

## **William Daigneau, M.B.A.**

**Interview Session One: October 3, 2013**

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### **Chapter 0** **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**0:00:05.6**

Okay. So we are recording now. I'm Tacey Ann Rosolowski. Today is October 3, 2013, and the time is about 9:14. I am interviewing William Daigneau for the Making Cancer History Voices Oral History Project. This project is run by the Historical Resources Center at the University of Texas MD Anderson Cancer Center in Houston, Texas. Bill Daigneau came to MD Anderson in 1994 as the Chief Facilities Officer and Vice President for Operations and Facilities Management. He held these positions during the institution's most explosive period of growth. He retired in 2012. This interview is taking place in Mr. Daigneau's home in Silverthorne, Colorado. This is our first session together, and we're hoping to do everything in a marathon

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today, but we'll see. As I mentioned, today is October 3, and the time right now is about 9:15. Thank you very much for participating in this project.

***William Daigneau, MBA***

**0:01:12.7**

Well, we're glad to have you here.

***Tacey Ann Rosolowski, PhD***

**0:01:14.3**

And for hosting me in your home, I very much appreciate that as well. It's been a pleasure.

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## **Chapter 1**

### **A: Educational Path**

#### *Always a Builder*

#### **Story Codes**

A: Character, Values, Beliefs, Talents  
A: Personal Background  
A: Professional Path  
A: Influences from People and Life Experiences  
C: Evolution of Career

*Tacey Ann Rosolowski, PhD*

**0:01:14.3+**

So I just wanted to start with some general background. If you could please tell me where you were born and when.

*William Daigneau, MBA*

**0:01:28.8**

I was born in Mansfield, Ohio in 1946.

*Tacey Ann Rosolowski, PhD*

**0:01:34.1**

And your birth date?

*William Daigneau, MBA*

**0:01:35.1**

It is June 1, 1946.

*Tacey Ann Rosolowski, PhD*

**0:01:38.4**

In 1946. Did you grow up there as well?

*William Daigneau, MBA*

**0:01:42.7**

No, my father worked for a large bearing distributor, and part of his job was to open new stores, primarily throughout Ohio. So for example, my middle sister was born in Dayton, Ohio, because he was opening a store there. He was in Mansfield when I was born. And then when I was about two years old, we moved to Cleveland. He stayed in Cleveland, so I grew up in Cleveland, Ohio.

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***Tacey Ann Rosolowski, PhD***

**0:02:13.8**

Okay. And did your mother work?

***William Daigneau, MBA***

**0:02:18.4**

No, she worked at home and basically took care and raised us kids.

***Tacey Ann Rosolowski, PhD***

**0:02:26.2**

How big is your family?

***William Daigneau, MBA***

**0:02:27.2**

I have two sisters. One's basically twelve years older than I am, and my middle sister—or the middle child of our family—she's four years older than I am, so I was the baby.

***Tacey Ann Rosolowski, PhD***

**0:02:44.9**

The baby of the family, right. Tell me, did your interest in the sciences and engineering begin real early? How did that happen?

***William Daigneau, MBA***

**0:02:54.9**

Well, it's interesting. When you do aptitude tests, I always scored high in mechanical skills. So my interests were always how things went together. Throughout school I did very well in math and all the sciences and struggled with English. I was always fascinated by history. So just as I grew up and evolved, as I got to the point where you're starting to have to decide, well, where are you going to go to college and what are you going to major in, I gravitated toward engineering because it was how things basically went together, which kind of fueled my mechanical interests.

***Tacey Ann Rosolowski, PhD***

**0:03:47.6**

Did you have hobbies when you were younger that sort of enhanced those skills?

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***William Daigneau, MBA***

**0:03:51.8**

Toy trains—basically, in the basement I'd build a train layout. I was always interested in that. I had an airplane—the old gas models where you had to spin the prop to get it started, and then you could fly the airplane. So I always had those kinds of toys—blocks, erector sets, all the toys that interested me in, as I said, how things worked and all that, so yeah, all those hobbies. I was a boy scout. I got the Eagle Award. That basically fueled my interest in the outdoors. I'm very comfortable outdoors.

***Tacey Ann Rosolowski, PhD***

**0:04:42.9**

I should say that this home is actually your ski home.

***William Daigneau, MBA***

**0:04:46.5**

Yes, it is. It was bought primarily because it sits equidistance from four major ski resorts.

***Tacey Ann Rosolowski, PhD***

**0:04:56.9**

So tell me how you chose your college. You went to Case Western Reserve for your Bachelor of Science.

***William Daigneau, MBA***

**0:05:04.6**

Yeah—I mean—I was a very good student in high school, so I was primarily looking for places that—because we were firmly middleclass growing up—I mean—comfortable, a modest home, but it wasn't like I could just go wherever I wanted to. So I was looking for colleges that based on my grades and my SAT scores would offer me a scholarship. I applied to Stevens Institute in New Jersey, for example. My fallback was Ohio State. At the time, they had Fenn College, which was a co-op. And then at the time, it was Case Institute of Technology. That was prior to the merger with Western Reserve. Even though Western Reserve—if you know anything about that is—

***Tacey Ann Rosolowski, PhD***

**0:05:59.8**

I don't.

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***William Daigneau, MBA***

**0:06:00.3**

It's in University Circle in Cleveland, Ohio, and at the time, Case Institute of Technology sat exactly right next to Western Reserve University. So eventually the two merged. They actually merged in the year I graduated. I was the last class who had a choice between a degree from Case Institute of Technology or the new university called Case Western Reserve. Since I'd spent three years at Case Institute, I got the Case Institute degree. I was the last class to get that degree.

***Tacey Ann Rosolowski, PhD***

**0:06:39.2**

How did you—? As you look back, how do you evaluate your education at that phase?

***William Daigneau, MBA***

**0:06:47.2**

My problem was things came so easy for me in high school, so I never really had to worry about homework. I mean, I'd buzz through my homework assignments, always tested well. Then I got to Case Institute of Technology—this is like playing college ball and then going to the NFL. All of a sudden you realize everybody sitting in the same room with you is smart or smarter than you are, and they're all doing homework. And I didn't really have that honed skill because I'd never had to do it.

So my freshman year, I struggled a lot at Case Institute. I had to learn how to study because the coursework was much more elevated than high school. So I struggled in my freshman year. The closest I came—the first time in my life—to “failure,” and in my family—my father did not have a college degree. He wanted all his children to graduate from college. And failure was not an option. My father had passed away by then, but it's deeply ingrained in your psyche by then that there are no C grades. You don't bring home a report card with a C on it. That's average. You're not average. So that had been built into me by the time I got to Case Institute of Technology. So here, for the first time in my life, I could fail. So I had to double my efforts. I had to basically learn how to study because I didn't know how to do it.

***Tacey Ann Rosolowski, PhD***

**0:08:36.4**

It sounds like that was a lasting lesson for you. What shape did that take? What did that teach you in the long run?

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***William Daigneau, MBA***

**0:08:43.1**

Well, it teaches you—I mean—you can succeed. You can overcome. Other than those random events in life that will befall people that you can't do anything about, like getting struck by lightning, somebody hitting you, being at the wrong place at the wrong time—I mean—you can't really prepare for that stuff. But anything else, anything else you can overcome. It requires patience and application, et cetera, but you can learn anything, and you can do anything. That's a wonderful thing about the human race. That's why we've survived as long as we have. We figured out how to deal with the mountain lion. (laughs)

So that kind of—if I could apply myself, I could learn this. I'd have to learn new things. As I said, how to study, because just reading it once—sometimes you'd have to go back and reread things over again until you really understood what they were talking about.

It also taught me there was a difference about knowledge and memorization. To understand something is much different than just to know the facts of it. So anyway, my grade point average, I'm proud to say, dramatically improved, though my freshman year was a drag on it. (laughs) But I kept on so that by the time I graduated I was back to my father's A's and B's.

***Tacey Ann Rosolowski, PhD***

**0:10:41.7**

What year did you graduate?

***William Daigneau, MBA***

**0:10:43.7**

I graduated in '68. High school was 1964. College was 1968. I will say, back in those days, there was no five years going to school.

***Tacey Ann Rosolowski, PhD***

**0:10:58.9**

Yeah, a different scene.

***William Daigneau, MBA***

**0:10:59.3**

It was you finished in four years. So you had to take credit hours—seventeen, eighteen credit hours every semester.

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*Tacey Ann Rosolowski, PhD*

**0:11:07.5**

Yeah, I remember that, too.

*William Daigneau, MBA*

**0:11:09.9**

The good ol' days.

*Tacey Ann Rosolowski, PhD*

**0:11:11.2**

The good ol' days. Now, I did notice that you also have an MBA. Did that come later, or did you work first? How did that fit into the scheme?

