so what would be the incentive to share resources from one department when each of them are sort of self-sustained things and then try to make them feel like a family, that became the challenge.

But the starting point is they were able to cross-cover each other and share the same sort of flexible and versatile attributes and had the fundamental attribute of having interest across disease, both clinically and then research areas that cut across disease, neuropathy, fatigue, chemotherapy, side effects, distress, you know, all kinds of things that cut across disease were kind of what we were into, and that's very hard. You'd say, well, everybody's interested in these things, but it's hard to make progress in other areas because if you—let's say you were interested in fatigue in breast cancer patients or even breast cancer survivorship. If you go into the breast department, the mission of breast medical oncology is to eliminate breast cancer in Texas, the nation, and the world. So what does fatigue have to do with that? I mean, it's not like we don't care about that, but it's not really what we're built to do. It's not really who we are. And we only have a certain number of dollars to spend and positions to hire to, so getting people to use a position to have somebody basically focus on something that isn't eliminating that cancer is not so easy to do. And if a faculty member took that on, if they got permission to do it in the first place, they may have trouble, you know, sort of holding serve in their group. They'd be a little bit marginal to that group. So it's a little bit easier to have a department where things that cut across disease are safe and appropriate, are consistent with—you know, the mission of the Department of General Oncology wouldn't be to eliminate such-and-such cancer in Texas, the nation, and the world. We'd have to have a different story that would allow the development of broader interests and basically throwing a block so that patients could get upfield and other kinds of cancer treatments could get upfield and score the touchdown.

[01:09:45]

Chapter 17

B: Institutional Change;

Concern about the MD Anderson Brand as the Satellite System Grows

Story Codes

B: MD Anderson History;

B: Institutional Mission and Values;

B: MD Anderson Culture;

B: The Business of MD Anderson;

B: The MD Anderson Brand, Reputation;

B: Building/Transforming the Institution;

B: Growth and/or Change;

B: Controversy;

Tacey Ann Rosolowski, PhD

[01:09:46]

So a couple of questions come to mind. I mean, first of all, I was recalling the conversation we had last time, the challenges that all of you were confronting in getting institutional appreciation for and acceptance of the kinds of support services you are offering, and I was wondering, at the time the department was formed, what was the level of acceptance and controversy over these different community-based actions and crosscutting disease approaches that were suddenly being gathered together in General Medical Oncology?

[01:10:25]

Michael Fisch, MD

[01:10:26]

Yeah, good question. I think it's just a little bit on the margin for most people. It didn't seem to get in their way. A little perplexed by it. In the Regional Care Program, a little bit of concern that our brand, the MD Anderson brand, is hanging out there in the hands of a couple of young oncologists. If a young oncologist treats the cancer we're expert in, if they treat lung cancer, than that's MD Anderson lung cancer, who qualifies them to carry the MD Anderson lung cancer flag? What are they doing on cancer? And that's not us. Are they us or they're not us? How are we managing that brand? So there were those kind of concerns. People didn't seem as concerned about that same issue at LBJ. They just felt like that that was the institution stepping up to the plate in a poorly resourced health system in trying to improve care in our community.

Commented [T17]:

Dr. Fisch responds to a question about the growing acceptance of General Medical Oncology at the institution.

He first explains the concerns about brand and quality of care that faculty have had as the satellite system grows. Dr. Fisch explains decisions that had to be made about protocols offered in satellite centers. He talks about his own view of the controversy and notes that it takes skill to work with community people and subspecialists alike.

He notes that "the MD Anderson story has been about subspecialization" and "becoming like our competitors is difficult." He explains that MD Anderson's general medical oncologists have raised the bar of care in the community and at the satellite centers. He also stresses the importance of building shared research programs and harmonizing budgets to stress that satellite centers create a shared win for MD Anderson rather than competition.

But in the regional system, in a sense, people could feel a little competitive, like why in the world would anybody with lung cancer go to the Bay Area and let those young people do what they can do out there when they could drive twenty-five miles and see the most famous people in the world in a tight team with the best resources, that, you know, the solution shop is right here. To them, it was like going on a merry-go-round in the Bay Area when Disney World was literally twenty miles away. Why would you not go to Disney World instead? That was the kind of mentality.

It was really completely befuddling most of the faculty, but they would come to learn that there's maybe only 20 percent market share for MD Anderson in our own area, and that was just impossible to understand for faculty, and I think that, you know, they didn't understand probably the patient experience of cancer. You know, if you're an older adult in the Bay Area, a lot of retired NASA employees and other kinds of people who have found a forty-five-minute drive through traffic daunting, if you're seventy years old and you're sick and you're short of breath.
[01:13:04]

Tacey Ann Rosolowski, PhD

[01:13:04]

Well, plus, just finding a place to park. (laughs)

[01:13:07]

Michael Fisch, MD

[01:13:07]

Yeah, overwhelming. And the idea that somebody will take care of them closer to home. Or even a mother who wants to be able to get treated for breast cancer and still make it to soccer practice, how do you do that and get treated closer to home? And then realizing that there are actually, for the bread-and-butter of oncology, the common diseases and common treatments, that there are well-trained general oncologists, community oncologists who are quite effective at taking care of people, meeting them where they are and giving them treatments, and they could do it and they could do it well, and there's genuine competition around that. If we wanted to influence the care of more people, we would have to be willing to go out closer to them rather than act confused that they won't come to where we are under the circumstances that we would think they would. And then figure out how to make that better and better and how to integrate what we're doing with community-based resources. Because even basic stuff, do we get our PET scan, give somebody an appointment and give them the chemotherapy in the Bay Area but send them all the way up here for a PET scan, or are we going to use the PET scans that are made here?

So we had to decide, well, what part of non-MD Anderson care are we willing to allow to be part of the package. And that was really hard for the faculty. “You mean you’re treating that person based on that PET scan and that pathology? That makes us very uncomfortable, because we think our PET scan’s better and we think our pathology’s better. We think our syringes are better and we think our chairs are better.” Everything’s a certain attitude about what makes MD Anderson MD Anderson and how much can you water it down with non-MD Anderson stuff and still call it MD Anderson and deliver good care. And I think actually that has been sort of a chronic hill to climb, because you can’t recreate everything about MD Anderson everywhere, including the presence of the specialists. So are we going to let a GU patient not been seen by our GU? Just over time, as the regional care paradigm has improved, it’s, in a way, become even less acceptable to the subspecialists. They’re like, “There’s more and more people who are getting treated out there and not coming here, and therefore it’s not right. It’s not right unless we go and do it.”

So trying to decide whether generalists are the right people, and I think most people will agree, if you get big enough, then you can subspecialize. The question is how big do you need to be in any one remote place to be able to hold together a subspecialist model. And maybe in the most common disease of breast cancer, maybe you can have a breast cancer specialist and then some generalists, but can you have breast and GI and thoracic and GU specialists? How would that work? We have not figured that out. That’s the trick.

[01:16:54]

Tacey Ann Rosolowski, PhD

[01:16:56]

So I get the feeling—where are you in all of that conversation? What’s your impression about the right balance?

[01:17:03]

Michael Fisch, MD

[01:17:05]

Well, you know, it’s a tricky matter. It’s a tricky matter because you have to understand what’s going on with referral patterns. How do we get patients? Why do they choose to come to those regional centers? What are they expecting? What kind of outcomes are they getting with that care? And if they’re being referred, who’s referring them and what do the referring doctors want? Are the referring doctors happy?

So I might think of a case of a patient with prostate cancer. If a local physician says, “I’m going to refer to the general oncologist that I see every day here in Katy on rounds, who’s very well trained, has taken great care of my other patients, and now I have a person with prostate cancer, and I’d like Dr. so-and-so to see that patient, because I know what will happen. They’ll say,

‘Glad to help you. I’d be delighted to meet your patient,’ and within an hour or few hours they’ll show up. And we have a relationship. I know they’re not a prostate specialist, but I know that they can read the protocols, they can learn from or they can call their colleagues, and it’s always worked out well.” So the patient’s happy. The referring physician’s happy. The only person unhappy might be the GU specialists here who feel like that person’s not a GU specialist.

Then you can try a model where you put a GU specialist out in that same area, but then the referring physician doesn’t know them, and they’re not always going to be there if there’s not enough cases. So then when you have a case, they’re like, “Oh, they don’t come until Friday,” or “They’re not here. They were just here Tuesday morning,” but now it’s Wednesday morning. “They’re not here until next Tuesday morning.”

They’re like, “Well, that’s not helpful. That’s not what I need.” So if you have a GU person behind the curtain at all times, that’s fine. But if you don’t, then give me who you have. So that kind of thing.

So how do you make it all work? Sometimes I think the challenge is we can become futurists, so you think so far ahead that you build for a model that doesn’t work yet. It doesn’t work until other circumstances come to be. So how do you get from A to B? And how do you do that without denigrating the people who are doing the work, if you say, “Our deep desire in the future is to subspecialize as fast as possible, but meanwhile you need to go do what you’re doing.”

[01:19:51]

Tacey Ann Rosolowski, PhD

[01:19:51]

Yeah. “You’ll do.”

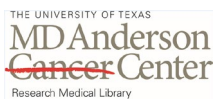
[01:19:52]

Michael Fisch, MD

[01:19:52]

Yeah. “You’re doing, but we kind of totally regret your existence, and we’d like to replace you at the first possible moment and rehab you from this.”

But there’s a skill to being able to relate to referring doctors across multiple diseases, to be able to show up day after day and deliver good care, and to be able to work in harmony with subspecialists. To me, that’s a valid skill to have. So trying to stand up for the elegant general oncologists that we’re developing and help them feel worthy and appreciated, that has been tricky. That’s been tricky.



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Again, the MD Anderson story has been subspecialization, you know, special expertise that other people—that has been our market advantage, so becoming like our competitors, functioning like our competitors with a generalist skill, local relationships, being like that is very difficult when we have been trying to anti-market exactly that and compete against that.

[01:21:05]

Tacey Ann Rosolowski, PhD

[01:21:06]

But is it really becoming like competitors? I mean, I'm just curious, because it seems like this model of care is different in the sense that the new general medical oncologist is a different creature, trained differently, different perspectives.

[01:21:25]

Michael Fisch, MD

[01:21:25]

Well, yeah, so that's the whole idea, that this is not exactly—like our general oncologist weren't intended to be exactly the same as, let's say, another competing general oncologist in Katy or the Bay Area in private practice from some other group. First of all, our idea is we would make friends with and harmonize and try to—in a sense, our presence would raise the level of care in those communities. You know, the tide would go up. They would work harder to keep up to date and would engage multidisciplinary discussions, and we would work together in certain ways, and we would just improve the care in the community, even though we don't have a monopoly of that care. And our oncologists would have a network of support, a very big family, and a lot of technology to support them in ways that might be hard to match.

So that was the idea, that we would be creating not the same as our competition, but a true academic hybrid, an academic general oncologist, well supported, with a chance to really make a difference in a community. But that's the idea. But I think it is easy to get confused or scared around that or perplexed around that.

[01:22:52]

Tacey Ann Rosolowski, PhD

[01:22:54]

Well, particularly since it's also a new field and you have to educate people about exactly what that creature is.

[01:23:00]

Michael Fisch, MD

[01:23:01]

And there's not a natural—depends how you pipe it in. If there's not a natural incentive, like if you were a GU specialist and the only thing that happens, if the academic general oncologists are successful, is that fewer of those GU patients come to go on your protocols and come to meet your budget targets, you're literally competing against your colleagues unless there's some shared win. So to make a shared win, you'd have to build a really good research program so that the patients in the community could enroll in the trials and make the in-campus doctors really happy about that, it would be a win for them. Or harmonize the budgets so that everybody could share in the overall growth of the market share and the overall improvement in the outcomes of the patients we treat, and that we would all share in that. But if you don't build the research and if you don't harmonize the metrics, then you literally compete against yourself. And it has turned out that, I think, those things are being addressed now, but for the first at least number of years, the history of the program was those things weren't addressed fast enough, and so the natural competition was a bit of an issue.

[01:24:24]

Tacey Ann Rosolowski, PhD

[01:24:26]

What about acceptance of Integrative Medicine and some of the—I mean, I don't want to say “softer” science, but the more qualitative research projects and approaches that the department houses?

[01:24:40]

Michael Fisch, MD

[01:24:40]

Right. Well, I think the Integrative Medicine has enjoyed success because of the rigor of the work that's been done. There's been really rigorous science led by Dr. Cohen and his team, looking at the biology of, say, mind-body work, and not just what was happening here, but I think happening in the field at large, more and more of an appreciation of the underpinning of the science, particularly around nutrition, exercise, mind-body. So that was important.

And then the other thing is that we did not try to be everything to everybody, so we have stuck to evidence-based integrative medicine, you know, things that are not maybe completely mainstream in the treatment clinic side but has a strong basis, and stayed away from things that might be in some fashion popular but completely unfounded, and we just would have no interest in it. So when somebody comes into our clinic and says, “I'd like to continue my Vitamin C infusions. They've always given me lots of energy,” there's no basis for thinking that that's a good idea. And even if we could make money doing that, we just weren't going to do non-evidence-based things.