*William Daigneau, MBA*

**0:11:22.5**

Well, at the time I went to Case Institute, they were quite open that the degree from Case Institute qualified you for one of two things, because it was basically a highly theoretical degree. So it either prepared you for graduate school, or it prepared you to go work for somebody who would invest a lot of time in training you for the practical realities of, in my case, engineering.

So as I say, I basically—after four years at Case, I was done, finished. I needed a break. So going to graduate school, I had no interest in that at all. So I went to—I originally thought I'd go into—my degree was basically a combination of structural and mechanical engineering. It had been created basically to support people going into the aerospace industry.

For example, air planes; there is a relationship between the size of the engine that creates the thrust, and the weight of the airplane. So the heavier the airplane gets, the larger engine you need. Well, when you go to a larger engine, what does that do? That increases the weight of the airplane. So now you have—there is a real relationship between—so you try to get, obviously, in order to keep these engine sizes down, as light of an aircraft as you can possibly make. Well, when you go to make a lighter aircraft, then things like vibration and fatigue—metal fatigue—become major issues. So my degree basically helped—supposedly prepared me to help design aircraft that were structurally sound but didn't weigh much and could withstand the vibration of takeoff and landing and all of that stuff.

So I interviewed for—I thought I was going to work for Boeing. As a matter of fact, my senior year they sent me the Seattle newspaper to my dorm room because they were sure I was going to go to work for Boeing. So the interesting story about that is that I'm looking at a brochure that they sent me about “join Boeing.” It was a promotion for young engineers to come and join their

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team. I looked at this picture, and it looked like an aircraft hangar. And that aircraft hangar was full of drafting boards, and at each drafting board was someone sitting there working. So I looked at this huge thing, and all of a sudden I saw myself as one of those people, sitting in this room the size of a hangar, and I thought, “I don’t want to do that. I’ll get lost in that.”

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## **Chapter 2**

### **A: Professional Path**

#### ***Early Job Experiences Inspire an Interest in Management***

##### **Story Codes**

A: Personal Background

A: Professional Path

A: Influences from People and Life Experiences

C: Evolution of Career

A: The Administrator

A: Overview

##### ***William Daigneau, MBA***

**0:11:22.5+**

So I had interviewed at another company called Chicago Bridge and Iron, a large steel fabricator. It didn't do bridges, though. All they did was pressure vessels and tanks. They had a year-long training program for their new engineers, and remembering those words of my counselor, I decided to join them.

So I went to work for Chicago Bridge in '68, and I spent six months in the field, three months in Engineering, and three months in Fabrication. That was the cycle. And I learned a lot. When I say "the field," I mean on the construction site. And at the time, that was when the nuclear industry was just really emerging in the United States, and because of their experience in pressure vessels, Chicago Bridge and Iron was really very active in the nuclear industry. Because they could basically fabricate, weld, roll, and bend very thick steel, up to six inches thick. They had the facilities to do that. They knew how to do that stuff.

So as a young engineer, I found myself being assigned to the nuclear projects. My three-month stint was in Memphis, Tennessee, where they had their heavy steel plate fabricating facility, and it was built on the Memphis River so that they could put together the reactor vessels, put them on a barge, ship them out to the coast—down the Mississippi—out to the coast, and then deliver them wherever the plant was being built. They were so big, you couldn't truck them, and they're so heavy. So they had to be basically—and a lot of nuclear plants are built near water sources—rivers and ocean—because they have the cooling requirements, so they need lots of water. So that's how basically—when you look at a map of all the nuclear facilities in the United States, they're all near where a large barge could—

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*Tacey Ann Rosolowski, PhD*

**0:17:00.3**

So how long did you spend with Chicago Bridge and Iron?

*William Daigneau, MBA*

**0:17:03.5**

Well, what happened was basically I spent two years with them, because I got into—this is where my interest in management started. I was assigned to the Plymouth Nuclear Station in Massachusetts. At one point in time we had over 2000 workers on this site. Now, the logistics of moving that many people around a confined construction site and having each actually productive and doing something is quite formidable.

*Tacey Ann Rosolowski, PhD*

**0:17:40.9**

Could you repeat the name of the project you were assigned to?

*William Daigneau, MBA*

**0:17:44.9**

Plymouth Station Nuclear Plant.

*Tacey Ann Rosolowski, PhD*

**0:17:49.2**

Nuclear plant, okay. I just missed that.

*William Daigneau, MBA*

**0:17:51.7**

Yeah, it's right on Cape Cod, Plymouth, Massachusetts.

*Tacey Ann Rosolowski, PhD*

**0:17:54.5**

Neat. Okay. I'm sorry. I didn't mean to interrupt you.

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***William Daigneau, MBA***

**0:17:57.9**

At the time, being the know-it-all, young engineer, I obviously had the solution to just about everything. As a matter of fact, it was interesting. One of my stints in the production facility, I developed this scheduling system for the fabricating shops to try to move things through the shop efficiently and on schedule. I thought I'd be hoisted on everyone's shoulders and applauded for that, but all the shop foremen said, "What's this?" And I was kind of frustrated at the time. Can't they see the advantages of this? And the guy I worked for at the plant says—you know—because I was a little dejected, "Bill, you've got to understand the context of it. You have to understand, Bill, that not everyone is as smart as you are." Not that I was that smart, but because I could see this, I thought everyone else could see it.

So to make a long story short, what happened to me is I wrote a report about what I saw wrong in the field erection services, comparing that to the manufacturing fabrication services of the company and how they could correct all of this. And at the time—this was before the word "mentoring" meant a lot, but basically, at Chicago Bridge and Iron, when you are a young engineer, you were assigned someone as your mentor, and usually it was an executive in the company. They would check in on you, how you doing, all this stuff. So I sent this report to my—he was a vice president in the company. I had talked to him about it. I said, "I kind of have some ideas about how we could really improve productivity on the erection side of things." He said, "Well, send it to me, and let me look at it."

As it turns out, he was going to a strategic meeting of all the executives. He took my report along with him, and put it down in front of the vice president for construction. (laughs) So anyway, to make a long story short, I wouldn't say I was blacklisted, but I was immediately transferred out of this VP's district. (laughs)

***Tacey Ann Rosolowski, PhD***

**0:20:56.0**

So it was a political thing?

***William Daigneau, MBA***

**0:20:59.8**

Oh, yeah. You know, I didn't know. I was just—for me, I was just solving the problem, and here's how they could solve the problem. It probably was totally bogus, but at the time, that was my thinking.

So based on that experience, I started thinking, well, what do I want to do? I thought, "You know, either I can work for this company for twenty years,"—because all of the senior

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executives were in their fifties. There was no fast track in that company. It was based on performance over years and years—very conservative company. Or I can fast track this. So I decided I'll get my MBA. The process of getting the MBA was pretty formidable back then. There were no executive MBA programs. You had to be admitted into the graduate school like any other student would be. Well, I'm an engineer. I'd never taken accounting, finance, business law. I'd taken none of that, so I couldn't get admitted into an MBA program without having the equivalent of a degree in finance or business. So I had to go back to undergraduate. And moving around the country in construction, I couldn't do that. So I left CB&I after two years.

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## **Chapter 3**

### **A: Professional Path**

#### ***An Evolving Perspective on People Management***

##### **Story Codes**

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Professional Path

A: Influences from People and Life Experiences

C: Evolution of Career

A: The Administrator

A: Overview

C: Professional Practice

C: The Professional at Work

***Tacey Ann Rosolowski, PhD***

**0:22:37.9**

So that was in 1970?

***William Daigneau, MBA***

**0:22:39.7**

In 1970. I took a job for the city of Peoria so I could attend Bradley University. Basically, they were—I was looking for a job and a stable situation, and they had—Peoria has Bradley, has a good reputation, accredited business school. So we moved to Peoria, and I stayed there until—well, I graduated in '74. It's only a two-year, full-time MBA, but it took me two years to get all the undergraduate credits, so it took me four years to get my degree.

***Tacey Ann Rosolowski, PhD***

**0:23:33.8**

So was that period of time—? How did working—? Where were you working? What were you doing in Peoria?

***William Daigneau, MBA***

**0:23:40.4**

I was basically—I had a very good experience in Peoria. I worked for the Public Works Department in the Engineering section. We were basically designing roads, bridges, all the utility systems. Like other places, they had their field unit that oversaw the construction things, and they had their engineering office that actually did design work. I was fortunate because I was in

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my twenties. I was fortunate because for some reason the director of Public Works took a shine to me. I tell people this: At the ripe old age of twenty-six, I was made the chairman of the Utility Commission for the city of Peoria. (laughs) But he had so much confidence in me.

***Tacey Ann Rosolowski, PhD***

**0:24:41.4**

Which of course gave you confidence in yourself.

***William Daigneau, MBA***

**0:24:45.7**

How can this happen? It dealt with all the—at the time they were all public utilities, but basically coordinated all the public utilities within the city.

***Tacey Ann Rosolowski, PhD***

**0:24:58.7**

Amazing. So tell me at the time how—in taking the MBA courses and in doing this work—how was your perspective changing in ways that would later influence your management skills and your approach?

***William Daigneau, MBA***

**0:25:14.9**

Well, basically up until then I had had no management responsibilities. It was all theoretical to me. So I really didn't have someplace to try this—what I was thinking—out. I was interested in motivation theory. Why do people get up in the morning and some are big contributors and others just get by? What makes that difference? That was interesting to me, and that was highly theoretical stuff. That goes into behavioral psychology, a whole bunch of things.

So I finished my degree there, and actually I decided I wanted to get my PhD. So this is where things really evolved for me. We had just bought a house, because I was doing pretty well with the city. The city manager had talked to me about my future with the city. Now I have an MBA, and things were going well. We had our first child, so we bought a house—our first house. And all of a sudden, I see this ad. I think it was in the *Engineering News Record*, which is a publication for construction. They wanted a construction manager at the University of Iowa in Iowa City. Well, if you look at a map, Peoria and Iowa City—I mean—it's just over the border. My wife laughs about this, because at the time, there was no word processing. It was still typewriters. And she was a very good typist, so she had done a lot of my term papers and everything like that for me because she's very fast. I mean, I can type, but she was about three times as fast as I was, so she did a lot of the typing.

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*Tacey Ann Rosolowski, PhD*  
**0:27:27.1**

And your wife's name is?

*William Daigneau, MBA*  
**0:27:28.3**

Carolyn.

*Tacey Ann Rosolowski, PhD*  
**0:27:29.5**

And your first child's name?

*William Daigneau, MBA*  
**0:27:30.6**

Is Julie.

*Tacey Ann Rosolowski, PhD*  
**0:27:31.6**

Okay. Just to get the players at the time.

*William Daigneau, MBA*  
**0:27:35.3**

Interestingly, at the time, we had just moved into this house, painting it and everything. So she says to me, "Bill, why am I typing this cover letter for your resume to the University of Iowa?" So I said, "Well, I don't think anything's going to come of it, but I thought I'd put my name in and see what my degree is worth now, see how it compares to what I'm making at the city." Well, to make a long story short, after three months of owning this house, we had it back on the market.

So we moved to Iowa City. I was accepted into the doctoral program in Organizational Behavior at their business school, and I began to work on my PhD. At the same time, I was working as their first ever construction manager at the University of Iowa. What had happened to them is all the projects—all their construction projects—were behind schedule, and they were all over budget and all of this. So I came in, and I did things I'd been taught when I worked for Chicago Bridge and Iron and at the city—you know—just routine construction scheduling, budgeting, record keeping. I put all that in place at the University of Iowa because they had none of that.

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*Tacey Ann Rosolowski, PhD*

**0:29:13.0**

Can I just interrupt you for a second and ask—I mean—what was it that interested you so much in this job?

*William Daigneau, MBA*

**0:29:19.9**

Well, the only reason I went there was to work on my PhD.

*Tacey Ann Rosolowski, PhD*

**0:29:23.1**

Okay, so this was to—

*William Daigneau, MBA*

**0:29:25.0**

But as a kind of a side effect to it, I found, well, I can make a living doing some basic construction management. I mean, this was not rocket science. I was putting in place things that everybody did, but they didn't have them at the university.

*Tacey Ann Rosolowski, PhD*

**0:29:43.8**

Why didn't they?

*William Daigneau, MBA*

**0:29:44.6**

I don't know. Because I think in universities, as bright as everybody is on the faculty side, on the management side they weren't able to ever attract really quality people. Not just the University of Iowa, all universities.

*Tacey Ann Rosolowski, PhD*

**0:30:03.0**

I was going to ask you about that experience of working at academic institutions.

*William Daigneau, MBA*

**0:30:06.8**

So I mean, some things that you would expect to find in almost any other business were not present at many universities and at the University of Iowa. That was—you know—building things was kind of a necessity, but it wasn't their primary mission, so why get good at this? We can hire consultants to do it.

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So I put in place these routine things, and, just for some reason, I became a hero. I mean, the treasurer of the University of Iowa—again, I was blessed over my career. I had very good superiors and mentors. He wasn't my superior. He was two levels up in the university from me—three levels up—but I met him because we used to do—the treasurer of the university had to be present at the bid opening. So since I was the construction manager, I would help him open the bids, and that's how I got to know him. And again, he took a liking to me. And pretty soon, I'm giving him monthly reports that show the status of very project on schedule, behind schedule, under budget, at budget, over budget. This was like feeding a baby milk. It was like this is nourishing. This is wonderful. (laughs)

***Tacey Ann Rosolowski, PhD***

**0:31:36.8**

Well, it's really interesting, because you don't—I mean, naïve as I am about the kind of work that you do, I'm seeing, oh, it's really interesting. You can actually come in, and through creating transparency—more efficiency and then transparency—you're effectively affecting budget issues. I mean, shaping the minds of people how to think about a budget for an institution.

***William Daigneau, MBA***

**0:32:03.6**

Yeah, and one of the lessons I learned—there was that whole transparency thing. There are no secrets here. Then the more that my superiors knew, the better off I was, because nobody likes surprises. Telling them everything's okay, okay, okay, and then coming and saying, "Oh, I can't fix it. Now we've got a big problem," that's not the way. So I brought them along on the ride. Everything was open, and as I say, I got very positive response.

But I still wasn't managing people. I was working on my PhD, and all of a sudden—I was at the University of Iowa two years, and it was difficult. My family, we had our second child there. And working in a university town is wonderful. I mean, you have—for a modest-income couple, you have all these things that you can do at little or no cost. There are the football games. The gymnastic team offers gymnastic lessons for kids. My kids used to go see the marching band practice for free. I mean, just fun things to do as a family, you know? And all these educational learning opportunities that other people pay for. In a university setting, they're very low cost or not cost. Swimming lessons—I mean—you name it.

So I loved this environment. I'm saying, "Golly, working for a university is great. It's great for the family. The family loves it. I love it." You have all the stimulation. Free lectures, art museums, libraries—all this stuff is free to you. Of course, they don't pay you anything, but—So I love this environment, but I still wasn't managing people. And at work it was a difficult

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situation because my immediate superior—my boss there—who had hired me, he saw my growing relationship with the treasurer and the business officer of the university, and I think he became jealous of that. Plus, he basically had a drinking problem as well. And so my relationship with my boss was basically getting worse because of this competition thing as well as his own physical condition. It was getting tough to go into work because there were outbursts and things, acting out stuff going on, which at my age, I couldn't figure out how to solve this.

I wasn't managing anyone, and so again I started looking down the road and said, "Am I going to stay here at the university? The director of Physical Plant is in his fifties. My boss is in his forties. I'm in my twenties. How long is it going to take me? When I get my PhD, what am I going to do with it? I really want to manage things. I want to be the guy in charge. I don't want to be a consultant. I don't want to teach. I want to do—you know—that mechanical thing in me. I want to actually fix things."

So two years in Iowa, and pretty soon I'm offered the job as director of Physical Plant at the University of Wisconsin-Superior. My first job truly as a manager—in management—where I was directing other people, had to set goals, had to improve processes. So I took the job.

***Tacey Ann Rosolowski, PhD***

**0:36:10.8**

And what year was this?

***William Daigneau, MBA***

**0:36:12.0**

This was in 1976, because we stayed there until '79. I always remember—you know—my biggest fear, my first day on the job—and I used to tell people this. As a new manager, your biggest fear is that you'll give direction, or give a directive—"We're going to do it this way," or, "We're going to do that"—and everyone will ignore you. (laughs) "Oh, no, we're not." I wonder if I say this and everybody says, "We're not doing that." But it didn't occur. So things worked out well there.

***Tacey Ann Rosolowski, PhD***

**0:37:04.7**

So tell me how that job—with the practical experience and really being a manager for the first time—how did that expand your skills?

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***William Daigneau, MBA***

**0:37:12.1**

I mean, I still was very theoretically oriented, so back then, [Peter] Drucker had talked about it in his book—and I can't remember the guy who really made it popular. But the big thing was management by objectives. And this had to go back to my interest in motivation theory, and it's something that actually has evolved over time. It's gotten stronger in me—my belief about this. I believed the solution to improving an organization was to set firm goals. So at the time, management by objectives was a process that was being touted as the way to improve organizational performance, and I embraced it.

Well, if you know anything about management by objectives, there's lots of paperwork and forms. Those poor folks—actually, I left there very well respected and like. I mean, the people that worked for me were sorry to see me go. But looking back, I put them through such heck, because, “We're going to do MBO, so I want—here's the forms. I want you all to fill them out.” (laughs) It was like my experience in the scheduling at Chicago Bridge and Iron. What the heck is all this about? What's this for? Big deal. So they begrudgingly did this stuff, and we reported every—but really, it didn't get the results I thought it would get, to be honest with you. But actually, I got promoted at Wisconsin. I went from director of Physical Plant—they created a director of General Services. I took over things like Security, the copy center—a whole bunch of business function in addition to the operations and maintenance side, the utilities side, and the planning, design, and construction side.