We spend a lot of time just—in my mind, it’s like a stealthy version of palliative care, with just a different icebreaker for the first sentence. The different icebreaker would be, “Isn’t there some sort of acupuncture which would make this terrible pain go away? Isn’t there some sort of vegetables I can take to make my joints not ache like this?” And sometimes there’s just other kinds of suffering. Sometimes it’s, “I want to know exactly what I can take so that this cancer won’t come back.” So the real issue is fear of recurrence. So a fear-of-recurrence issue ends up in Integrative Medicine if you start it with, “Isn’t there some sort of vegetable blend?” If you start with that phrase saying, you, the same person will end up in a different place. So if that’s true, then you need the people with the assessment skills to get it right and not just translate that phrase into a vegetable juice recipe. (laughs)

So we see a lot of people with a big bag of pills and, “I take this for that. I take this for that.” But there’s a lot of assessment of, “What are you hoping for? What job are you asking these pills to do for you?” And then in a sense, opening up the dialogue, “Take me through your day. Who’s around?” And the goals of care get negotiated in, and then the place of these pills becomes clearer. And these are things that maybe oncologists, depending on who they are and how they are working, they either don’t have the skills to do it, or they may have the skills but they certainly don’t have the time, that that is not in flow for how their clinics are expected to function. And some patients who will pop up with a bagful of forty medicines that neither they nor their staff are really in a good place to go tackle that, so there needs to be another place and another set of skills applied to getting some patients’ needs met and—

[01:28:25]

Tacey Ann Rosolowski, PhD

[01:28:26]

What’s the name of the clinic where that assessment is done? That’s the Integrative Medicine Clinic?

[01:28:30]

Michael Fisch, MD

[01:28:30]

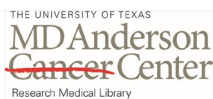
Integrative Medicine Center now. So the Integrative Medicine Center is the clinical piece of the Integrative Medicine Program, which also involves education and research pieces.

[01:28:39]

Tacey Ann Rosolowski, PhD

[01:28:40]

Okay. Now, do the patients self-select to come to the Center, or are they sent to the Center by their [unclear]?



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[01:28:47]

Michael Fisch, MD

[01:28:47]

Well, that's a really important question, isn't it? The answer is they can self-select and self-refer, or they can be referred, and both of those things happen, but that is a bit of an issue across all these realms. There's not some sort of central triage at MD Anderson that says, "When you have these kind of needs, this is how we're going to address them." So it's all sort of idiosyncratic at a certain level.

So if somebody with cancer pain—if you have back pain and fatigue, you could end up in Palliative Care, you could be referred to Cancer Pain Clinic with Anesthesia, you could end up in an Internal Medicine-run Fatigue Clinic, and you'll get good care in any of those places, and a lot of the assessment skills are similar, but it's not the same. So, depending on what random things happen, you'll go down a chute that may lead to different kind of treatment orders. You're not going to go to Palliative Care and get a pain procedure, for example, because they're just not going to do it and they're not qualified to do it, and they'll probably solve the problem without it, overwhelmingly. If you go to Cancer Pain, you might get a medical treatment but you might also get a procedure. And if you go to the Fatigue Clinic, you'll get comprehensively assessed and you might get your pain and your fatigue managed. But I'm just telling you, it's not centrally managed. There's [unclear] many ways to solve the problem. It depends where the patient wants to go and where individuals refer them.

[01:30:34]

Tacey Ann Rosolowski, PhD

[01:30:36]

Do you find that there's greater institutional, institution-wide acceptance of Integrative Medicine? I'm trying to get a sense of, like, how does the institution see—

[01:30:44]

Michael Fisch, MD

[01:30:45]

Yeah, I think the institution—well, the institution is impressed with the, I think, patient-centeredness of it, that people want this to be an option. The institution, I think, sees itself being competed against through groups like Cancer Treatment Centers of America, who invest heavily in this aspect of what people want. So, in a sense, it meets a need and helps us compete. It has an evidence basis, so the expertise is important and considered a valid and important part of good care, guideline-based care in some instances. It's considered an aspect of hopefulness, so a big part of the brand of MD Anderson is this is where you come to have the most hope and to hope for the best results. There's a certain amount of hope that people will sometimes associate in these realms, hope that they can do something for themselves by exercising or eating better, or hope that they can mix Chinese medicine with conventional medicine by adding acupuncture into the treatment to preserve their salivary flow during radiation or whatever. That kind of hopefulness, I think, is part of our brand.

I do think that MD Anderson sometimes feels ambivalent about this because we also have a brand of rigorous best science, conventional care, and I think there's sometimes a fear element of being associated with softer care or things that are not right. So I think there's a lot of responsibility on our Integrative Medicine Program to sort of find the right thread there, to get it right, to stay on the safe, effective, evidence-based side of that fence, and they do that very well. But by its nature, the field sometimes makes the institution unsettled. They stopped doing certain things like energy balance work and some of the things that were just too soft. They just decided we'll live with those things off the menu. It's not worth it. It makes the institution a little bit crazy to be in certain theories of disease or homeopathy that people just don't want to endorse here.

[01:33:17]

Tacey Ann Rosolowski, PhD

[01:33:17]

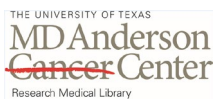
Yeah. It's almost like a marketing problem, you know, how do we represent ourselves within the institution in order to get acceptance.

[01:33:25]

Michael Fisch, MD

[01:33:25]

Yes. But I think it's now been sort of pared down to such a nice solid block of this realm that people are quite comfortable with it, and it's the most mainstream part of Integrative Health. In fact, once you start doing that, then you start realizing it's not very integrative. I mean, this is good care. I mean, it's sort of like palliative care is unique and cool until you realize palliative care is good care, and then you don't need palliative care; it's just part of care. And integrative is



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sort of heading the right same direction. You start saying, “That’s just nutrition, exercise. That’s apple pie and mother. That’s nothing special. That’s mainstream.”

So just like General Oncology in a way could drown in its own success, it gets so big that it doesn’t hang together anymore, each segment is its own—like a parent growing up a child that gets out of the house and is independent. Failure of the parent? No, that’s what happens. But integrative medicine fully realized and evidence-based starts to look like good care, along with palliative care.

[01:34:35]

Chapter 18

A: Professional Path;

Accomplishments at MD Anderson and a New Career Opportunity

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Professional Path;

B: MD Anderson History;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: Institutional Politics;

D: Fiscal Realities in Healthcare;

D: The Healthcare Industry;

Tacey Ann Rosolowski, PhD

[01:34:36]

When you look back on—since you’ve been involved with this, I mean, arguably since 2004 with the Community Clinical Oncology Program, and then since 2008 when you took over as interim head, and then 2009 formally head, I mean, as you look back over that span of time, what are you really proudest to have accomplished with this department?

[01:34:58]

Michael Fisch, MD

[01:35:00]

Well, I’m proud of the faculty that have come into it with energy and skills and a lot of healthy goals, trying to do good science, to give good care, and to make a difference, and watch them come and be successful, you know, exercise their skills, implement their vision, show resilience for things that didn’t work perfectly, or ability to escape through the ups and downs of any growing programs. But each of these realms have been successful. They’ve grown and succeeded and produced grants, papers, good care, generated developmental funding and other investments. The institution hasn’t discarded and distanced itself from any piece of this. It’s really embraced it all. So that didn’t happen by magic. That happened because the faculty were successful.

So I’m proud of that, but it’s sort of like a parent. You know, I’m proud of my children, but my children’s accomplishments are not completely the making of—you know, I have some influence and pride in it, but they’re successful because they made themselves successful, you know, and you try to raise them and influence that, and I feel the same about these programs. I try to recruit people and inspire them and set them up to be successful and enjoy their success, and what

Commented [T18]:

Dr. Fisch notes his contributions to MD Anderson: faculty recruitments, the growth and success of each program within the department and their acceptance by the administration. He next talks about his growth as a leader.

Dr. Fisch then talks about his plans to leave MD Anderson for a position as Medical Director of Medical Oncology Solutions at Ames Specialty Health in Chicago, Illinois. He notes that, with changes at the institution, general oncology and cancer control are not top priorities, and he wanted a new opportunity to rise to the next level.

Dr. Fisch talks about the skill set he will bring to Ames, where he will be assessing value-driven quality care. It is also an opportunity for him to learn a great deal, saying “It will be like doing a fellowship in managed care” and give him an opportunity to have an impact on care.

attribution I had to their success is often not that important and not that easy to figure out either.
[01:36:47]

Tacey Ann Rosolowski, PhD

[01:36:48]

I'm curious how you feel you've evolved as a leader over this time, because, I mean, as you were describing the challenges that you were [unclear], my god, I mean, talk about an infinity of moving parts. (laughs)

[01:37:02]

Michael Fisch, MD

[01:37:03]

Yes, I've always been attracted to complexity, but this has been wildly complex, wildly complex. Again, I remember some specific advice. If I had two phrases, again, in the whole leadership period, the first one was when I first took the job—and I think I already said this—that Dr. Hong said, “Your job is very easy: healthy goals, step-by-step processes.” And I think I've thought about that all throughout, and that has rang true.

But another thing he told me at one point in my tenure here is, “Mike, you've got to learn how to lose. You've got to learn how to lose.” And I've always remembered that phrase as well, and I think about that. And learning how to lose means having a certain kind of patience for things not be being right or the institution not being ready to implement your vision, even though it's clear to you that something should happen, that they're not going to do it. Or even sometimes just flat-out bad behavior, just things that just go astray. Somebody says or does something that you think was a mistake. And you have to play through those things.

In my sports analogies, I translate that into, like, I imagine like a basketball player who has somebody tugging on their shirt, and the referee doesn't always see it. You're either distracted by that, get angry about it, get angry at the referee, get angry at the player and get out of your game, or you somehow figure out how to play through that. You might not like it, but if you can't play through getting a bad call or getting hassled or picked at in ways that you think shouldn't happen, then you're too frail. You're not going to be successful. So you've got to learn how to lose means you've got to learn how to get a bad call or get interfered with on a play and still make the play, or make the next play. (laughs) Make the next play.

[01:39:21] So I think I have learned a lot about that resilience, learned too many things the hard way, and that makes me think of other advice I got from George Sledge, who was faculty at Indiana University, a breast oncologist, a brilliant guy, and he became ASCO president, who's now at Stanford. But at one point, George, who is incredibly well read and sort of a Renaissance man, I was in clinic with him seeing breast cancer patients, and he quoted Otto von Bismarck, and he said that Von Bismarck said, "Only fools learn by their mistakes. I learn by other people's mistakes." And I love that quote, but it haunts me in a certain way because so many of the things that I learn and that we all learn literally do come from things you wish you could take back.

[01:40:23]

Tacey Ann Rosolowski, PhD

[01:40:25]

Tell me about this next opportunity that you're taking, because you're leaving the institution soon.

[01:40:30]

Michael Fisch, MD

[01:40:31]

Yes. So I'm leaving the institution. Today's a Friday, so this next Wednesday, the 18th of February, is my last day at MD Anderson, and I will start working the following Monday, the 23rd of February, for a company called Ames Specialty Health. This is a company that is located in Chicago and is a wholly-owned subsidiary of Anthem, the health insurer. And my job will be to be the Medical Director of Medical Oncology Solutions, and that essentially means working with teams of people who know this business and trying to drive high-quality, high-value care in oncology.

[01:41:28]

Tacey Ann Rosolowski, PhD

[01:41:30]

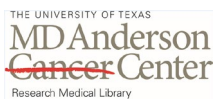
Why did you decide to leave the institution, leave MD Anderson?

[01:41:33]

Michael Fisch, MD

[01:41:34]

I decided to leave because I was restless for a way to creatively apply my skills and also sort of realizing a career has certain segments. Like if I look at my career as a stock, I feel like my stock was high, but I couldn't figure out that the next peak would be straight up. It seemed like it was getting flatter. General Oncology here, the other programs are growing up and are more self-sufficient, so the generalist piece that you need the chair to have a vision around was not as acute.



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The institution is in a phase where there's complicated and important opportunities in genomics and immunotherapy and need to, in a sense, completely revise our electronic medical records system, converting to Epic by March of 2016. I think we're really trying to figure out how to change a lot of other things in the workforce, you know, what titles do we need to do what jobs to deliver care in the environment that we're in.

So there's a lot of complicated forces in the institution, and General Oncology, Cancer Control, Supportive Oncology are really not at the top of the story here right now during this part. So I felt like my stock here was high, but when your stock is high is the right time to sell. So I would sort of sell high, and then see if I could buy some other stock that seemed in a way low, not very low but lower, that I could rise to the next level.

So this was an opportunity to find a company that would say to itself, "Somebody that has broad understanding of general oncology is very useful to us. Somebody that understands palliative care and research-integrated care and patient-centered care and is interested in quality issues and has some track record." We haven't talked about that aspect, but quality is something that threads across disease and has been integral to some of the things we've been doing in General Oncology as well. I've been part of the Ad Hoc Quality Planning Committee at MD Anderson as well.

So this confluence of things, interest in quality, supportive and palliative care, general oncology, research-driven care, that's a great platform to work for health plans. And a health plan will say, "Gosh, we have this number of million members." I'll make up a number, 10 million. "We have 10 million people in our health plan, and when we look at the details, seven out of every 1,000 people are getting treated for cancer, and maybe two or three of them are towards the end of life. Are we giving good care to them? What do they need? What does quality care look like? What are we spending on them? Are we getting our value of our spend, and how are we going to figure that out? How are we going to drive making sure we get the right care for the right person at the right time, and if our principles are we want effective care, we want it to be safe, we want it to be consistent with guidelines and norms, and we want it to be cost-effective, and taking all that into account, how do we get it right?" That's a very hard puzzle to solve. That's a hard job. And if you're a health plan in Rhode Island or in Alabama or California, are you going to hire oncologists in all these places to do that? It becomes expensive, so you start to work with companies that can help you.

Also I realized that there's a lot to learn, sort of like looking under the hood of healthcare. Like a guy's been driving around the healthcare vehicle finally looks under the hood and tries to figure out how it works. But to make all this stuff work, you start understanding the regional variation of the culture of how cares are given, how it's structured, how medical policies are put together, and then how do they exactly execute on the medical policies? Like how do the oncologists know what the medical policies are of each plan of the patients that they're taking care of, and what technology is being used to help support the decisions of the treating teams around this person's health plan, and how are patients understanding the financial consequences of the treatments and their real choices?