***Tacey Ann Rosolowski, PhD***

**0:39:27.2**

And that title was Director of Physical Services?

***William Daigneau, MBA***

**0:39:30.3**

General services.

***Tacey Ann Rosolowski, PhD***

**0:39:30.9**

General Services.

***William Daigneau, MBA***

**0:39:32.8**

Yeah, I was the—I think the first—I don't know if they still use that title, but they created the position for me so they could give me more. (laughs)

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***Tacey Ann Rosolowski, PhD***

**0:39:41.4**

So what were the big lessons learned during that time at Wisconsin?

***William Daigneau, MBA***

**0:39:46.2**

Well, that I—I mean—it was a confidence builder. I mean, here was my first management position, and it was turning out very well. Again, I had good mentors. The guy I worked for there—his name was Danielson—liked me, encouraged me—an older man. The chancellor, Karl Meyer, at the time, liked me—encouraged me. As a matter of fact when—I reported to the vice president for administration—when he retired, the chancellor decided just to have me report directly to him, so for about a year, I reported directly to the chancellor. But they were encouraging people.

And here's one thing I found out is I thrive under people who would give me a long leash. "Go ahead and try it, Bill. Yeah, do it." They let me do these things, because I was experimenting. I was trying to see what worked and what didn't. So it was a confidence builder. It was the first time—and I was successful. I was well respected. I knew everybody. Everybody knew me. In my office—the dean of the theater—I'd helped him solve a problem for their summer theater program using one of our plumbing trucks. He gave me this nice photograph of their summer program. It was a very confidence-building experience, and I knew I could do well.

I was now in an environment that I liked, I enjoyed. I liked the openness. I liked the intellectual side of it. My family enjoyed it. It didn't pay anything again, but it was a very, very rewarding experience. And so I knew I could only get better at this. Not everything worked—you know—school of hard knocks. Some things work, some things don't. But during that period of time, in my own management innovations, at least I discovered things I knew—instead of doing for forty years that way, I discarded them. It really didn't make any difference.

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I learned how a university operated there. I learned the politics of it. I learned that obviously I had a management style people liked. It goes back to some of my previous experiences. For example, when I was at the city of Peoria, the city engineer, who I reported to—not the director of Public Works, at the time—decided that the engineers were taking—some of them were abusing breaks. Well, there were a whole bunch of us who would work right through break. When it came to 5:00—you know—we worked an extra thirty minutes, or whatever, to finish something up. Nobody was in a hurry. The job had to be done. So in an engineering office of about twenty people, maybe there were two people that were abusing the breaks. Instead of dealing with those two people, he writes a memo and says, “From now on, breaks will be taken at 9:30 and at 2:30, and everyone will remain in the office until 5:00 p.m.” So I remember that experience and the fact that now, instead of dealing with those two that were abusing the system, we had all—the other 18 of us who had not been taking a break—we now took a break at 9:30. We’ll show him. (laughs) You know? What’s this about? All right. Well, we’ll take—and instead of working until 5:30 or 6:00, we’re out the door at 5:00.

So those kinds of experiences taught me there are some things you don’t do, and they formed my basis of management over the years. At Superior, it just reconfirmed—and the other thing is, since I had been an employee and knew what I liked and knew what I didn’t like, I pledged that I wasn’t going to treat people the way I didn’t like as an employee. So it reconfirmed—it was, as I say, a confidence builder—that I was on the right track and I could be good at this.

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## **Chapter 4**

### **A: Overview**

#### ***A Theory of People Management and Another Career Move***

#### **Story Codes**

A: Professional Path

A: Influences from People and Life Experiences

C: Evolution of Career

A: The Administrator

A: Overview

C: Professional Practice

C: The Professional at Work

A: The Leader

C: Leadership

D: On Leadership

D: On Mentoring

D: On the Nature of Institutions

***Tacey Ann Rosolowski, PhD***

**0:44:49.0**

Tell me about your management style.

***William Daigneau, MBA***

**0:44:50.6**

Well, it evolved over the years, quite a bit—I mean—dramatically. As I say, I was blessed with this inquisitiveness about how things work. And if it's not working, I would abandon it. I would throw it overboard and try something else. The old saying is, "When all you have is a hammer, everything looks like a nail." Well, if the only management tool you have is a hammer, then truly everything looks like a nail to you, so you're going to pound it. Well, the same with my experience was I realized that some things couldn't be driven in.

***Tacey Ann Rosolowski, PhD***

**0:45:42.4**

Can you give me an example of how something wasn't working and how you had to strategize to fix it?

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***William Daigneau, MBA***

**0:45:50.1**

Well, this took me almost thirty-some years. Now, you're going to say, "This is obvious, Bill."

**Tacey Ann Rosolowski, PhD**

**0:45:56.0**

No, I won't.

***William Daigneau, MBA***

**0:45:56.5**

But in management, it's not obvious. This is what I'm writing about in my book. So how many times have you been at your annual performance review, and you finally get around to next year, and your supervisor says to you, "Well, our goals for next year are the following: A, B, and C. We're going to improve production twenty percent"? Very common in business. You sit at that and say, "Well, our goals for next year are—" So here's the process at work. Whose goals are they? Your boss.

***Tacey Ann Rosolowski, PhD***

**0:46:49.1**

Yeah, absolutely.

***William Daigneau, MBA***

**0:46:49.9**

They're his goals or her goals. They're not your goals. But even in almost every business school, the Personnel Department, as a new manager, they bring you in and say, "You've got to set goals for your folks. That's one of your jobs. You've got to set the goals for them." This is taught routinely. It's the old hammer and the nail. As a manager, you set goals. It doesn't work. What does work? When the employee sets their goals.

Okay, so now here's the dilemma we have. Most people will set some goals for themselves, like, "I've got to get my grocery shopping done on Saturday because Sunday we're going to the football game." Goal. What is the likelihood that that is going to occur? Pretty high. It's very high—90%. Now, something could happen, but it's very likely to happen. Why? Because that person has set a goal, and there's a rationale, there's logic behind it, and they're purchasing out their time. They're going to make it happen. They're actually going to make this happen. If I say to a person, "Look, I want you to do your shopping on Saturday because I want to take you to the football game," what are the chances of that goal happening? Fifty/fifty, because, well, I can't get inside your head. "Well, I actually have my Book Club on Saturday." And so what comes up? I don't do my shopping, we go to the game, and on Monday, let's go out to dinner. (laughs)

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So the odds—the chances of goals actually occurring drop dramatically when they're imposed. Yet in management, we teach the opposite. So one of the greatest changes in my own self occurred—was somehow I had to have someone sitting across from me tell me that their goals for the year were consistent with the objectives of the company or the organization. I had to create an environment where I would say, "So, let's talk about goals for next year." And it's a dialog. What happens is a dialog. You start saying, "Well, one of my goals is I want to learn critical path scheduling." "Good. That's a good goal." So then I might say, "How can we apply it to our business? What can we do to use the benefits of that here?" And that creates a dialog where it now becomes their goal that's tied into the objectives of the organization.

***Tacey Ann Rosolowski, PhD***

**0:50:12.4**

And tied into their learning process.

***William Daigneau, MBA***

**0:50:14.6**

Yes. So now the chances of this actually happening have just dramatically ratcheted, and that was the problem with MBO—management by objectives. I was giving these people their goals and asking them to fill out how they were going to accomplish them. It wasn't their goal; it was always my goal. It took me thirty-some years for that light bulb to finally go on that I could dramatically improve performance if I could somehow figure out how people would set goals for themselves that would support the objectives of the business. I spent thirty-some years honing that skill. So anyway, that was one thing that evolved for me significantly.

***Tacey Ann Rosolowski, PhD***

**0:51:06.5**

Well, obviously, the difference between theoretical and practical, taking that theory and then understanding how it actually works with the real context of individuals with their own motivations and agendas.

***William Daigneau, MBA***

**0:51:17.9**

And we management teachers, the HR departments, their standard management classes on supervision, et cetera, you've got a problem employee, how are you going to correct that problem? You give them a list of expectations. Right? Hand it to that person, and you're going to see dramatic improvement. Oh, no, you're not. (laughs) And so you're scratching—well, now we go into progressive discipline, so we hit them with the hammer. And that's going to correct the problem. Sometimes it does; most of the time it doesn't. It may improve for a while, and then it

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falls back, because that person has not decided for themselves to change their behavior. They haven't made that commitment. It's like alcoholism; until you've come to grips with it—you have this problem—you're not going to fix it.

We have all these things in management over the years I tried and nothing happened. I didn't get the expected result. But on my journey, I have to say, I wasn't committed to it. I never felt like, "All right, well, that didn't work. I ain't going to do that again." So it evolved.

*Tacey Ann Rosolowski, PhD*

**0:52:40.9**

So how long did you end up staying in Superior?

*William Daigneau, MBA*

**0:52:43.5**

Well, so this is the problem with higher education. Unlike a company—you can work for GE, and they keep promoting you. You may go from the Plastics Division, because you're a good manager there, to their turbine engine plant, because they expect you to be a good manager there. But in universities, either, A, you're just going to sit out your career there, or what you have to do is you have to go to larger and more complex universities. So to borrow a phrase, "My work is finished here." George Eastman. Of course, he shot himself. (laughs)

But my work is finished at Superior. I could have stayed, but I wanted something more difficult and complex, so I took a job as assistant vice president at the University of Northern Colorado in Greeley. That's how we got out to Colorado the first time. I was there eight years. Went through two presidents there, saw a change in leadership in presidency, and stayed there—and actually, that was more family time. I continued to—I developed a master plan for the campus that is still being followed to this day. I really started to learn the value of creating a management team there, that it was important who you had working with you. We did a number of innovations there. It was one of the first—and still is in existence—cogeneration plants—combined heat and power cogeneration plant. So I did a number of things there.

*Tacey Ann Rosolowski, PhD*

**0:54:51.3**

What exactly is a cogeneration plant?

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***William Daigneau, MBA***

**0:54:53.1**

It produces both electricity and—a lot of universities are in what is called central plants. They provide heat and in some cases chilled water to all of the buildings instead of having a boiler and a chiller in every building. They're all interconnected by these pipes. It's a very efficient system when you have a number of buildings like university campuses have. They're very common in universities. Not so common elsewhere. Large industrial parks—like Kodak Industrial Park in Rochester was on a central plant. So because of the fact that you have one plant that's heating a whole bunch of buildings, you have economy scale in your boilers—you know—you have these big boilers that are producing steam or hot water. So in the case of a cogeneration plant, when you generate electricity, you throw off lots of waste heat. That's why those nuclear plants need to be by water, for cooling purposes, because you're cooling off all this waste heat. You've taken all of the productive energy out of the heat, but there's still a lot of it left over. That's not enough to run a turbine or anything, so you have to get rid of it somehow. Well, in cogeneration, you produce the electricity, and that waste stream that would normally be vented to the atmosphere, you use it to boil water to make steam to heat buildings. So whenever you have a situation where you have—it's called a balanced load—you have both a heat load as well as an electric load—you can really make cogeneration work. But at the time, this was a new technology. We're back now in the early '80s, and the utility companies would not accept electricity into their grid, so what do you do when you don't use all of the electricity? But the laws changed, so all of a sudden, cogeneration became feasible. So we were one of the first plants.

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## **Chapter 5**

### **A: Professional Path**

#### *University of Rochester and a First Experience with Health Care Institutions*

#### **Story Codes**

A: Professional Path

A: Influences from People and Life Experiences

C: Evolution of Career

A: The Administrator

A: Overview

C: Professional Practice

C: The Professional at Work

A: The Leader

D: On the Nature of Institutions

D: Fiscal Realities in Healthcare

#### *William Daigneau, MBA*

**0:54:53.1+**

So we spent eight years there, and then I got to another crossroads in my career, and that was the guy I reported to was the vice president for administration, and he was a good mentor. His name was Al Barnhart. He's since passed away. And Al said, "I'm going to retire in a couple of years, and I think you could be a very solid candidate for the vice president for Administration." I thought about that for a while, and said, "Do I want to run Information Technology, HR, residence halls?" I'm still basically an engineer by training. I like to build things. I tell people that I like to build things. I don't care what it is. If it's an organization, I like to build it. If it's a building, I like to build it. If it's a new process in maintenance, I like to build it. Anything, I like to do that. So do I want to run this stuff? Nah.

So at the time, I'd just come back from a World Bank tour of China, which the university supported me going to, and I got a job offer. An executive recruiter contacted me, and I got a job offer from the University of Rochester.

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Now, this was a turning point for me because the University of Rochester not only had a university, but it has a big medical school and a hospital. So this was my first foray into the health side of things.

***Tacey Ann Rosolowski, PhD***

**0:58:46.5**

And what was the job you were assuming?

***William Daigneau, MBA***

**0:58:48.7**

I was the director of University Facilities. I held that title—the University of Rochester, very conservative. Nobody gets a vice president title. There are not assistant vice—at the time, there were none. You were either director, or you were a vice president, and there are only six vice presidents. (laughs) Everybody else is directors. So I went from assistant vice—some people say, “You took a step down,”—I really didn’t—“in title,” but my income—I always gauge my progress by income. My income went up dramatically, and my responsibilities went up dramatically. I went to a campus that was almost three times the square footage of the size I was leaving.

So I went to the University of Rochester. There, I continued to experiment with my management style, but I knew what worked by then in terms of—what happened was the medical school and the hospital, even though it was part of the university, had kind of divorced themselves from the rest of the university in terms of their facilities management, which is not uncommon. Even to this day, at most, you go to Duke University, you go to any of them, the medical school has its own facilities operation, and the university has another one. Well, that’s the way it was when I went to the University of Rochester.

***Tacey Ann Rosolowski, PhD***

**1:00:32.5**

What were the pros and cons of that, or was it, it just was?

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***William Daigneau, MBA***

**1:00:40.6**

Well—which will lead into the MD Anderson story. The problem is that organizations—you’ve heard the terms silos—organizations create barriers by their existence—the boundaries of that organization. Sometimes the boundary is pretty impermeable. Most of the time, it is not. I mean, pretty permeable, but most of them, it’s impermeable. So organizationally it creates difficulties in information flow, coordination. That leads then to productivity problems, sometimes legal problems like unions. For example, the merger of Continental and United—they’re still not fully merged because they can’t get the union agreements. See? That’s an example of where the barrier is pretty impermeable.

So in the university setting, having these different facilities groups means that there’s competition, there’s lack of cooperation, there’s inefficiency, etc. And for higher management—for the executive level—it means that you don’t often get to a full solution of a problem because you get the partial solutions, you get the suboptimization. All these things start occurring because of those organizational boundaries.

So I went to the University of Rochester, and they had these—well, next thing I know—I mean—I’d only been there a year. Pretty soon reports coming back from the main campus—the academic campus—this new guy is solving problems, taking care of things here. Breath of fresh air. (laughs) It started filtering over into the medical school. The next thing I know, I get this invitation from the head of the hospital—Strong Memorial Hospital. He said, “Will you come over here and evaluate our facilities organization for us? No discussion about merger or anything like that. Just evaluate it for us.” So I wrote this thick report. At the time, I didn’t understand the value of executive summaries. (laughs) I figured if I had written it, it was worth reading. So I delivered it to them. Within six months of that report, I’m now truly the director of all university facilities.

***Tacey Ann Rosolowski, PhD***

**1:03:36.2**

Oh, wow.

***William Daigneau, MBA***

**1:03:37.1**

Yeah. I was basically given the task of addressing my recommendations. That’s the part—you make a recommendation—that’s why I love consultants, but I don’t want to be—even though I do consulting work, I really don’t want—I never wanted to be a consultant because it’s easy to make that recommendation because you’re not the one who had to implement it. So you get a

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bunch of these consultants that say, “Well, you should do this.” Well, that’s obvious, but how do you do that? “Well, that’s your problem.”

So I was given the job to implement those recommendations, which I did. I eventually merged everything. It took me probably a good four years to complete the complete integration, but it was achieved, and everybody was happy.

*Tacey Ann Rosolowski, PhD*

**1:04:29.0**

Wow. How long were you at Rochester?

*William Daigneau, MBA*

**1:04:33.2**

I was there seven years, until I went to MD Anderson.

*Tacey Ann Rosolowski, PhD*

**1:04:38.9**

Okay. Do you mind if we take a quick break?

*William Daigneau, MBA*

**1:04:42.6**

Nope.

*Tacey Ann Rosolowski, PhD*

**1:04:43.0**

Okay, just want to pause here.

**1:04:44.6** (end of audio)

[The recorder is paused for about seven minutes.]

(begin audio)

*Tacey Ann Rosolowski, PhD*

**0:00:00.0**

Ready to roll again?

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*William Daigneau, MBA*

**0:00:01.1**

Ready.

*Tacey Ann Rosolowski, PhD*

**0:00:02.2**

All right. We're back after a quick break, about seven, ten minutes, something like that. So you were talking about your experiences at the University of Rochester. I guess one of the questions I wanted to ask you—kind of a more global question related to a comment I made earlier about realizing that you could have an impact you larger institutional policies or directions through working with Physical Plant—I'm wondering about some ways in which you saw that happening at U of R, for example? You obviously were having connections with people who were very high up. They were in executive administration and were starting to rely on you very heavily. How did you see yourself having impact on some of those larger institutional issues?