How are oncologists understanding the real costs of the care, so that if there are sixty-five different ways to treat non-mutated metastatic lung cancer that are consistent with NCCN guidelines, but maybe there are six or eight of them that are particularly high value if you take into account efficacy and safety and guidelines and costs, do they know which ones are high value? How will they know? Have they been trained to know this, that one regimen is \$65,000 for twelve weeks, and there's a choice that's \$20,000 for—and that the survival outcomes and safety are very similar. But how would they know that? Do they know that? And can you put systems together to help them understand that? And do they understand the consequences on that patient and family, that maybe a person who spent their whole life saving money so their kid can go to college, if they get put into the wrong therapy and they have a big copay, they're changing the family legacy for an incurable disease. Do they know that? Do the oncologists know that? Are there choices around that? What are the goals of care? How do you bring these things up? How do you drive value?

So there's a lot to this, and I remember thinking it'd be like doing a fellowship in managed care and value-driven care, that I will learn a lot of things that I don't know and I'll have a chance to try to influence care for the better towards the aims of the Institute of Medicine that I've become interested and familiar with, that I want care that is safe and effective, timely and patient-centered and equitable and efficient. We're always working towards that, but there are ways to work towards that from this other sector that require teamwork and skill. It's a different kind of interdisciplinary team. Maybe they're business analytics people, maybe they're actuaries, maybe other people who are highly familiar with the economics and the pricing and government policies, and they know the culture of the health plan and the evolution of care in a state.

There's many things to know that I've never thought of, so I'm going to have a whole new spectrum of contacts, a new view of healthcare as it applies to cancer care. And I remember thinking, "I've got my own health plan card in my wallet. If I have to go to the emergency room or advocate for my family," and I remember thinking behind that card, there's some sort of plan. If I got multiple myeloma or some other—if I needed a bone marrow transplant for leukemia, I'm thinking that this card somehow will have it right, that if I needed something, that they'll

give it to me. They won't just say, "That's expensive, Dr. Fisch. We don't like to pay for expensive heart transplants." If that's what I need, I would expect then they're going to want to give it to me, not just say no.

But I also know that if they tried the heart transplant or bone marrow transplant way too many people, then they'll be charging me way too much for that card, and I don't want to spend all my income overpaying for the unskillful use of healthcare in a whole plan. So how do I get that right? I'm counting on these—somebody, that my per-member per-month fees are appropriate but still give me what I should want, according to the Institute of Medicine. But that's not easy.

I remember talking—when I was a resident and I first got my first paychecks for whatever, \$20,000, I went from always having no money to having some money, and I thought, "I'm supposed to know what to do with this money. I'll talk to my uncle's financial advisor, because he'll let me dial him up."

I remember asking him on the phone what I should do with some very small amount of money, and he said, "Well, what are you goals?"

And I remember saying, "Oh, well, I want the biggest possible return with the lowest risk possible."

And I could almost hear the palms slapping on his head, like, "Oy, this is what I'm starting with here."

But it's like it's no chip shot to figure out how to do these things. These healthy goals are simple to state, but figuring out how to drive high-quality, high-value cancer care is a healthy goal. How to do it is not easy, and people will have to be creative and will have to be team oriented, and things will separate based on how well that gets done. I remember thinking, I sort of thought about my health card, and I thought, "I hope there's somebody who's kind of like me, with my attitude and approach and maybe good background, on the other end of this health plan, who's trying to get it right. I'll feel better if there's somebody like me."

And then, well, why not me? I'll learn things, I'll try to do some good things, and if I'm good at it, if things work out, then that'll be great and I'll contribute that way. And if they don't work out, I'll learn something, kind of like Michael Jordan learned that baseball is not an easy game and maybe basketball is the game he should come back and continue to play. But Michael Jordan came back very much energized and ready to be successful at his main sport. If that's how it turns out, then so be it, but I suspect there's plenty to apply in what I know and in sort of taking advantage of my unusualness of this kind of eclectic concoction of experiences and skills. That unusualness is beginning to not be easy to translate into anything here right now. It's all a matter of timing, but that unusualness sort of played out a certain way. But right between now and, say, the next thirty-six months, it doesn't seem like there's an obvious way for me to parlay that unusualness into something other than some extra weight and some organizational heavy lifting that could be done by others as well. But the unusualness could be much more valuable in a different place.

So anyway, so it has, to me, not so much to do with anything negative about MD Anderson, but just the evolution of a career that's ready to move on. And in sports you see this happen to certain kinds of players, too, that they have skills that don't fit the team that they're on, that is certain that did but don't, and then they go to another team and many times there's this addition by subtraction. The team that they're on gets better because they left, and the team they went to got better because they came. So I literally think that's going to happen, that General Oncology and MD Anderson are appreciative of what I've contributed, will literally improve by my subtraction in a paradoxical way, and I will improve and Ames will improve by my addition. And it seems like a cool thing, and we'll see.

I've also learned that things that seem emergent and obvious are sometimes not what they seem, and life is humbling and cancer care is humbling, and so I'll just have to keep open to what will happen. But I try to teach my son to have that same sort of attitude about whatever he's doing, that nobody can tell you what's going to happen or how things will turn out, but you try to make some reasonable judgment and start there.

[01:54:50]

Tacey Ann Rosolowski, PhD

[01:54:52]

Well, it's an exciting next step, and I wish you luck with it.

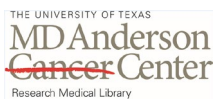
[01:54:54]

Michael Fisch, MD

[01:54:54]

Thank you.

[01:54:54]



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Tacey Ann Rosolowski, PhD

[01:54:55]

And we're actually a little over time right now, so I want to make sure that I let you go so that you can continue with your busy day since your last day is coming so quickly.

[01:55:03]

Michael Fisch, MD

[01:55:03]

Okay, yes. Well, thank you.

[01:55:04]

Tacey Ann Rosolowski, PhD

[01:55:04]

Thank you. And I am turning off the recorder at about five minutes after twelve. Thank you very much, Dr. Fisch.

[01:55:07]

(end of session two)



Michael Fisch, MD

Session 3 – February 18, 2015

Chapter 00C

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. So we are recording, and today is February 18th, 2015, and it is about quarter of nine in the morning, and we're having our third session today in General Medical Oncology with Dr. Michael Fisch, and it's your last day at the institution.

[00:00:19]

Michael Fisch, MD

[00:00:19]

That's correct.

[00:00:20]

Tacey Ann Rosolowski, PhD

[00:00:20]

(laughs) Well, thanks for fitting me in today after yesterday's little technical glitch and all of that.

[00:00:26]

Michael Fisch, MD

[00:00:26]

My pleasure.

[00:00:27]

Chapter 19

A: The Clinical Provider;

International Travel and Providing Team Care to VIP Patients

Story Codes

A: The Clinician;

A: Activities Outside Institution;

B: Beyond the Institution;

B: The Business of MD Anderson;

D: Cultural/Social Influences;

D: Global Issues –Cancer, Health, Medicine;

C: Patients, Treatment, Survivors;

C: MD Anderson Impact;

A: Personal Background;

B: The MD Anderson Brand, Reputation;

Tacey Ann Rosolowski, PhD

[00:00:27]

So we were plotting and planning a little bit before, and did you want to start with that story about international care just as an interesting example?

[00:00:39]

Michael Fisch, MD

[00:00:40]

Sure. One of the things I've been asked here in my last days at MD Anderson as I reflect on the job of things that I'll miss and things that will disappear from the scope of work that I'll be doing, and one thing that is going to change will be the amount of travel that I do on an international basis. As I was telling my children this weekend, I was sort of reflecting on places I've been, and I've been to some countries in the Middle East and South America and to some countries in Europe and Australia and Africa. So there's a fabulous opportunity to travel, and it makes one think, well, the mission of MD Anderson is to eliminate cancer in Texas, the nation, and the world, right? So there's the world component, and that very much has been true in my career.

And then as I think about the different context of the travel, some of the context has been for academic meetings, so I might give a talk or be part of a conference in Capetown in South Africa, or I may have given talks in other part of the country. I was part of a cardio-oncology workshop in Milan, Italy, for example. But another context is MD Anderson business. Sometimes what has been called global oncology, now sort of a part of a cancer network paradigm, there are MD Anderson partners in other parts of the world. So in Madrid there's MD

Commented [T19]:

Dr. Fisch notes that global oncology has become an increasingly important dimension of MD Anderson's business. He explains that, as MD Anderson set up links with international partners, he helped them set up team-based treatment plans, multi-disciplinary care, and research. He gives examples of the types of research projects that might be set up.

Dr. Fisch talks in depth about his participation in international clinical care teams making "global house calls." He explains that his role was to offer palliative care, manage anxiety, sleeplessness, and rehabilitation, sometimes spending weeks abroad. He notes that these special trips helped clarify the services he could offer as a general medical oncologist and demonstrate their value to the patients and the institution. He also describes how people would receive MD Anderson faculty overseas, which helped increase his own feeling for the institution.



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Anderson there, and I've been to that facility and talked to those folks and had a chance to travel with MD Anderson personnel to sort of fulfill some relationships on behalf of MD Anderson. I've been to Brazil in that context as well.

[00:02:59]

Tacey Ann Rosolowski, PhD

[00:03:00]

What kind of role do you serve on those trips and have you served on those missions?

[00:03:06]

Michael Fisch, MD

[00:03:06]

Yeah, different kinds of roles. So sometimes it just seems like I'm holding serve for MD Anderson, like an MD Anderson faculty to represent this or that. In my case, I'm pretty versatile. So, general oncology. Most other places in the world are not so super specialized and fragmented, and so they can really relate to the concept of general oncology. They see a lot of different diseases. The doctors that they have are versatile. They don't get to just see lymphoma. They're expected to see multiple diseases and there's a case mix in their center.

Then many times my context has also been at the interface of palliative care and supportive oncology and cancer care. So in a team of people, there may be specialists in other diseases, and then my general oncology plus palliative care perspective just rounds out the group. It makes all the other things they're talking about interesting to me, still, and I'm sort of a relevant additional perspective. But then again, I can bring a subspecialty perspective that isn't already there.

[00:04:23]

Tacey Ann Rosolowski, PhD

[00:04:24]

Can you give me an example of the kind of conversation you would have when visiting with partners? What would you hope to accomplish, for example?

[00:04:33]

Michael Fisch, MD

[00:04:34]

Yeah. So it depends on the nuances of each place, but sometimes it's helping partners understand how they might construct multidisciplinary case conferences, how they may do team-based treatment planning, how they may engage their own teams plus MD Anderson teams so that how about their radiologists, their radiation oncologists, their surgeons, their medical oncologists, plus some of our radiation oncologists or some of our medical oncologists, maybe not a gigantic team, but how do you configure some of these things so that you get a mixture of disciplines and

sometimes an inter-institutional perspective, and then how do you logistically work that out. How often are you going to do it, across which conditions?

It's very hard to do that pervasively, because it takes time to do that. It takes MD Anderson faculty time to regularly participate in those things, and it takes those teams, I mean, just like we do with team-based care, if you spend too much of your day meeting in multidisciplinary teams, then there's not enough people to do the work, and there's a lot of patients you want to take care of. So trying to figure out how to set that up, how much of that you want to do, and then how to bring some educational piece into that mix, and how to bring clinical research and research in partnership with MD Anderson into that.

Some of it is sort of database research, like what is our experience with chemo-radiation for head and neck cancer for patients who are HVP-positive, and then to even describe that in some other institution, they have to understand how to properly stage the patients, how to characterize their HVP status, how to database it. And then what's the purpose of collecting that information, right? If they're going to make an investment in following that, for what? So lots of decisions to be made about those sort of things.

And for that matter, one could be thinking, well, what about the symptom status or how often are people hospitalized during their treatment for head and neck cancer, because they get pain or they can't eat well or they get an infection? And then as you start thinking about those kind of events, what's their symptom status? How are we measuring pain? How do we treat pain? Do we have opioids? Do we use narcotics here? Do we feel culturally comfortable using narcotics? Are narcotics available in our country in the same way they're available in your country? So all those kind of things come into the mix.

So I was talking about context. So that's MD Anderson business context. There's research meetings. Professional society context, so I've had a chance to teach palliative care in Saudi Arabia and twice in Ghana as part of professional organization initiatives. ASCO is the main one in those contexts. And then I'm traveling not with MD Anderson colleagues, but just meeting other academic colleagues and spending time with them and meeting people from those countries and trying to understand where that country's story is and what's the goal of the conference and how they're trying to build capacity to deliver certain kinds of care and how they view MD Anderson and how they view cancer care. So, very broadening.

And then one unusual context, because I think many faculty have this experience of professional society or MD Anderson business travel to some degree, but I've also had the chance to be part of a literal clinical care that MD Anderson delivers globally, more or less like a house call, you know, but in other countries. And that's very unusual, but for certain circumstances, when there's enough resources and when the circumstances are there, MD Anderson has sent teams of physicians to deliver care remotely in other countries for important people. So I've done that kind of travel and had a chance to sometimes travel on very short notice.

I remember one time getting a call from my office and giving some advice. This is basically a patient in an international setting that I'd already visited before, but I'd come back from that. Then I get a call, and I'm giving some advice over the phone about what I would do, and I remember the person saying, "Well, okay, thank you very much. Well, so why don't you just come and do that?"

I thought, "Well, it's because I'm here."

And they're like, "Why don't you just go to the airport and come?" They were quite literal about that, like, "Drive to the airport and fly here." And I ended up doing that the next day. I negotiated a chance to go get some luggage. But this is not just me doing things. This is led through MD Anderson leadership, and there were mechanisms for meeting the needs that we were being asked to meet and for fulfilling the responsibilities here that needed to be fulfilled. So it takes a leadership and a whole logistical engineering to make that. That's either possible or it isn't. Either you can do it or you're willing to do it under selected circumstances or you're not. In this case, under the right circumstances for MD Anderson has done some of that, and I've had the chance to do it, and it's quite interesting.