*William Daigneau, MBA*

**0:01:01.3**

Well, you've probably heard this before, but management is looking for people, no matter what the business is, that can get results. So they don't really want to hear about all the problems. Why they hired you is because somehow you can give them the results they need, and the people who do that routinely then are exposed—are included. They're included into other things because people all of a sudden realize, well, if they could have fixed this for me—I kind of like their insights on things, so I think I'll involve them in things other than what I brought them here to do because they're good at seeing—they have good perspective on things. They see things I don't see. So you find yourself being drawn in because you can show that you can apply sound solutions and get results. It's no longer a problem for them.

Of course, it doesn't hurt—which I found out—to point that out occasionally to folks.

“Remember when nothing came in on budget?” “Oh, yeah, I remember those days.” “Have you seen that happen since?” “No.” So it doesn't hurt to occasionally—it's not blowing your own horn, but it is, in some ways, of subtly reminding people that this thing's problem has disappeared. So that doesn't hurt to do that.

I think what happened to me at almost all the places I ever worked is all of a sudden complaints and criticisms started disappearing. And for a lot of people, that means an executive you're working with, or for, doesn't have to spend their energy or time dealing with your stuff. “Just give it to Bill. It will be taken care of.” And they like that. They appreciate it. And also, when you look at, like, the university center, what's the main mission here? It's not to build buildings. Fundamentally, the whole business of higher education is to create and transfer knowledge.

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That's the primary mission. So you'd like to think your president, your senior vice presidents, those people are focused on how best to accomplish that, not worrying if they're going to have electricity tomorrow. (laughs) So in my business, if you can remove that concern from them, they're very appreciative because they don't have to worry about it.

*Tacey Ann Rosolowski, PhD*

**0:04:45.6**

Right. Well, and also, for example, in the case of cogeneration, you probably freed up some funds because of innovative uses of your knowledge.

*William Daigneau, MBA*

**0:04:53.8**

Also, you create money—money stream.

*Tacey Ann Rosolowski, PhD*

**0:04:55.8**

You create money that helps go toward the main mission.

*William Daigneau, MBA*

**0:04:59.1**

That's right. And it's part and parcel. That's why—you know—when we were talking before a little bit about the components of facilities management, there's the hardware side of things. There's the plant operations. There's the building process. There's the utility. But there's a whole aspect of administration, and administration covers those things like finance and people, so you get into training programs, etc. So administration, there's a whole side of the business that has nothing really to do with the hardware side other than creating opportunities for people, for income, to avoid expense, etc. And truly, you're right, especially chief financial officers. They love it when you walk in the office with—"You mean we can make money on this?" Or, "We won't have to pay that expense anymore?"—I mean—its equivalent—any time you create an opportunity where you solve those kinds of problems.

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## **Chapter 6**

### **A: Joining MD Anderson/Coming to Texas**

#### ***Lured to MD Anderson: A New Position and The Three-Building Plan***

#### **Story Codes**

A: Joining MD Anderson

A: Professional Path

C: Evolution of Career

A: The Administrator

A: Overview

C: Professional Practice

C: The Professional at Work

A: The Leader

D: Ethics

***Tacey Ann Rosolowski, PhD***

**0:06:11.0**

Well, tell me how MD Anderson came into the picture.

***William Daigneau, MBA***

**0:06:17.2**

So I'm sitting in Rochester, and I'm doing very well again there.

***Tacey Ann Rosolowski, PhD***

**0:06:23.6**

And the year was?

***William Daigneau, MBA***

**0:06:25.1**

This was—let's see—it must have been around '92. Anyway, I, as part of my professional activity, participated in these organized peer reviews through the Association of Higher Education Facility Officers. They're called an FME—facilities management evaluation. And basically how they're run is usually there's three to four facility officers create a team and go and visit a campus and look at their processes and their policies and their management, the results they're getting. They'll look at resource use. So you get into productivity, how many square foot per custodian, things like that. And then you write up a report with recommendations. It comes from people who are in the business, as opposed to somebody that never turned a wrench before. So it's looked at as pretty valuable because you're getting it from your peers. And just really the

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advantage is that somebody from the outside can look at something without any baggage associated with it and give a fresh look at the whole thing.

I was at the University of Rochester. And with my profession—because I write articles and made presentations, pretty soon I have this invitation from MD Anderson Cancer Center—University of Texas MD Anderson Cancer Center—for a peer review of their facilities management and what's called the team leader—basically the point person for interaction with—and it came from their member of the association. It came from their executive vice president. His name was David Bachrach, which you may have heard his name. David lives out here in Boulder. He does consulting work.

*Tacey Ann Rosolowski, PhD*

**0:09:05.0**

And so just so I'm clear, did David Bachrach ask for you specifically?

*William Daigneau, MBA*

**0:09:11.2**

Yeah, because for many years, the Texas—like, MD Anderson was number two behind Sloan-Kettering in New York. So there was this aura around the eastern establishment—Johns Hopkins, Sloan-Kettering—all of the big medical centers of the east versus the lowly Houston, Texas. I was at the University of Rochester, New York, Strong Memorial Hospital, so there's some name recognition with that. I think he selected me because he was from the University of Michigan, and he'd gone down to Anderson and kind of was aware of this, well, we're struggling to be number one here. So somebody from an eastern medical center was valued because a lot of the faculty came from eastern—you know—Harvard Medical.

So I don't know. I was selected as the team leader and invited to bring a team down, which I did. And at the time, they were just beginning planning of the Major Building Program, which consisted of the new Alkek Hospital and what's now called the—it was called the Clinical Services Building, which is now called the LeMaistre Clinic, and the Clinical Research Building—CRB. They were just beginning that process. So I brought my team in, and we looked at various criteria and things like that, wrote the report, made our recommendations, sent it off. Voila, we're done. About three months after sending in the report, I get a call from an executive recruiter. They're looking to fill a position as assistant vice president for the Major Building Program. Would I be interested?

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Well, I had a dilemma there. I mean, sometimes I would look at things because they always provide a benchmark of where you're at, how much you're making, are you fairly compensated. So over the years, I've interviewed for various positions even though I really didn't have an interest in them, but it's good to keep your hand in it.

*Tacey Ann Rosolowski, PhD*

**0:12:08.0**

Sometimes you can negotiate a higher salary?

*William Daigneau, MBA*

**0:12:09.8**

That's exactly— But I had a dilemma here, because I just submitted this report. So I called up the executive director of the association and said, "You know, this doesn't feel right. I just made a bunch of recommendations. To be hired there would kind of cast a pall on the whole process of peer review that people are out there trying to create jobs for themselves. So they'll be critical and then hope they get an offer." So I turned down the recruiter. It just did not sit well with me. I thought, "I wouldn't want to have that done to me." And I don't want to damage the program because it's valuable to people, and have people afraid that, well, the team leader comes in and creates a job for themselves. So I turned the recruiter down. I said, "No, for ethical reasons, I can't talk to you about this. I just did a peer review there." So I hear nothing for two years. Now we're stepping up into '93, right in that time period.

*Tacey Ann Rosolowski, PhD*

**0:13:20.8**

And you explained to the executive recruiter your reservations? I'm sure he/she passed it on.

*William Daigneau, MBA*

**0:13:26.4**

Yeah, I told him, frankly, I can't have my name in because of this report.

*Tacey Ann Rosolowski, PhD*

**0:13:31.7**

Right. Absolutely. Which I'm sure served you in very good status.

*William Daigneau, MBA*

**0:13:34.9**

It must have, because two years later, evidently enough time had passed. (laughs) Well, now they're looking for—which was the first time ever—a chief facilities officer. They expanded the job. Evidently, it turned out they hired somebody. That person didn't work out. They had to let

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them go. But that was for the Major Building Program. But now David Bachrach wanted to bring in somebody who had melded all of the stuff together, because that had been one of the recommendations in the report. (laughs)

*Tacey Ann Rosolowski, PhD*

**0:14:15.1**

And when you say meld everything together, what are you referring to?

*William Daigneau, MBA*

**0:14:17.7**

Well, remember I told you at the University of Rochester they had these groups—well, Anderson had the same thing. They had the Major Building Program that reported up to the president. They had the physical plant operation that reported to David Bachrach. They had a subset of a hospital operation. The police reported to David—I mean—it was all broken all up. So they had a research group doing their own thing on planning.

One thing I did as chief facilities officer I did at both Rochester—actually, I did it at every campus I was at. Either I created or revised, in a major way, their master plan. And the same thing at Anderson—their master plan had not been updated for years.

So part of the recommendations were to create this position as chief facilities officer, bring all this stuff together. So two years later, executive recruiter again. Anderson is looking—I said, “I turned that down.” “No, this is a different position. They want a chief facilities officer.” “Well, what kind of salary range are they looking at? Sounds good.” And it was a good point in my career for my family because my youngest daughter—I had two daughters in college, and my youngest daughter was just going to start high school, so if I was going to make a move, now was the time, before she got into high school, so she could finish high school. All right, I’ll take a look at it.

Well, one thing led to another. Well, a couple things impressed us about Houston, Texas. Number one was in Rochester, I’m looking out the back patio door with snow halfway up the patio door, so it as half white and half you could see the blue sky. Get off the plane, and there’s pansies growing. (laughs) Wow! So that factored in. The family situation factored in. Again, here was an opportunity to build something from the ground up, which I was getting increasingly good at. And the salary—the compensation—was good. The benefits were good. The climate was good. It must have been the right thing because we sold our house without ever putting it on the market. So everything just kind of fell in place. We made the move to Houston, Texas.

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## **Chapter 7**

### **B: Building the Institution**

#### ***Background: The Three-Building Plan***

#### **Story Codes**

A: Overview

B: MD Anderson History

B: MD Anderson Snapshot

C: MD Anderson Past

B: Institutional Processes

B: Critical Perspectives on MD Anderson

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

B: Obstacles, Challenges

B: Institutional Politics

#### ***William Daigneau, MBA***

**0:14:17.7+**

So here's the beginning of the story. When I went in '94 to MD Anderson, we had the three campuses—the main complex in Houston, Smithville, and Bastrop. The outposts obviously Smithville and Bastrop, very specialized mission, very small campuses, very simple buildings. The main complex, roughly about three—let's say about three-point-five—just for round numbers. It was actually less than that, but about three-and-a-half million square foot, all contained—except for the Bob Smith Research Building—all contained in the Texas Medical Center proper. I mean, we owned Houston Main Building across the street. Rotary had just opened the year before I got there. We had Smith on the south campus. But everything basically was right there in the main complex, the bulk of it.

At the time David Bachrach recruited me, they were just launching—I told you, two years before they were just planning it—but they were just launching what was called the Major Building Project, which was going to add a million square foot to the campus. David Bachrach tells me, at the time I was hired, that, “Things are going to be pretty busy around here the next couple years as we add this million square foot,” which at the time was a lot of building. “But Bill, things are then going to quiet down.” I said, “Great.”

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*Tacey Ann Rosolowski, PhD*

**0:19:18.0**

And just let me say, because I want to make sure that we have on record, the Major Building Project, as I was doing my research, is also referred to as the Three-Building Plan, so people may encounter different names for that as they look through articles and everything, and institution records.

*William Daigneau, MBA*

**0:19:41.5**

Yeah, within the organization, they had created—it was headed up by Mary Ann Newman, who had come from strategic planning. She had no background in construction, but she was a good planner.

*Tacey Ann Rosolowski, PhD*

**0:19:54.3**

Okay, and you're talking about the management team for this project?

*William Daigneau, MBA*

**0:19:58.3**

For the Major Building Program. She headed that up, and she had put together a team primarily robbing the physical plant of various people like Gary Kimbrell. So she had assembled a team, but she hired some people. She hired Janet Sisolak, for example, who is still with MD Anderson. So is Gary, by the way. But she robbed some people out of their planning and design group, and then hired some folks and created what was called the Major Building Program, which was over in a temporary building. I say temporary; it was originally a motel, I think, that had been converted to offices over on what was called Andy's Backyard, which is right where the parking garage now is, at the intersection of Braeswood and Holcombe. But there were some buildings there. You look at old photos, and you can see them. We had a daycare center there, and then we had the Major Building Program offices there.

*Tacey Ann Rosolowski, PhD*

**0:21:06.0**

Now, if I'm derailing you, just let me know, and we can answer this question later, but I wanted to ask you—you talked about the master plan, so I'm obviously curious. How did this Major Building Plan, or the Three-Building Plan—was that the master plan, or how did that fit into the master plan? And where does Charles LeMaistre fit into all this?

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***William Daigneau, MBA***

**0:21:32.1**

Well, Mary Ann Newman was in charge of strategic planning and reported directly to Dr. LeMaistre. Dave Bachrach is the executive vice president for Administration, had all of the physical plant operations—Security, Information Technology—you know—just the traditional stuff. Remember I told you about the silos that were created when you have different organizations? So they were encountering some rough water because here they had Mary Ann, who didn't report to David Bachrach, kind of running the physical plant-type thing. There was a lot of—you know—within the organizations—a lot of finger pointing. And of course, whenever Mary Ann had a problem, she would run to the president. I won't say that. She'd go to the president with the problem. And Dr. LeMaistre was very accommodating. But I wouldn't say one of his management styles was to kind of let people work things out, so he didn't issue edicts at all. He wasn't that type of leader at all. So while the decision was made, it wasn't necessarily communicated, so there was lack of clarity. There were a whole bunch of issues going on at the time. So David Bachrach, in creating this chief facilities officer—and the arguments that had been made in the report are to get, again, better communication, better integration, better results overall.

So they put together a master plan to try to site these buildings—to figure out where to put these buildings. So that had been done, which basically justified the locations.

***Tacey Ann Rosolowski, PhD***

**0:23:33.1**

Now, let's just go through. So there's the Charles LeMaistre Clinic Building, the Alkek Hospital, and the Clinical Research Building. So what was the function? I mean, is now the time to talk about the proposed function of those three buildings and their location, or do you want to let that evolve as you tell your story?

***William Daigneau, MBA***

**0:23:50.1**

Well, Dr. LeMaistre was a physician, and he had Dr. [Frederick] Becker run the research. Dr. Becker ran the basic sciences, which were all the theoretical research—why cells work the way they do. Well, there was a growing, at the time—you know—Dr. LeMaistre was an innovator. He came up with a lot of things at the time, especially on the smoking issue, that were taking on some behemoths in terms of the tobacco industry, for God sakes. Movies—people were smoking. And to say this is no good? So he wasn't a shy man about doing what was right. And at the time, there was just an emerging field called translational research, where you're taking things out of the basic science side and trying to create medications or treatment protocols that you could actually use in patient care, and that was kind of the stepping stone between the basic research to

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the actual protocol, or practice, in health care. That was emerging, and Anderson, frankly, over the years, had been—bench to bedside—had been pretty innovative, especially on radiation. So there was a culture that had been created as well as evolving. I mean, Dr. [R. Lee] Clark started it when he demanded research to be combined with the tumor hospital. He wanted to understand what was causing this and treat it.

So that whole culture at Anderson had been, from its earliest years, started, and it was growing. So at the time, they needed another research building and an animal facility to support the clinical side. That's where the name came from—the Clinical Research Building. It was more to support some of the translational research that was going on without taking space away from the basic science side of things. So that was the clinical research side.

Then the original hospital was—you know—it was a double-loaded corridor, older, inefficient, couldn't supply the advanced technology, both on imaging. The surgical suites were constrained. You couldn't expand them. There were a lot of good reasons that led to it, but the idea was to create a replacement hospital. Alkek was designed to replace the old Anderson hospital. It wasn't a brand-new hospital. It was a replacement hospital that would allow expansion of the ORs, allow increased use of technology that the older parts of the building would not—of the original building built in the fifties.

So that's where the hospital came from. And then the LeMaistre Clinic, from what I understand, and Dr. LeMaistre probably has a better recollection of this. Anderson had accumulated a lot of cash, and the Clinical Services Building basically was, "Well, okay, we're building this replacement hospital, but we're not doing anything for the outpatient clinics. Let's do"—it was more of an afterthought—"and add on to the project." And basically to use up some of the cash because there was some fear at the time that the legislature would look at the cash sitting at Anderson and just say, "Well, let's use it for parks." And Dr. LeMaistre wanted, as president—wanted to further the mission of Anderson and so wanted to commit some of those funds to improve health care. He was doing it on the inpatient side. He was doing it on the research side. Let's do something on the clinical side of things. So that became the Clinical Services Building. And that basically was designed to support expansion of the outpatient clinics. It would create—you know—there was the library for the patients and more diagnostic imaging. I allowed replacement of the emergency—it upgraded the Emergency Center. So it did a lot of things to enhance quality. So that was added on. That was probably the last piece that was added on.

*Tacey Ann Rosolowski, PhD*

**0:28:34.1**

And how do all of those buildings fit into what the master plan was at that time?

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***William Daigneau, MBA***

**0:28:39.9**

There wasn't really a good master plan. And they were just looking for places to put these buildings, and these were the open plots of land. They were parking lots, basically. All of them were parking lots. I mean, you can see the Lutheran Hospital. The original entrance to Lutheran is still there. Now it's our Emergency Center. But that was the main door to the hospital. And from Lutheran, then you went to the Anderson wings, where the rest of the hospital is. And then there was the Clark Clinic entrance for the ambulatory side of things. And the rest of it was surrounded by parking lots—surface parking lots. So where are we going to put a new hospital? Well, let's put it here. Where are we going to put a clinic? Well, let's put it there. All constrained by the boundaries of the original deeded portion to Anderson from the Texas Medical Center. So they basically built in the remaining open spots. And that's why I say the master plan that was created was more a justification to put the buildings there as well as per thinking it through, well, how do we want this to evolve?