It's quite an interesting way to relate to your colleagues too. You go spend sometimes weeks in unfamiliar settings working with other MD Anderson colleagues, trying to deliver care, MD Anderson care. It's like a road game, you know. Can you do this outside of your own stadium? You're familiar with your own locker room and the other kinds of people in your lives and people in your work environment who exist when you're playing a home game. You go to an away game, it's very different. Can we adapt some of our skills and get good outcomes and be creative and effective? It's a different kind of teamwork. So, anyway, I've done that a number of times, and it's quite interesting.

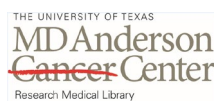
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Tacey Ann Rosolowski, PhD

[00:11:47]

So your role in those sort of scenarios, give me an example of what your role might be.

[00:11:53]



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Michael Fisch, MD

[00:11:53]

So my role, again, was more in the palliative care skill set, but understanding the underlying illness, the oncology part, what's happening to the person, what's going to happen, what we're trying to do to help them, what the different team players are doing, and then adding specific value about how might we manage their anxiety or help them sleep or take care of this pain or achieve certain goals in their rehabilitation or what have you. So, supportive, palliative, rehabilitative elements of care and care planning, that would be my sort of added value for being one amongst others on the team to go out there.

[00:12:43]

Tacey Ann Rosolowski, PhD

[00:12:44]

Well, clearly they see your value. I mean, that's a highly privileged function to serve—

[00:12:52]

Michael Fisch, MD

[00:12:53]

Yes.

[00:12:53]

Tacey Ann Rosolowski, PhD

[00:12:53]

—going to take care of these international kind of VIP patients.

[00:12:55]

Michael Fisch, MD

[00:12:56]

Yes, yes. So, yeah, I felt very honored to fill those roles and tried to do my best and put a lot of thought into what I was doing, and it was very gratifying.

[00:13:09]

Tacey Ann Rosolowski, PhD

[00:13:10]

Did you feel that being selected to go on those kinds of missions, as it were, helped support the value of the kind of work that you do here at MD Anderson?

[00:13:23]

Michael Fisch, MD

[00:13:24]

I think so. First of all, my department would get reimbursed for this time, so it was not like our work product suffered. The overall sort of production of the group was credited and some funds would be delivered back to the department for these efforts, so it contributed in that sense. But I think you're right that it does sort of help tell the story if people are not sure. People are sure what a breast oncologist does and people are sure what a radiation oncologist does, but a general oncologist who does and understands supportive and palliative care is a little harder for some people to get their head around. Depends on what they know and how clinically familiar they are, and sometimes just have you been exposed to somebody who brings that to bear, you know, to sort of even understand what it would be.

I'm always thinking in sports analogies, but maybe if you're a football team that's never played with a tight end, you don't know the value of a tight end, but if you've had one or you've seen one in action, you might begin to have a flavor for how that could be useful for certain kinds of offenses or certain kinds of plays. So people start to become familiar with what that position might add, in particular what the experience of the whole team. So you talk to the other team members, and what's it like having Mike there, or on this next trip or for this next patient, do we want him with us or do we need that? And, you know, people can sort of speak to what that brings.

So I thought that was a very interesting experience and certainly one I'm grateful for. This whole dimension of international travel has been a great part of what my experience of MD Anderson has been and, I think, one of the things I appreciate about MD Anderson overall. It's quite remarkable how people receive MD Anderson faculty internationally. You get so appreciated, it makes you particularly proud and attached to this work, because, like anybody else, you might feel less appreciated by people who are super familiar with you. (laughs)

[00:16:04]

Tacey Ann Rosolowski, PhD

[00:16:05]

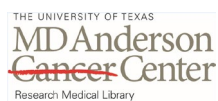
This phrase, "You're never a hero in your own land." (laughs)

[00:16:08]

Michael Fisch, MD

[00:16:08]

Yeah, you're never a hero in your own land. So we have so many talented people here that it becomes very ordinary, but you can really see how much you can add in faraway places by the depth of our knowledge and teams that we bring and then see how appreciative they are when we're able to help. So, very gratifying.



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[00:16:34]

Tacey Ann Rosolowski, PhD

[00:16:35]

A great experience, yeah.

Chapter 20

A: The Researcher;

The PREDICT Trial: A Unique Study of Biomarkers for Cardiotoxicity

Story Codes

A: The Clinician;

A: The Administrator;

A: The Leader;

A: Career and Accomplishments;

A: Overview;

A: Definitions, Explanations, Translations;

C: Discovery and Success;

B: Multi-disciplinary Approaches;

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

D: The History of Health Care, Patient Care;

Tacey Ann Rosolowski, PhD

[00:16:35]+

We had talked, too, about going through the story of the different areas in which you've done research since coming here. We kind of covered the period coming to MD Anderson, but really didn't explore how your research evolved. So I wonder if you want to take some time and do that this morning.

[00:16:54]

Michael Fisch, MD

[00:16:55]

Sure. Yeah. So I think I covered some in the context of the Community Clinical Oncology Program, and some of what I've done has been doing facilitation of research, but also some of my own research has been important. I'd say a couple of the studies that have been most important that I've been directly involved in, one of them an MD Anderson study through our CCOP here, called the PREDICT trial, P-r-e-d-i-c-t, and that has been a collaboration with cardiologist Dan Lenihan, who is an MD Anderson faculty and really the brainchild of the study when he was a faculty here.

[00:17:48]

Tacey Ann Rosolowski, PhD

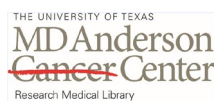
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I'm sorry. That's Dan—

[00:17:50]

Commented [T20]:

In this segment, Dr. Fisch talks about the PREDICT trial, a landmark study he conducted in the late 2000s on predictors for cardiotoxicity in patients treated with anthracyclines. He explains the effects that anthracyclines can have on the heart and notes that this is a survivorship treatment issue. The study asked Can you use point-of-care biomarker testing to assess cardiac toxicity of chemo regimens. Dr. Fisch notes that when this project began around 2007, cardiac studies were very new. He describes some challenges enrolling patients (eventually enrolling over five hundred) and reports the outcomes. He says that it was a good descriptive study, unique in the realm of oncology. His role, he explains, was facilitating set up and implementation of the project and executing the trial as part of a team effort.



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Michael Fisch, MD

[00:17:51]

Dan Lenihan, L-e-n-i-h-a-n. A terrific clinical cardiologist and clinical researcher, heart failure specialist. And then the study evolved collaborating with some other oncologists and others.

[00:18:07]

Tacey Ann Rosolowski, PhD

[00:18:08]

When did that work start?

[00:18:09]

Michael Fisch, MD

[00:18:10]

So that work started around 2007, and then it was probably 2009 or 2010 by the time we started to enroll patients. But the gist of the study was trying to predict cardiotoxicity in patients who were getting exposed to a certain type of chemotherapy called anthracyclines. Anthracyclines are a class of chemotherapy medicines such as Adriamycin or Doxorubicin and some other related drugs. These drugs are important in the management of breast cancer.

[00:18:55]

Tacey Ann Rosolowski, PhD

[00:18:55]

Could I ask you just to pause for a sec.

[00:18:57]

[recorder is paused]

Tacey Ann Rosolowski, PhD

[00:19:00]

Okay. We're recording again. (laughs) I may have to pause again.

[00:19:03]

Michael Fisch, MD

[00:19:03]

That's okay.

[00:19:03]

Tacey Ann Rosolowski, PhD

[00:19:04]

You were saying—

[00:19:04]

Michael Fisch, MD

[00:19:05]

So I was telling you about anthracycline chemotherapy and where those drugs that fall into that category have a role in the treatment of breast cancer and the treatment of certain kinds of lymphoma and leukemias and also sarcomas. So, kind of interesting for general oncologists, right? Sometimes when you're talking about the toxicity of a class of drugs, that class of drugs is used in several categories of diseases, and so the perspective of a sarcoma doctor or leukemia doctor or lymphoma specialist is of a certain kind of perspective with respect to this drug and its toxicities.

But if you are seeing a broad mix of patients, you might be interested in the larger issue, and the issue is that these drugs can cause heart failure and that heart failure, when not managed quickly and recognized early, doesn't always get better. So sometimes you can cause heart failure that doesn't allow you to finish the treatments and doesn't allow you to accomplish the goals that you had when you started treatment, and then sometimes you can use these drugs and achieve the goals of treatment in terms of treating the cancer but render the patient debilitated with a cardiac problem, either as a sort of chronic effect of an effect of the treatment that got started during the treatment or what I call late effect, sort of a ticking time bomb, so that you develop problems that don't surface for a while, but down the road sometimes a few years and sometimes even ten or fifteen years later, the effects of the chemotherapy on your heart start to play out a very difficult hand for the survivor. So it's a survivorship issue but also a treatment issue.

So anyway, we did this study called Predict, which is really a landmark study which hasn't yet been published. We were talking with the NCI yesterday about the study is completed and some of our plans moving forward to publish some of the main papers and various work products of the big study. The goal was to see if you could use point-of-care testing, like in the clinic, prick somebody's finger, take a little bit of blood, check for cardiac biomarkers, one called troponin, the other called BNP, which stands for brain natriuretic peptide. These are things that could be measured with a little bit of blood at the point of care and see if the values of those point-of-care tests could be then an indicator of cardiotoxicity during treatment that might trigger early recognition in appropriate cardiac-directed care to start prescribing cardiac medications to start to protect the heart, to get a cardiologist involved, and to ultimately see if you could complete the treatment and get safer and better outcomes.

[00:22:28]

Tacey Ann Rosolowski, PhD

[00:22:30]

Can I ask you a quick question? You mentioned the different perspectives of, say, the person treating leukemia versus somebody who's more general. Am I assuming correctly that the person treating leukemia might be willing to accept that kind of heavy fallout from the use of a drug or not be quite as concerned as a generalist?

[00:22:54]

Michael Fisch, MD

[00:22:55]

Yeah, well, let's see. So the different perspectives and what does that mean. I would not agree that it's exactly that, because leukemia doctors are trying to cure their patients in the safest way and have them have good survivorship too.

[00:23:06]

Tacey Ann Rosolowski, PhD

[00:23:07]

Right. That's why I asked. (laughs)

[00:23:08]

Michael Fisch, MD

[00:23:08]

So, for sure, that's not exactly the issue. But for some diseases where the results are not that good, then the late effects aren't there, right? You've got to have survivors to have late effects, so sometimes you're just trying to get a little bit of response and improve people's quality of life towards the end of life, and then late effects are generally a lesser concern.

It also depends on how many other drugs you have that are effective. So what might happen, say, in the land of sarcoma treatment is a drug like Adriamycin is so important because there's so few effective drugs and it's sort of impossible to get the best results if you take that drug out of your armamentarium, and sometimes they want to keep going back to that drug and really push the dose, and they're sort of much more motivated to try to figure out how they can protect the heart and jack up the dose and exposure over time of Adriamycin, just because they're bereft of better choices. Not completely. I'm not trying to completely oversimplify it, but they're just more attached to it, say, compared to breast cancer doctors, who might think, "Well, we're trying to steer away from that category sometimes, and we do have some other options when we need them."

It's still very important in breast cancer, but maybe breast cancer and sarcoma would have a different perspective. Leukemia has a different perspective. It depends on many different factors. But to even understand those factors, you've got to understand the natural history of the diseases, the treatment choices, where it fits in the role of therapy. So it's complicated. To understand cardiotoxicity, you need medical oncologists. It's very hard for cardiologists working by themselves to really figure out how to make this better. Likewise, you need cardiologists to do this stuff. This is truly an interdisciplinary realm.

But, anyway, when we started this Predict study, this was very new, the idea of cardiologists and oncologists working on a study. We'd never had a cardiologist involve in the CCOP. Since 1987 till now, there's been no cardiac-related studies, and there've been no cardiac-related studies in the rest of the groups either. So we were amongst the very first.

This wasn't really an interventional study as much as a descriptive study, to see if point-of-care biomarker testing would predict cardiotoxicity, and it had a little bit of an intervention component, to the extent that we didn't want to just find cardiotoxicity and watch it roll out on patients. So if we thought we found it, we certainly wanted to do something about it, and we didn't prescribe medicines or make that a strict part of the protocol, but we would certainly raise attention and then, per protocol, ask cardiologists to get involved when there were significant abnormalities. So that the reason for participating in the study for patients was not pure altruism, just so you people can learn about these scientific issues and clinical issues but also that it may be used to help me get better care. Even if it's a little bit nonspecific, we're not indifferent to your experience as a patient as we monitor your heart using this technique. Of course, if you're not sure if the technique is predicting cardiotoxicity or has utility, then the hazard of participating is it may draw attention to something that shouldn't have been tended to (laughs) and may subject you to consultations or procedures that, in hindsight, weren't necessary, right? So I suppose there's a risk component to this as well. Potential benefit as well as potential risk, mostly descriptive study.

Our intention was to enroll 830 patients, and the way research is done, we felt we needed to have eighty-three cardiac events to assess the predictive value of these biomarkers. So we thought, from pilot research, that about 10 percent of patients exposed to anthracyclines would have an event within a year, by the way we defined it. Anyway, we ended up enrolling 597 patients, didn't finish the whole study in terms of the accrual goal, but that's because it turned out that we had troubles with the FDA approval of the point-of-care biomarkers. It was approved, but then the company had to change the way they were making their test cards, and the FDA's asking them to make different batches affected the pace of our trial. We had to slow the trial down. We had to amend our trial. We had to then use some blood testing rather than the point-of-care testing.

And then a Data Safety Monitoring Board looking at our study said, “Based on the 597 patients you already have, you can draw some pretty strong conclusions about these markers, so the value of enrolling another 200 patients or more is not enough to justify finishing that.” So, in a sense, it was disappointing that we didn’t finish the study exactly the way we intended, but still this number of patients very well characterized for their cardiac risk factors, the cardiac medications they were taking, their physical exam findings with respect to cardiovascular things, and their echocardiograms that we did at baseline six months and twelve months, that very well-characterized prospective cohort looking at this issue of cardiotoxicity is very unique in the realm of oncology, and we’ve learned some things about it and presented them at ASCO already, and we have much more to learn and publish on that. So we’re very proud of that.

Again, this is, in a sense, an example of, I guess, my contributions, because I didn’t invent the idea, this is Dan Lenihan’s brain child, but trying to figure out how to work with Dan, see the value, seeing the uniqueness, build the trial, work with oncologists in the community setting, build a team here, sell it to the NCI, execute the trial, you know, that’s my role. I became a part of a team science project and sort of had an eye for the unique value of it, importance of it, and tried to make it roll out.

Chapter 21

A: The Researcher

A Landmark Study on Chemotherapy and Depression;

Story Codes

A: The Clinician;

A: The Administrator;

A: The Leader;

A: Career and Accomplishments;

A: Overview;

A: Definitions, Explanations, Translations;

C: Discovery and Success;

B: Multi-disciplinary Approaches;

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

D: The History of Health Care, Patient Care;

B: Beyond the Institution;

Michael Fisch, MD

[00:23:08]+

I felt similarly about an earlier study that was the ECOG SOAPP Study. ECOG, Eastern Cooperative Oncology Group, one of the other oncology groups that are now called network groups that I'd been working with since the time of my fellowship and where I've served as the chair of the Symptom Management Committee. Working with them and realizing that we wanted to do interventional symptom studies and we sometimes had trouble justifying those studies because we didn't have enough pilot data about the symptom experience of patients.

So an example would be right around 2000 or so, we were interested in studying the question of whether using an antidepressant would improve the symptom experience of patients who were getting treated for lung cancer with chemotherapy and radiation. Andrew Miller at Emory University, a psychiatrist and very interested in the biology of depression, he and his group had already looked at this idea of using antidepressants for people who were getting treated with Interferon for melanoma, and found that they had some better results. We thought, well, the sort of cytokine storm, the biological milieu when you give chemo and radiation had some real effects on the brain that could be mitigated by using antidepressants so that people would be having less depressed mood, less fatigue experience, better sleep, and might be able to even have better cancer outcomes because they'd be more likely to complete the full course of therapy at full doses.

Commented [T21]:

Dr. Fisch begins this segment by explaining that as Chair of the Eastern Cooperative Oncology Group's Symptom Management Committee, he wanted to study how to manage patient symptoms, but there was a lack of basic data about symptom experience. This led to a landmark study of more than three thousand patients that surveyed a broad range of symptoms and practice patterns for lung, breast, colorectal and prostate cancers. (He observes that such long-term studies sometimes fail, discouraging some researchers in the process.)

Dr. Fisch notes that the SOAPP study continues to make a unique contribution. An unusual feature is that the study has a website (<http://www.ecogsoapp.com/>) to facilitate dissemination of information. Data also is available through twelve published papers, with more coming. Dr. Fisch talks about the difficulties of maintaining the website when money runs out.

So we wanted to study that, and so we proposed that to the NCI and they said, “Well, that’s an interesting question, but here’s why we think it’s not ripe for doing the study. We don’t really know how often people getting chemo and radiation are depressed, and we also don’t know how often they already get antidepressants. So if that’s already the practice pattern, you won’t be able to enroll people and randomly assign them to an antidepressant versus a placebo.”

So we thought, “Well, are you going to fund us to do some of the pilot work that gives us that information so we can do the study?”

And they said, “We might consider that, although that’s not normally what we do in this mechanism, descriptive work, but if it’s fundamentally important to some of the research you want to do, we might do it.”

Then we started to put together the symptom surveys, where we’d look at the symptom experience and the practice patterns, but then we thought, why do it just for lung cancer patients? Because this is not the only research we want to do. So why don’t we look at a broad set of symptoms, physical and psychological symptoms, and look at function and then look at all the prescribing patterns for pain medicines and nausea medicines, all kinds of things that people are prescribing or consults are asking for, like what are they doing, what’s the patients’ effects, and what are people doing about it? And then let’s not just look at lung cancer, but let’s look at the four common solid tumors: lung cancer and colorectal and breast and prostate cancer.

And then we’ll just take people as they are, flowing through outpatient oncology, like who’s coming through outpatient clinics in the community and the academic centers, what is their symptom experience wherever they are in the course of their care, and we’ll do this on a large number of patients, and then we’ll have the data to plan whatever studies need to be planned. We will have enough data to not run into that kind of problem when we propose the next thing, and the next thing might be we want to study Dronabinol, sort of cannabinoid for nausea, and we’ll then be able to say this is how many people are already getting Dronabinol and this is how many people have nausea, and we’ll have something to say about all these things to help us plan the research.

So the SOAPP study was ultimately put together and conducted between 2006 and 2008. These things take years. I mean, these are not meteoric career contributions. These things are part of your long-term portfolio, because for a long time you work on a study like that and you don’t even believe it’s ever going to happen, because you can just have call after call and negotiate, negotiate, and then sometimes it just never comes together. Many people have this experience in the group system, and they say, “I worked on some study for a long, long time and it never happened, and I feel burned by that, and so I’ve decided to never do that again.” So some people have that experience and they leave.

I actually had experience like that earlier in my career, and it had to do with wanting to use Sildenafil, which is Viagra, versus placebo, for prostate cancer patients with respect to erectile dysfunction. And when I proposed it, nobody knew whether it would work for those patients, and it wasn't commonly done, and the whole idea was would it work under that circumstance. But anyway, I got all that through and it was approved, and then we were working on it. And then the NCI changed its mind and withdrew its approval. That made me very frustrated, but I didn't leave the system and didn't stop trying. I came back to play again. (laughs) And ultimately, still at the time we were working on this study for several years, negotiating, writing one version, trying to see if the group would approve it, the committee would approve it, the NCI would approve it, and then what scope and what number and how many measures do we want to do and can we justify all the data we want to collect. Anyway, many, many steps, but eventually we did it, and we enrolled basically a little over 3,100 patients. It was a very large prospective study.
[00:37:07]

Tacey Ann Rosolowski, PhD

[00:37:09]

What does SOAPP stand for?

[00:37:10]

Michael Fisch, MD

[00:37:11]

Symptom Outcomes and Practice Patterns. So actually at least right now, if you go to www.ecogsoapp.com, that website is a website for the study that would describe for you the study, some of the data, the publications, the background, how you can get some of these data to plan your research. So that was actually another unique contribution of this study. We did this big study, but then how to disseminate and make this resource available not just to us but to everybody. It's one thing to disseminate it by publishing, so we published a dozen papers or so, so far, from this study over time, and we are still publishing on it, because it's a very large dataset, and it's not just me and a few people, right? So you wait to see who's got a question that the dataset might be able to inform, and they come up with hypothesis and then submit that for a secondary concept, and it gets approved and they deliver the data and they publish it.

But anyway, the idea that a study would have its own website and would use that website to interact with others and data-share and disseminate, that was a unique element of the study as well, and that required another set of dialogue, some proposals, some other funding. And then, like anything else, the funding for the study runs out, then the funding for the website runs out, and then the study, the data are still there, the website's still there. The money's gone, and you're still trying to manage these legacy things. So all that has a certain life, but the SOAPP study is a landmark study, kind of like the Predict study.

Chapter 22

A: The Researcher;

An Emerging Field of Cardio-Oncology

Story Codes

A: The Clinician;

A: The Administrator;

A: The Leader;

A: Career and Accomplishments;

A: Overview;

A: Definitions, Explanations, Translations;

C: Discovery and Success;

B: Multi-disciplinary Approaches;

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

D: The History of Health Care, Patient Care;

This is something I was part of, and, in this case, was the P.I. of these trials, but played a certain role along with a lot of other people, but these were very unique contributions. There wasn't another big symptom study. There's not been anything as big as this, and there's not been anything like Predict, and there needs to be. But now there's an International Cardiology Oncology Society. Now just in the last week they've activated a new journal of cardio-oncology emanating from the International Cardiology Oncology Society, and there's also a Canadian Clinical Oncology Network.

So basically a small band of oncologists and cardiologists and a few others have, in the course of the Predict trial, bubbled up worldwide. It's not like the Predict trial was the first moment, was the big bang, but there was a small pulse before this. Predict is just one of those things that happened that was my point of entry. But since that era of 2007, in the last seven or eight years it has continued to grow and become more and more important because we're finding out that each new class of drugs, or many of the new classes of drugs that are coming up, are cardiotoxic, and that many of the signal transduction mechanisms that we learn about and tweak when we're treating cancer, if you go hang around cardiologists, they talk about these same pathways all the time, but they're not talking about cancer. They're talking about the heart. These same pathways are part of the normal pathways of growth and regeneration for the heart. So drugs like tyrosine kinase inhibitors are just categorically going to have cardiotoxicity because that's part of how the heart works, and if we want to tweak it for cancer treatment purposes, we'd better be willing to measure, understand, and mitigate the effects on the heart. There's no free lunch.

Commented [T22]:

In this segment, Dr. Fisch notes that field of cardio-oncology emerged over the last seven or eight years, concurrent with the PREDICT trial. He observes that the field is becoming important because new classes of drugs are cardio-toxic and many of the molecular and genetic pathways involved in cancer are also important to cardiologists. He notes that his own contributions to this field have become increasingly important.

So, anyway, that connection has been more and more appreciated in the sciences, rich in the—and then what’s happened is the need to understand the patient’s background cardiac risk factors. Like during my training, nobody was saying, “Make sure you measure the blood pressure and you need to know whether they have a family history of heart disease and other comorbidities.” I mean, that just wasn’t really drilled into my head because there was no sort of deep-set reason to do that, other than the general instincts of an internist to be a good doctor. But oncologists were becoming more focused and busy, and we kind of do our thing, but now a good oncologist needs to know what a good blood pressure is and need to know how to prescribe certain cardiac medications.

When I work with fellows in clinic and they’re using a tyrosine kinase inhibitor and I ask them the blood pressure, they go, “I don’t know. Let me check.” I try to help them understand that, “You’ve got to know that because these drugs are much more toxic in the face of high blood pressure, and it’s your job to notice that and treat it if you want to safely get this drug.” So people are learning that, but I’m learning it because of research and hanging around cardiologists and studying the science in that sense. So I’d say those are two of the bigger important studies that I had a role in.

[00:42:45]

Chapter 23

A: The Researcher; *Compassionate Care*

Story Codes

A: Overview;

A: The Clinician;

C: Human Stories;

C: Offering Care, Compassion, Help;

C: Patients;

Tacey Ann Rosolowski, PhD

[00:42:48]

I had some other topics that I kind of gleaned from my background research, and I don't know if they're actually kind of themes that you've championed in the institution or if they're topics of research, but I thought they sounded really interesting. One was compassionate care, and I'm wondering what the story is with your involvement with that.

[00:43:11]

Michael Fisch, MD

[00:43:11]

Right. Well, so, compassionate care, first of all, the compassionate way of talking to patients and an attitude and approach to patient interactions and team interactions is part of what you learn in palliative care. People will ask things like, "Oh, well, what is palliative care and what's in that palliative care syringe?" And it's really symptom management skills, knowing drugs to prescribe and ways to prescribe them and ways to assess patients over carefully and repeatedly. But that symptom management piece is probably 25 percent of the work product, you know, and then communication and compassionate care is probably 40 percent of what palliative care is all about, and then interdisciplinary teamwork is probably the rest, the other 30 percent or so, 35, whatever, whatever those proportions turn out to be. I'm making those numbers up, but that's the flavor I have.

But the point is that words matter, how to choose your words, how to talk about topics, and even more important, how to elicit things from patients by asking them questions and by listening. One of my colleagues, Tom Smith, said at a recent conference where he was speaking at MD Anderson, he referred to the three most important words in the English language: "Tell me more." And I know that you specifically could relate to that in your work. But that takes some skill to learn how to ask questions.

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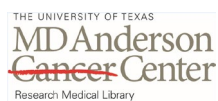
Dr. Fisch begins this segment by defining compassionate care along with the division of labor required between symptom management, communication and inter-disciplinary team work. He stresses that "words matter, how you talk about things matters," and notes the importance of learning how to ask patients questions to encourage them to tell their story, though current time pressures make this challenging. He stresses, however, that there are skills a physician can learn to make patients feel they are receiving compassionate care.

We often learn in medicine how to—we have our own agenda of what we don't want to find out. I'm going to go take a history. I'm not going to be *given* a history; I'm going to go *take* a history. I'm going to *get* the review of systems. Have you had frequent urine? Have you been going to the bathroom a lot? Have you seen blood in your urine? Are you coughing? Are you having trouble sleeping?" blah, blah, blah, blah. But you ask specific questions, you get an answer, you elicit some things, you take a history, as it were.

But then many times you're left with a very narrow view of your own construct of what's happening. But figuring out how to get patients to tell their story, and, you know, we don't have forty-five minutes in every encounter, so how do you allow patients to tell you what's important, and how do you do some listening and still get through your day? You know, that's the ultimate thing, that that's the fear factor that oncologists bring to the mix, and all doctors. If I go around listening, then I won't be able to finish rounds, I won't be able to finish my work, and I'll be very ineffective. So I don't understand how that would happen unless I just get to see five patients a day.

But the truth is, there are skills for being able to get the same amount of information in basically the same amount of time with a different style, but it's a skill you learn. And you learn how to sit down, do experiments, as Dr. Bruera has done here, kind of using a videotape technique where showing patients a video of one doctor and a video of another doctor and sort of doing the same encounter, and really the only different thing is one doctor sat down and the other doctor didn't. And then the patient's not being told that was the purpose of their—grading how compassionate the doctor was, how long they were there, estimating how long they spent listening, and figuring out that people feel like they're better cared for, they feel like they were listened to longer by people who sat down. So if you do research like that and you figure out that you've got to learn how to sit down.

And then the question might be, well, how do you do that when there's no chair in the room? And then we figure out, you've got to bring your own chair, you have this, like, little chair, the kind that you would take, like, to a golf tournament, these little pump-out chairs. They look like a little cane, almost, and you just fold them out. People then see me carrying around this little chair when I'm going on rounds, and then that becomes a distracter in its own right. People think, "Well, have you hurt yourself? Or what's going on with that?" It becomes a talking point that sometimes make me weary. But when you can pop into a room and pop that chair and sit down and actually put it wherever you need to, right, you can position yourself where you can be close to the patient and talk to the patient at eye level but also their caregiver, who's nearby, and not be sitting on their bed or standing in places that doesn't work very well. But, you know, you learn some things and you figure out how to solve a problem, like where's the chair going to be, and then how to deal with carrying the chair around and trying not to lose it and making sure that it's clean and safe to do that kind of thing.



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But, anyway, there's a lot of skills and a lot of research that can be done in the realm of compassionate care.

Chapter 24

B: Building the Institution;

The Schwarz Rounds at MD Anderson and Mindful Medical Practice

Story Codes

A: Overview;

A: The Clinician;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

C: Human Stories;

C: Offering Care, Compassion, Help;

C: Patients;

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

C: The Life and Dedication of Clinicians and Researchers;

D: The History of Health Care, Patient Care;

Michael Fisch, MD

[00:43:11]+

One of the things we did at MD Anderson is something called the Schwartz Rounds, and these were rounds that were initiated in Boston through the Schwartz Center. There was a specific patient who had been very much touched by the compassionate care he received towards the end of his life as he died of lung cancer, and there was some money that was donated to found this initiative towards compassionate care. What they were doing is having these rounds where the providers, instead of focusing on the medical problem at hand, that sort of typical case conference where the patient's problem becomes the issue, you know, "This is a patient with human papillomavirus-induced anal cancer who's been treated with this and that, and this is what our outcomes are," and blah, blah, blah, but the patient gets lost in this, and the emotions and the experience of the providers get lost. The Schwartz Rounds was more focused on the providers and their own experience and their own reactions and sometimes emotions in the course of the care. So, a very different kind of rounds, and almost hard to wrap your head around.

So when this came up, the reason it came up is to solve a problem, and the problem was that the medical oncology fellowship, as we're being evaluated by the Graduate Medical Education reviewers, the fellows indicated a certain amount of fatigue, too much fatigue and sort of burnout in their work. And then you have this gap, you know, you have this issue, and then you have to dream up what your action plan is going to be. So people were brainstorming on this action plan. And Dr. Bob Wolff, who's actually now the ad interim chair of General Oncology, and who was also the head of the fellowship program, and at the time he'd heard somebody mention Schwartz Rounds, and he thought, "Maybe we'll implement Schwartz Rounds as an action plan to address

Commented [T24]:

Dr. Fisch talks about the Schwarz Rounds implemented at MD Anderson in 2007. He describes the focus on the experiences of the care providers and the emotions that come up for them while offering care to patients. He explains that the need for the Schwarz Rounds arose because the Medical Oncology fellows were experiencing fatigue and burnout. Dr. Fisch explains why the program stopped.

Next, Dr. Fisch talks about mindful medical practice, which helps reduce burnout and fatigue among. He gives examples of the stresses of an oncologist's job. He notes that the value of awareness is increasingly recognized in medicine. He has worked to bring visibility to the issue at MD Anderson by drawing attention to research that shows how mindfulness can ensure delivery of high quality care.

this gap and see whether our fellows—we'll ask them to come and we'll see if their fatigue and burnout would improve because they'd have a chance to talk about their own experience of care, and this would be healthy."

[00:51:20]

Tacey Ann Rosolowski, PhD

[00:51:20]

When did that happen?

[00:51:21]

Michael Fisch, MD

[00:51:26]

I'm trying to remember. I'm thinking this might have been 2007 or so. That's my guess, roughly that. So it's a while ago.

But anyway, so we ended up going to Boston to see the Schwartz Rounds in action, because it was hard to wrap our head around exactly what this would look like. But it's one of those "See one, do one, teach one." But once we saw it, we got what this was about, and then we started to do it here, and the audience would be our fellows. We'd divide everybody, the whole—anybody in the institution that wanted to come to Schwartz Rounds could come, but we focused on our fellows, made sure it would work on their schedule, made sure we got them to the table, and started to conduct these things.

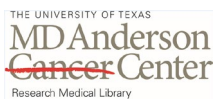
You needed to be able to moderate with not just a doctor, but a doctor and social workers. So Marlene Lockey, who is a social worker in Palliative Care, she co-facilitated it with me, and we started to do that and we had a lot of success. That is to say that we had interesting topics. It was very much appreciated by the fellows in the institution. The Schwartz Center was very careful about and very regimented about their evaluation process and how it was implemented, and they were happy with how it was going. In fact, they started to send other people who wanted to start Schwartz Rounds, would come and watch our Schwartz Rounds learn, just like we had in Boston. We became kind of like a regional place. If it was easier for you to get here, then you could come see us do it, and then you can do it.

[00:53:09]

Tacey Ann Rosolowski, PhD

[00:53:10]

How quickly did it take the fellows—how quickly did they understand what it was about and really participate in it wholeheartedly?



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[00:53:17]

Michael Fisch, MD

[00:53:18]

It didn't take them very long. I'd say within the first two Schwartz Rounds. Because the one thing about the fellows is, you know, they get to know each other and feel safer around each other. So once they kind of figure out what you're doing and then became part of the woodwork, it's easier to make it—it's easier for them when it's part of the woodwork, you know, because they come in tabula rasa. You know, training is whatever it is. If Schwartz Rounds is part of what you do here, you know, then it's not that weird. The weird part's for the rest of the world.

[00:53:48]

Tacey Ann Rosolowski, PhD

[00:53:49]

Yeah, I was going to ask what about the faculty then.

[00:53:50]

Michael Fisch, MD

[00:53:50]

Right. The faculty, harder. Fellows, you know, this is all they know if they're getting started. It's maybe a little harder for the fellows who had two years without Schwartz Rounds, but the ones that just come in and then Schwartz Rounds is part of the show, well, it's part of the show.

(laughs)

So I thought it went very well, and they sort of became a guaranteed audience, you know, like a guaranteed number of ticket sales at an event or hotel bookings. We got a certain number of guaranteed bookings because we knew the fellows needed to come. And then there was a certain amount of energy in the room, and other people would come, and people seemed to really appreciate it.

And then you think, well, are you still doing Schwartz Rounds? And the answer is we're not. And what happened was there was sort of institutional financial crisis, like a cash crisis, for a while, and even though the Schwartz Rounds was paying for lunches—I mean, part of the way this worked is the Schwartz Center would pay for the lunches and you'd have a lunch conference, so people during their lunchtime would get to eat food and participate in this thing. But the institution was saving cash and said there was sort of no food allowed at conferences for a while, and even though the food was free, it still fell into the no food, like, "If we can't have Schwartz-paid food, well, we're not doing food anywhere else." So it sort of screwed it up in that sense.

And then when that cloud lifted, we sort of lost some energy. And the other thing that we lost was the institutional—like you need to prioritize the scheduling preference. That is, if the Schwartz Rounds was once a month in a different random place in the institution, it's hard to want to go. Sometimes it's far from your clinic. Sometimes it's a little closer. At lunchtime, if you can't get there on time and then get back to where you need to be, it doesn't work. So for a clinically oriented thing, it needed to be situated closer to the clinical flow, but we didn't have priority place in the scheduling, so we were very much left to random scheduling and often difficult scheduling.

So I just became kind of weary of fighting that fight, and it had already sort of served its purpose. That is to say, it was born of a certain need and then that need came and went, and even though it was a good thing, it had no owner. Nobody institutionally said, "This is important. Let's keep doing it, and if it needs to be prioritized space-wise, then we'll do that." There was sort of no overarching caretaker of that, and so we let it go. Now we're trying to invent it again.
[00:56:52]

Tacey Ann Rosolowski, PhD

[00:56:52]

Yeah. I was seeing the whole mindful medical practice, but is that where you were—

[00:56:58]

Michael Fisch, MD

[00:56:59]

Yeah. So the mindfulness is can you notice what's happening to you, what your thought process is? Can you get your head on around what's about to happen? I'm about to break bad news. I'm going to go in and tell this woman that her cancer's relapsed, which is going to be very hard for her because her son's in the ICU with relapsed cancer right now, and her other son is very upset and needs her, and her husband is taking off too much time from work, and they're not going to have enough money. And, you know, you start to realize this is really bad and this woman is—her son's my son's age, and just noticing what you're dealing with and how it's affecting you and—

[00:57:45]

Tacey Ann Rosolowski, PhD

[00:57:46]

There's that idea of vicarious traumatizations, you know, that people have, I guess, in working in emergency sites where you just take on and take on the emotions of the people around you as they're suffering.

[00:57:58]

Michael Fisch, MD

[00:57:59]

Yes. So can you notice what's happening within you? Let's say bad news breaking. Bad news breaking goes particularly bad when you don't know that's what you're doing, where you haven't thought about it as a procedure. If I'm going to go have a family conference, that's a certain kind of procedure. How do I want that to go? What's going to happen here? What are the best practices around that? What's a skillful way to do that? If I'm breaking bad news, noticing my own reactions, knowing what I'm trying to do, knowing how skillful people do that.

[00:58:33]

Tacey Ann Rosolowski, PhD

[00:58:35]

Now, aside from becoming more functional, I mean, obviously what you're saying, getting your head around it, learning how to perform better, what are the other advantages of mindful medical practice for the clinician?

[00:58:48]

Michael Fisch, MD

[00:58:50]

Well, I think it helps clinicians reduce their own burnout and fatigue, that once they notice what their own experience is and have a game plan, that they tolerate it better. It's sort of like maybe there's still rain, but they have a bit of an umbrella and they don't get quite as wet, so the mindfulness umbrella, partial protection, a little drier, a little bit better able to sustain the work.

One of the real connections around this stuff is also being willing and able to get support from your own colleagues, to talk about what you're doing. "I'm about to break bad news. How can I do that better?" Or, "I feel very frustrated now. I'm going to take a very short break before I get ready to go back and see my next patient." If you don't know that that's what's happening, and you just keep going into the rain, things go worse. But if you can notice it and you can verbalize it, or maybe somebody—you can verbalize it and notice it and then somebody could say, "Why don't you take a short break, and we'll help you and we'll do this or that while you go gather yourself for a few minutes." Or maybe somebody needed to go cry or whatever, but then come. But you can't begin to make anything work out if you don't notice what's happening. So you make that more part of the culture of being a doctor and being a team member.

And there's quite a lot of progress in that regard in medicine overall, but trying to let some of that progress take shape for us personally and for our trainees and make sure our trainees become affected by the growth in that work and notice it when it's being published in our own journals and notice the world around us, because we can get into our own little cocoon where we notice a

specific subset of that which is happening around us scientifically and medically, but ignore another set of progress and not know how to pipe it all in.

It'd almost be like the world of cardio-oncology making progress and somehow that being off the radar, so we would just become indifferent or just late to the show. You don't want that, right? When cardio-oncology techniques start to be known, you want to be able to apply them to our patients as soon as there's knowledge to be applied. And if there's research questions to be asked, we want to be able to participate or innovate in that regard. And I'd say the same about compassionate care, palliative care, mindful practice. We want the best for our patients and for the science, and this is part of it.

But again, I think it requires not just a set of people who know this, but they're a little bit marginalized and don't interact with others, so it could be that the psychiatry nurse liaisons know all about that, but the oncology fellows don't. So if you can't connect them, then it's not going to do us as much good. So how do you bring these people into interaction in an inter-disciplinary sense? Again, that's where this onco-palliative intersection has been so valuable, because some things you can't connect unless you're part of these groups. You can't connect to cardiology if you don't have at least some people who are in the cardiology group. They won't all do it by strangers. They need some people to grow up within them who are connecting to oncology. You know what I mean?

[01:02:45]

Tacey Ann Rosolowski, PhD

[01:02:46]

Mm-hmm.

[01:02:46]

Michael Fisch, MD

[01:02:48]

And if Palliative Care has no oncologists, then that doesn't work. So our Palliative Care group has some oncologists, and then our Oncology group has some Palliative Care people, and that allows for a much more robust way of staying attuned to and applying the new knowledge at that interface of different disciplines.

Chapter 25

B: Institutional Processes;

Exploring Uses of Social Media

Story Codes

D: Technology and R&D;

C: Discovery, Creativity and Innovation;

B: Building/Transforming the Institution;

B: Growth and/or Change;

B: MD Anderson in the Future;

B: Critical Perspectives on MD Anderson;

Michael Fisch, MD

[01:02:48]+

I would even say in my own career that the interface of social media and medicine is another sphere altogether. It's not a medical sphere, but communication, you know, communication and media. It is part of what's important, right? People want to eliminate cancer in Texas, the nation, and the world. To do that, you need to have some of the principles and practices of public health, and some of that involves communication with diverse communities, not just talk within the medical community, but interacting with the lay public and starting a dialogue and seeing what could be done, and engaging the public, the patient community, and the lay public, the people who are unaffected but interested in preventing cancer and interested in seeing their family members get good care.

[01:04:18]

Tacey Ann Rosolowski, PhD

[01:04:19]

When did you first kind of realize that social media was going to be an interesting tool?

[01:04:24]

Michael Fisch, MD

[01:04:26]

Well, I'll take you back one step further and tell this story. It started, I think it's 2005, for me, where I had the sense—I actually kept seeing things in clinic, and I thought if my patients were better prepared before they got into clinic, if I wasn't having to start the curriculum right there, it'd be better, like if they knew something even before. So I thought, how could you get more people—the general health literacy or cancer health literacy elevated so that people came into their clinic visits with a little bit more to start with.

Commented [T25]:

Dr. Fisch talks about his fascination with social media and his attempts to introduce its creative use at MD Anderson to communicate more effectively with patients and the public.

[the recorder is paused]

Dr. Fisch talks about his introduction to Twitter and his efforts to use it in healthcare, beginning with the Community Clinical Oncology Program. He explains why ASCO now has a Social Media Working Group. (Dr. Fisch serves on that committee.) Dr. Fisch explains the impact that social media can have on individuals and institutions and stresses the importance of making education about social media part of medical curricula. He states that MD Anderson has made some headway in this area, and he lists the consequences of not keeping up.

Dr. Fisch next talks about his involvement in a clinical trial that proposed to use social media to increase patient enrollment. He contributed to the grant, which the South Western Oncology Group has funded.

I was thinking about that general issue, and this is at a time when the radio show [*Car Talk*] Click and Clack, the car guys, was popular. So I was thinking about the car guys, and, first of all, I'm not really into cars. I don't know much about cars. I'm not a car aficionado. And I wasn't religiously listening to every show, but I'd hear that show and I would listen to it. In the course of listening to the car guys, I ended up learning things about cars. So I would say that my car literacy, how car guys think, how they diagnose things, how basic things work, I was becoming smarter about cars with no intention for that, because the car guys were able to bring their reasoning as car guys into my midst by having the show that was a little bit light and entertaining, and I was willing to listen to it, and I was getting car-literate through it. So I thought, "We need the Click and Clack of cancer." And I thought, "Well, how do we do that?"

I'd been to a faculty development workshop where a guy named Christopher Avery, who's sort of an executive coach, leadership guy, he had written a book called *Teamwork is an Individual Skill*. So he had his book and he was here. Janis Apted and her wonderful Faculty Development group had him there. And I remember very keenly one specific thing in this Christopher Avery lecture. He said, "How many of you have ever been part of a bad team?"

My hand shot up. "Yeah, I've been part of a bad—." You know.

And he goes, "How do you know it was a bad team before *you* got there?"

And it's like, "Oh." The hand goes down. That was a good hook.

But I thought, wow, so Click and Clack of cancer means sort of palliative care, general oncology, and then like a normal guy who could ask—you know, talk to me like I'm a two-year-old. So what does it mean to be staged for cancer? And a very logical, reasonable, very mature way of thinking about personal responsibility, somebody like him and somebody like me, we could be the Click and Clack of cancer, although I don't claim to have that kind of entertainment skill. I'm not a professional radio host, and I've never done anything like that. So it's not that I felt like I had skills like that that I didn't have, but I thought something like that. I was almost thinking not like this is what I want to be, but this is something that should be, and I wish somebody would do it. It doesn't have to be me, but then nobody will begin to even understand it unless we're willing to do something or show them. You know what I mean?

Excuse me.

[01:08:13]

[recorder is paused]



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Tacey Ann Rosolowski, PhD

[01:08:16]

All right. We are back recording again after about a ten-minute break, and you were talking about becoming the Click and Clack of—

[01:08:23]

Michael Fisch, MD

[01:08:23]

Yes, so this idea of Click and Clack of cancer. So I tried to pitch that to MD Anderson, that let's do a radio show, an MD Anderson radio show, and we want to call it "The Cancer Guys." Click and Clack of cancer was just a way of describing it, but we'd be "The Cancer Guys," and it could be Christopher Avery and me. But it didn't matter to us; it could be anybody else. But we needed "The Cancer Guys."

So then we went and bought web domain cancerguys.com, cancerguys.org, and put together a logo, and we tried to pitch it to Communications. I went to Sarah Palmer [phonetic], was her name at the time. She has a new last name. But Sarah Palmer, head of Communications, and Steve Stuyck, executive leader from Communications, and our whole Communications group, and pitched "The Cancer Guys." They were very entertained by this and it was interesting, but in the end, no action plan. Again, I don't know, sometimes you pitch things, you don't get a specific answer, "We're not going to do anything, and here's why." But you just, "Thank you for coming," and no thread of follow-up. So, just shared some information with them.

So then I tried to pitch it to ASCO, and actually got invited to go to Alexandria, the new ASCO headquarters area. I guess it was in Alexandria. It was in the D.C. area. I don't know if the new ASCO headquarters was in place then. It might have been the old ASCO headquarters. But I went to D.C. area, the Cancer Communications Committee, and they flew Mr. Avery and I there.

[01:10:13]

Tacey Ann Rosolowski, PhD

[01:10:14]

Wow.

[01:10:14]

Michael Fisch, MD

[01:10:15]

I think Bob Mayer was—I don't know if he was ASCO president, but he might have been the person who was in charge of that committee. One of my colleagues, Roy Herbst, was there. I remember Roy because he still to this day when he sees me, he'll go, "Hey, it's the Cancer Guy," and he just remembers me pitching this thing.

The committee was very intrigued by what we were talking about, and some ASCO staffers and other people thought that's something that maybe ASCO should do, but I think that a lot of the other members of the committee who were academic colleagues thought it sounded like sort of self-promoting MD Anderson faculty or just sort of a self-aggrandizing opportunity that ASCO shouldn't have a part of. And part of it was also a fear thing, of, well, if ASCO sponsors "The Cancer Guys" and these two guys start talking about cancer, what if they say stupid things? What if they say things that ASCO doesn't agree with?

It reminded me of like if you were being the Baltimore Orioles radio announcer. Jon Miller and Joe Angel, I think, were favorite announcers of mine when I was growing up, and sometimes I'd listen to the Orioles or Harry Kalas with the Phillies. But you realized that these guys were calling a game and they were basically hired by the Phillies or at least approved by the Phillies or approved by the Orioles, but nobody could expect every description of every play to be the official position of the Baltimore Orioles or the Philadelphia Phillies. So you had to let your announcers be announcers that worked, in general, consistent with what the organization would hold up, but that the listeners would know that they're just some guy calling the game.

If you want some official ASCO statement about something, you need to find the official ASCO statement guideline about something. Otherwise, ASCO's just sponsoring some dialogue, trying to improve the cancer health literacy. But hard for people to wrap their head around, and so in the end, I tried a few times. I went that one time personally. I tried them once and again two years later, and it never took flight. But it was the same premise that became this social media thing. Because I think it was—I don't know. I'm trying to remember exactly when Twitter started, but, I mean, Twitter, like, didn't exist at all until, what, 2008 or so?

[01:12:51]

Tacey Ann Rosolowski, PhD

[01:12:52]

Yeah.

[01:12:52]

Michael Fisch, MD

[01:12:53]

I mean, this was pre-Twitter period, and I didn't get started on Twitter until—and it says right on my Twitter account, because it gives you kind of your born-on date. But I think mine was like February of 2011 or something like that. I think that's when it was. But it was right after the Arab Spring. I remember seeing the stuff happening at Tahrir Square and all these tanks in Tahrir Square. You'd see on the news, photographs of tanks they said that they got from Twitter, and I was trying to understand how does that happen?

So some Egyptian citizen is taking a photograph on their smartphone, and then somehow the national news is seeing the photo. How do they get that from their smartphone on the national news. How's that work? And then sort of understanding, oh, the photograph then gets turned into a—put on the web, shrunk into a bitty link, and then contextualized into 140 characters of other description of some tweet, and then how do they find it? So you tweet it, but how do they find it? And then I realized that hash tags were kind of indexing, right? So somebody would say “Tank in Tahrir Square, #Jan 30, #Egypt,” and then if you're NBC News, even though you don't know that citizen at all, you have no reason to follow them, and you didn't know they existed on the planet, but you're just following a stream by #Egypt and that day, and then you just look at what tweets are coming from all the world on that, and then some of those tweets have pictures, and then you can put together the pictures and you can confirm that this story holds up, that these pictures are consistent and that we've decided that this is true, and then you can report it.

I thought that is unbelievable. So basically, each of these people has more or less their own version of CNN. They are like a reporting outlet to the world. Even if they're not individually followed, they could be found as reporters. And then I thought, well, we should do that in healthcare, right? That's the Click and Clack. The Click and Clack of cancer can start to affect health literacy by using Twitter, and it doesn't cost you anything.

So I started to try to do that, and I started to do that for our CCOP, and at one of our CCOP meetings, I think maybe in the spring of 2011, I started to describe Twitter and try to get people to start tweeting things about our studies and things about things we care about: healthcare disparities, cancer care, symptom control, cancer control.

One of the people who came to our CCOP meeting at the time, Michael Thompson [phonetic], Mike was one of our fellows at MD Anderson, and I'd worked with him in the LBJ Clinic, and he's just an amazingly talented individual. He has an MD/PhD and was just a top-performing fellow and had gotten ASCO Young Investigator's Award and ASCO Career Development awards. But he had taken a road less traveled and went into practice in Waukesha, Wisconsin, in a community oncology setting and turned away all kinds of other academic job opportunities. But he wanted to academize. He wanted to have an academic career from a different platform, and he is and has been extremely successful at doing exactly that, sort of free agent, teaming up with former colleagues at Mayo Clinic and other places.

But anyway, so Mike was there, and he took to this and he set up his Twitter handle. He's @mtmdphd, Mike Thompson, MD/PhD. And my Twitter handle, @fischmd. So we started to share stuff just with each other. But he's been enormously successful, so he's now one of the preeminent tweeters in oncology, and he's done many great things. He started tweet chats in myeloma, and he's very well known to the top people in cancer care. And particularly in the

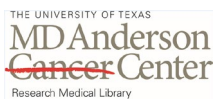
certain areas of focus that he has in myeloma, everybody knows Mike, and they know him because he's a talented guy and knowledgeable, but also because he's easy to know through Twitter. All the advocates know him, and the Myeloma Foundation people, and people all over the planet can see things that he's sharing, because he's using Twitter kind of like the NBC was using it at Tahrir Square.

Sort of that vision of how that could be done has been realized through Mike and through others in social media, but I think we got started basically right around that time, and now ASCO has just basically in the last two months approved the official Social Media Working Group, because people were starting to tweet at ASCO meetings, and then they liked it because there would be, like, millions of impressions about the ASCO meeting. Then last year, for the first time, they had official ASCO tweeters, so they would start to promote a set of people who would be more or less reporters through Twitter. Now they've started to formalize the working group so that they would have a formal process, because then some people would say, "How come they get to be ASCO tweeters? I want to be an ASCO tweeter." Right? So then you have to have some way of managing this and some rules of engagement.

ASCO has subsequently, through this informal working group that Mike Thompson and I and others are part of, Don Dizon [phonetic], Robert Miller [phonetic], David Graham [phonetic], a handful of people, have published a social media guidance. ASCO has sort of tips on social media, good social media practice, trying to professionalize social media.

It becomes an educational point, too, like if faculty are using social media in a healthy way, in a professional way, then we can help guide our trainees on how to have the right professional way of being in social media, so that bad things can happen if you violate HIPPA through this or if you create an unprofessional impression or if you think that you're obnoxious persona as a sports fan isn't really you, it reflects on your professional self. There's no way to disappear some other social media avatars you have. So people have to understand this stuff, but if there's no faculty to understand it, then you can't coach anybody. So it's become part of a good medical education is to have some people—and the more the merrier—who are mindful of this, can teach it, and can model it and make it part of the new reality.

Then within the institution, how does MD Anderson promote itself? You've seen in recent years, now Mayo Clinic has developed a social media—what do they call it—a Center for Social Media. So some other places have gone big. Here we can talk about it all day long, but then they go big and at high levels start to resource it and start to ask faculty not to wonder whether they're doing it, let them get away with it, and try not to make a big deal out of it, sort of like a risk mitigation. "Just don't hurt us with this and we'll leave you alone," versus, "Please do it, do it well, and let's use it to help the organization achieve its lofty goals." That's a different approach. So Mayo has taken a different approach.



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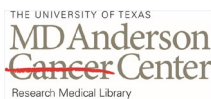
MD Anderson has come along. Places like the Cleveland Clinic and the Mayo Clinic, again, if you go to the Cleveland Clinic or Mayo Clinic Twitter handle, they have—I don't know, we can check it now. But they must have 800,000-plus followers, so they are able to send out a signal on their network and communicate things about health information or Mayo or Cleveland Clinic's way of looking at health that's very influential. MD Anderson has a version of this too. I think we had, last I checked, maybe slightly less than 30,000 followers. So, a significant gap.

So if you're sort of slow on the uptake of these things, there are consequences in your scope of influence. But MD Anderson is such an amazing place, so we don't always have to be first out of the gate, we don't have to win the first quarter of the race, so we frequently sort of hang in the middle of the pack and then we turn on the jets. So I'm always confident that MD Anderson, when it wants to turn on the jets, it's got massive burst, and it just has to decide it's time to come out of the pack and just get busy, but we haven't made that significant burst yet.

What happens in the other groups, I think, is in the end they engage faculty to help lead these things, so it's not like the Social Media Center has no Mayo faculty. It's faculty-led. It's not led by a vice president of communications; it's led by a physician. And then there's other communications professionals supporting that. But you're not going to run our melanoma department without a physician. You might have other kinds of people that help make a great team, but provider organizations ultimately, if they're trying to organize healthcare, get physicians involved, and that hasn't really happened in social—we don't have a social media leader here. We don't have a chief experience officer either.

So Mayo Clinic with its social media, Cleveland Clinic, with patient experience, have physicians leads and have parlayed those innovations into big progress that has really helped their scope of influence, helped them move up the rankings in what people trust in healthcare. MD Anderson has always been way high in cancer, but they're noticing people coming out of the pack that didn't use to be on their radar in cancer care, and they're sort of coming up not through massive prowess in some cancer advances, but through unusual channels: patient experience, social media. That's not that they don't have anything else going, but those are the things that are sort of getting separation in realms that seem to me really helping.

[01:24:29]



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Chapter 26

B: Building the Institution;

MD Anderson's Focus on Patient Experience

Story Codes

B: Building/Transforming the Institution;

C: Patients;

D: The History of Health Care, Patient Care;

C: Leadership;

B: Critical Perspectives on MD Anderson;

B: Institutional Mission and Values;

B: MD Anderson Culture;

B: The Business of MD Anderson;

B: The MD Anderson Brand, Reputation;

Tacey Ann Rosolowski, PhD

[01:24:30]

Let me just ask you a timing question, because I assume that you wanted to stop at ten-thirty this morning. Okay. So we only have about five, ten minutes left, depending on if we believe your clock or my watch. (laughs)

[01:24:41]

Michael Fisch, MD

[01:24:41]

Yeah.

[01:24:41]

Tacey Ann Rosolowski, PhD

[01:24:43]

So what would you like to do in these last moments? You began talking about—

[01:24:49]

Michael Fisch, MD

[01:24:50]

Let's see. I think I've covered a lot of different things: mindful practice, compassionate care.

[01:24:54]

Tacey Ann Rosolowski, PhD

[01:24:55]

There's the patient experience you began talking about a bit. Do you want to talk about that?

Commented [T26]:

Dr. Fisch talks about two initiatives to involve patients as partners in planning processes: the Patient Experience Steering Committee and the Patient and Family Advisory Council. Dr. Fisch notes that though he received invitations to serve on both committees, he was given no charge or mission and there is no natural momentum on patient experience at the institution. He talks about the advantages to the institution of addressing patient experience and notes that MD Anderson's attention to this matter is a response to an Institute of Medicine report that other institutions are moving ahead.

Dr. Fisch then observes that if an institution is not patient-centered, shifting focus is difficult. He suggests ways in which MD Anderson communicates that it is not patient centered. He then talks about Leadership Rounds, which help leaders see the institution from a patient's perspective. He acknowledges that the institution is listening to patients more and coming up with creative ways of reorganizing care.

At the end of the session, he makes some final comments about working at MD Anderson.



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[01:25:00]

Michael Fisch, MD

[01:25:00]

Yeah. So I talked social media, and in a sense, I talked social media and my little story, but then in the end—well, actually, let me finish the social media story a little bit—

[01:25:16]

Tacey Ann Rosolowski, PhD

[01:25:16]

Sure.

[01:25:16]

Michael Fisch, MD

[01:25:17]

—and then talk patient experience briefly, and maybe that's about all. Are we still going?

[01:25:25]

Tacey Ann Rosolowski, PhD

[01:25:26]

We're recording, yeah.

[01:25:27]

Michael Fisch, MD

[01:25:27]

Okay. Yeah. Well, so, in terms of backtracking to maybe the next step of the social media story, so I've been tweeting, I talked about Mike Thompson, I talked about ASCO initiatives, but then Chuck Blanke, who's the chair of SWOG, one of the major network groups, as the network groups got consolidated and they were competing to be one of the four adult cancer network groups and writing those grants, Dr. Blanke, who was a fellow with me at Indiana University during my training so I've known him for many years, and along with Craig Nichols [phonetic], who was a faculty at IU during my tenure there, they approached me about involving social media as part of their grant. The question is, can we use social media to enhance enrollment on the clinical trials. They're not interested in social media for social media's sake at all, but they're interested in anything that would help enhance clinical research and clinical trials participation. The question is, could social media be used to enhance clinical trial participation? I think the answer to that question is that it's not yet clear, but it certainly seems like it has a lot of potential, because social media is the new media, and media can be used to improve cancer health literacy, to influence attitudes and beliefs about things people do in respect to their care. So it seemed like a very good idea to try to develop that.

So we put a specific aim into that grant around using social media to promote clinical trials participation, and I wrote that aim, and it became part of the SWOG grant, and the grant was very successful and got funded. And then I was invited to give a plenary session at one of the SWOG meetings to talk about use of Twitter and basically, with Chuck's support, make an appeal to the members of SWOG to get their hands dirty with social media and to sign up on Twitter or to start to become familiar with this so that we can begin to work together in this space to meet our common goal as part of SWOG, to make this not a silly little habit that is a way of wasting your time, but to make it part of the acceptable work that you might do for your professional organization, or in this case for your research organization.

So just like it's becoming acceptable from an ASCO point of view to be doing this, and from the cancer research SWOG point of view to be doing it, and now there's social media policies at MD Anderson and other places. But the policies are mostly to tell you what not to do and how to keep yourself out of jail, but there's not been organizationally somebody in a position of power who said, "We would love to see the department chairs working towards getting some of their stuff out through social media." I mean, nobody has given permission of that sort, of the sort that Chuck did with SWOG, here yet. But I think that day will come.

[01:28:41]

Tacey Ann Rosolowski, PhD

[01:28:41]

Yeah.

[01:28:42]

Michael Fisch, MD

[01:28:43]

Just like I'm convinced that there will be a chief experience officer at MD Anderson in the future, because now there's a Patient Experience Steering Committee. Dr. Buchholz invited me to work with Kay Swint, who's an experienced nursing leader, and Barbara Summers, who's the vice president of the Department of Nursing and chief nursing officer, and to work on patient experience. We have a Patient Experience Steering Committee and a Patient and Family Advisory Council. So this whole notion of patient engagement and getting patients directly involved, not just answering surveys about satisfaction and other Press Ganey-type marketing things and quality things, but to engage the lay public as true partners and have a carefully vetted Patient and Family Advisory Council, which was just created this year, again, under Kay Swint's leadership and Barbara Summers' leadership.



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I think it's twenty-seven or so patient and family advisors who come to MD Anderson on a monthly basis and sometimes visit with us on themes. They'll talk to us about the electronic health record and the conversion to Epic and what it means to them. We hear from Dr. Buchholz about our strategic framework, and so they get briefed and then they get a chance to interact and have positions about things and give us ideas and be truly part of the team.

[01:30:31]

Tacey Ann Rosolowski, PhD

[01:30:32]

What was the reason for establishing these committees at the time they were created?

[01:30:36]

Michael Fisch, MD

[01:30:37]

That's a good question. One of the things that never happened for me was I wasn't called into anybody's office where they told me a vision and asked me to do something, and they'd say, "Mike, we think patient experience is potentially important. I'd like you to work with Kay and Barbara and explore this, and we're trying to decide this or that, or we're trying to see this or that." So I didn't get a charge. I just got sort of a secondhand invitation to get involved and start showing up. So I don't know how to answer that.

But I do think that, like I said, it's pretty clear that there's been momentum in Patient Experience. There are Patient Experience meetings. There's a lot of dialogue about it that's being talked about in publications like *Health Affairs*. So I think MD Anderson, again, we're still in the pack, using that analogy of running in the pack. But the pack was starting to speed up, so we weren't ready to do our turbo charge and take the lead or try to take the lead, but we're having to run faster because at the pace we were running, the pack was getting out in front of us.

[01:31:48]

Tacey Ann Rosolowski, PhD

[01:31:50]

What's the need for addressing patient experience? I mean, what's the advantage of doing that?

[01:31:53]

Michael Fisch, MD

[01:31:53]

Well, I think the advantage is that the expectations of patients and the public are changing, and people are expecting truly patient-centered care, and more and more patients are expected to be functional members of their own healthcare team. So it kind of resonates with what I was talking about, the purpose of "The Cancer Guys" and social media as well, cancer health literacy, and all

that, but that engagement at the level of their care and their experience and what is it they want to see.

We talked about patient-centered care as being one of the cornerstones of good care as part of the Institute of Medicine's report this past fall on the quality of cancer care and this sort of crisis in the quality of cancer care, and part of it is that we don't have enough prepared, proactive practice teams working with informed, activated patients and families and working together and getting the right health outcome, and also not enough integration of palliative care was another part of that report. So there's a lot of these themes have been crystallizing as part of a gap in the quality of cancer care in this country.

So I think MD Anderson is responding to the Institute of Medicine's reports and the world around them, and, again, the pack is getting out ahead of us, and we've got to speed up just to stay in the middle of the pack and start to have some mechanisms to do that. I think it starts by getting caught up to the pack and then figuring out how to do things that are creative and innovative and get us to be leaders, in that sense, but right now I think we're in the catch-up mode.

But it's very hard. It's a sort of fundamentally big shift to go from being sort of centered on our own things to being centered on the patient, and this can even come up—I notice it in little things like tagline or we might have a conference or be saying, "We want to bring the best translational research forward. For us it's bench to bedside and back. That's going to be our theme." We can say that all day long and not notice what that sounds like. Bench to bedside and back. So what that sort of sounds like is our mind starts at the bench. Who's at the bench? We are, researchers in a lab. Then we're going to the clinic, getting some ideas or fuel or energy, and then taking it back to where we are. So the patient is in the middle. That's just sort of like the fuel to the engine, but it's not the center or the purpose of the care. So you go around saying "bench to bedside and back" enough, it becomes part of your culture. You're putting the patient as a necessary but not central part of what it is you think you're doing.

So, patient-centered care is a little different thing. It might be bedside to bench and back. That would be good. That would be a nice adjustment. But I remember saying that at a big meeting, and it almost just befuddles people to even—don't even understand the distinction. It's like it's all circular. It's like you're arguing, it's circular, it's going around and around and around. Well, it doesn't matter. But it does matter. I mean, it may matter to who's this for. Is this all for you because you as researchers need it? You have jobs, programs, and you have things, and you need to do what you do, and that's what you like to do, and you need us just so you can do what you like to do? Are you trying to help improve the health of Texas, the nation, and the world? What's the purpose of the work? What's the actual mission? Is it patient-centered, and if it's really patient-centered, then how might we want our care to go? Do we want to be able to sit at the

bedside in the ICU, or is it important for you to be able to get us out of there so you can do the work? What's this for? (laughs)

So it takes some doing, and if you do leadership rounds and go around—and I haven't done this, but Kay and other have done this. They'll go round on patients who are in the hospital and say, "How are things going?" Kind of like a maître d, "How's your meal?"

"It's great. Everything's good."

"Great. Thanks. I'm glad you're appreciative of being here in the hospital. Is there any little thing you think we could do just a little bit better?"

"Well, you know, I guess when I press my button, if somebody would come, because when I have to go to the bathroom, I hate—especially at night, or you know, whatever."

And they start to really understand what it is it really like, what do people really want to see happen. Do they really understand the plan? How come they don't understand what they're supposed to do when they get home? How come they come back to the hospital because they're confused about this or that, or they didn't change their dressings properly, or this or that?

Then it's like, well, when the nurses do their checkout, they checkout with each other at the front desk, and then sometimes they get this stuff all wrong. What if the nurses checked out right in front of me so that I heard what one nurse is telling the other, and I could go, "Yeah, I'm part of this"? It's all us, me and them, instead of them, and me here just—you know, stuff like that. So what's this for? (laughs) Patient-centered care, patient experience.
[01:37:48]

Tacey Ann Rosolowski, PhD

[01:37:50]

So these are the stories that you hear from the patient and family advisors?

[01:37:53]

Michael Fisch, MD

[01:37:53]

Yeah. You don't ask patients, "Is there any little thing that could help you suffer less and heal faster or heal better, feel safer, feel better cared for?" You've got to really want to know, and when they tell you, you've got to be willing to not say, "Well, let me tell you why we do checkout the way we do." Say, "How might we do checkout better so that you feel safer, so that you feel understood?" It's an attitude.

[01:38:20]

Tacey Ann Rosolowski, PhD

[01:38:21]

Mm-hmm, and feel part of your own healthcare.

[01:38:23]

Michael Fisch, MD

[01:38:23]

Feel part of your healthcare team so that we can help you get the best outcomes for this surgery that you've had. It's an attitude of patient centeredness, patient experience being the reason that you're doing and you're willing to adjust things that are for your perceived efficiency or comfort zone as an organization or an individual provider for the sake of the larger goal of the patient getting the best outcomes and having a better experience. That's a big shift. That's a hard shift. Not everybody can do that well. Sometimes it takes massive reorganization to have any chance of doing that well.

Even little things like—just think about this. What if people said, “I really wish I could get some of my chemotherapy between seven and nine p.m. on weeknights, after the kids are tucked in”? Well, that's not very easy to do. That might be patient-centered, but exactly how you make that happen, and you have to pay overtime, you change your shift schedules and the workflow, and how does it work for—so patient-experience things are not always easy to figure out how to implement, but you've got to be willing to think about it, hear it, and deal with it.

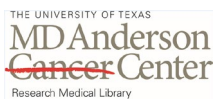
So it's not like we just for the first time ever started to listen to patients, but I think it's been ratcheted up what it means, what the conceptual models are around that, how important it is, how we do it. So not an invention, but maybe an acceleration of attention to that and some more creative things that are being done to reorganize care in certain ways, and it's almost easier to start from scratch. People who are starting from scratch can design it better from the beginning, but when you have a big ship and it's designed the way it's designed, it can be hard to change and to keep up. So it's tricky business, and so I notice things that we may be working on or that we may be seemingly behind on here and there, but it's not without a sense of the challenge and the respect for the people who have to figure out how to get that done. So I had a chance to work with Kay Swint and Barbara Bowman during my final year here, to be part of that, and they're off to a great start.

[01:41:02]

Tacey Ann Rosolowski, PhD

[01:41:03]

Well, we're a little bit over our time, and I wanted to thank you. Is there anything else that you'd like to add at this point before we close off for the morning?



Making Cancer History®

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[01:41:12]

Michael Fisch, MD

[01:41:13]

Really only that I feel very lucky to be part of the MD Anderson family and to have worked here for fifteen years and have the relationships I've had, and I know there are great things ahead at MD Anderson.

[01:41:27]

Tacey Ann Rosolowski, PhD

[01:41:27]

Well, thanks very much for your time, Dr. Fisch, and I really wish you bon voyage and good luck in Chicago.

[01:41:35]

Michael Fisch, MD

[01:41:35]

Thank you very much.

[01:41:35] (end of session three)