Now, there's where my experience came in, because when I got to Rochester, the original medical school that had been constructed in 1925, over the years they built right around it. So now I was faced with the dilemma of, well, how do you get into the interior where your oldest buildings are because you built newer buildings all around it? So by the time I got to MD Anderson, I was familiar with this issue about encapsulate your oldest facilities in the center. But basically the buildings had been funded by the time I arrived there, so there was—you know—if I had gotten there when I was first recruited, I would have, time out, let's think this through, because this may get bigger someday than even what you think. So someday we've got to get back inside this center core and fix it. How are we going to do that? But that had all passed by the time I did arrive. It had been approved by the regents. Design had basically been completed, and construction had just started on the Alkek. We were still in the foundations. It was a big open hole when I got there.

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## **Chapter 8**

### **B: Building the Institution**

#### ***The Three-Building Plan: Building Relationships, Facing Challenges, Creating the Project Core Team and the Design-Build System***

#### **Story Codes**

A: Overview

B: MD Anderson History

B: MD Anderson Snapshot

C: MD Anderson Past

B: Institutional Processes

B: Critical Perspectives on MD Anderson

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

B: Obstacles, Challenges

B: Institutional Politics

B: Institutional Mission and Values

B: MD Anderson Culture

C: Professional Practice

C: The Professional at Work

#### ***Tacey Ann Rosolowski, PhD***

**0:31:20.2**

So what were your first moves in this job—your first day on the job?

#### ***William Daigneau, MBA***

**0:31:29.3**

You know, this all evolved over time, but obviously when you're the first—a new person—you have to build relationships. You have to develop—you know—because nobody knows you. They don't know what you can do. They're certainly not going to trust you. They have no basis to trust you. So you've got to basically show that you—as I say—you can fix things, you can get results, and you've got to build your relationships.

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One thing I'd learned was the importance of those relationships, because the—I used to tell our folks—even before Anderson, but when I got to Anderson, I really communicated this—we do not want the clinical chiefs, the department heads, calling up Dr. LeMaistre, David Bachrach, or Dr. Becker. We want them to feel very comfortable whenever they have any problem at all to call us directly, and we're going to fix it. We're not going to argue with them. We're not going to tell them it's against policy. We're going to find a solution. It's got to be within policy or regulations, but it's going to solve their problem. And they're going to feel comfortable saying, "Well, I'll just pick up the phone and I'll call."

The area of the Major Building Project (the Three-Building Plan):



Mitchell Building  
Clinical Research Building  
Alkek Hospital

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***Tacey Ann Rosolowski, PhD***

**0:33:05.4**

Now, what sorts of problems were they calling—or did you anticipate that they would call with?

***William Daigneau, MBA***

**0:33:11.0**

Well, at the time that I got there, there was a unit called Design and Engineering. They had just bailed it out of several projects that had run over budget. They were in the hole in terms of a recharge unit. They didn't have a real good reputation on the campus. Radiation Oncology didn't really want them doing projects for them. Diagnostic Imaging didn't want them doing projects for them. So the Physical Plant was viewed as kind of nonresponsive at the management level, but most people learned to bypass management and deal directly with a lot of the workers because they would get things done for them. But you don't want to get into the management group because you're going to get this well-we-can't-do-that-type of response. The best respected group was in Environmental Health and Safety because they basically review it as necessary and you could work with them. Then there was the Major Building Program, which was "viewed as off running, doing their thing without any input." "Nobody's talking to us about this stuff."

I had found in the two years prior, there were a lot of things that were fixable there in terms of improving performance and relationships. By then part of my management theory had grown to the point of I wanted to shorten communication channels as much—so that affected a number of levels in the management. So my goal was there should be only basically three levels between myself—including myself as one of them—and the customer—the worker, a supervisor, me. (laughs) That's our goal, because that way communication—distortion in the flow of communication gets reduced, and that way we can get the things faster and better and understand customer needs. If we can't do what we want exactly, what can we do? How are we going to do it? When are we going to do it? All that gets collapsed. So one of the first things I did was create what we call the Facilities Management Design Group, and it basically was all the existing supervisors, including the people working in the hospital, off in their own thing, the people in research working on their own thing—Mary Ann's group. I pulled everybody together and I said, "We're going to design a facilities management group for the future, in a whole organization, and how we want it to look. Not looking back at what's wrong; just looking forward. You folks know what works well and what doesn't. So if we were starting with a blank sheet of paper, how would we design this organization?" So that was one of the first things I did on the facilities group side.

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On the institutional side, I made a point of establishing—introducing myself, meeting every section chief. I told my assistant, “Schedule the meetings at their offices because it will help me orient myself to the campus,” and furthermore, they shouldn’t be coming to my office. I’m not king here. I’m working for them. So I met with every division—Dr. [William A.] Murphy—every section chief, every vice president. I introduced myself. Before I left I said, “Anything, absolutely anything you have a problem with, here’s my card. Call me directly. I assure you I’ll fix it.” I had only one exception to that in all the years I was there where I failed to do what I said, and it’s still emblazoned in my memory, by the way.

So those are the two major things. I started on the facilities side of the group. I started making connections with the institution. One of the issues was to try to get my arms around—because—and I won’t go through the details of this, but the structure of construction management within the University of Texas was highly bureaucratic. They had a group out of Austin called OFPC—they still do—that would actually come in and run the construction program. All the contracts with the architect and the contractors were held by OFPC, not by the institution. And then there was the institution that had its group—like in this case, the Major Building Program—which was trying to interface with all of the eventual users, which OFPC didn’t really care about. They were just, “Get out of my way. Let me build this for you then we’ll leave.” Well, that doesn’t work. So we had Major Building Program, OFPC—you know—the existing plant operations and all of that and then all of the people we were building this for. [Dr. Donna] Sollenberger [Oral History Interview], Dr. [Waun Ki] Hong [Oral History Interview], Dr. [Charles] LeMaistre [Oral History Interview], Dr. [Frederick] Becker [Oral History Interview], all the department heads, section chiefs—we’re trying to build this for all these people. We have this next group called Major Building Program, we have OFPC, and we have the design construction group for the physical plant organization. This can’t work. I mean, I could see it coming. The train wreck was coming. (laughs) It almost came, by the way. It almost came. So I had to deal with that, and I had to deal with that early.

***Tacey Ann Rosolowski, PhD***

**0:39:42.1**

And how did you resolve that problem?

***William Daigneau, MBA***

**0:39:43.9**

Well, it started something that exists to this day. We created, at the time, what was called the core team—the project core team. And now every project at Anderson—well, up until the new management—but until I left, for every project we created what was called the core team because it worked so well. The principle of the core team was you had somebody that represented the user, you had somebody who represented the plant operations, you had

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somebody who represented the planning, design, construction activity, and you had an executive, and the executive was basically the tiebreaker. When we can't get agreement, we've still got to make a decision. We've got to do something.

So the core team, in the case of the Major Building Program, consisted of Mary Ann Newman, who because of her background with strategic planning I viewed as primarily representing the users. There was the head of OFPC, Jim Broaddus, who kind of represented the design and construction group. There was, in this case, the onsite senior project manager, which managed the project from day to day onsite, and myself—the four of us. And we would meet on a regular basis to go over every aspect of the project. And that was my way of trying to get the decision making to occur, stop the wasteful finger-pointing and blaming, create more of a coherent team. We're all working to build this, folks. If this is not successful, we are all gone. (laughs) So I created the core team, and that proved very effective, to the point where we used that on every project from then on, over eighteen years. Every project had a core team. So initially, that's how I got—you know—

Now, the train wreck we almost avoided was the way the OFPC had set this up, they had things like design-build—construction management contracts were not legal in Texas. Everything was hard bid like highways. Buildings were hard bid. In order to try to get the project underway as quickly as possible because of this money issue, OFPC had decided to break the contract into two pieces, what's called shell and core, which is basically the foundation, structure, and outside of the building and the build out, which is basically finishing off the interior of the building. So one contract was let to one contractor; the second one was let to another contractor. Well, that's a train wreck right there, just waiting.

***Tacey Ann Rosolowski, PhD***

**0:43:17.8**

And what kinds of things can happen in a situation like that?

***William Daigneau, MBA***

**0:43:20.7**

Well, what happens is basically a contractor warrants their work for a year after construction. What happens when you have two contracts like that—hard bid contracts—is you have to draw a defining line in the project. Okay, so I finished the shell and core, so the contractor that is now going to do the build out inside has to say, “I accept all of this.” Because the problem is, a year later, the walls start cracking, well, is it bad drywall work? Is it the foundations? Is it the structure? Who is at fault here? Is it something that the finish contractor did to the structure that caused everything to crack? Who's at fault here? Who do you, as the owner, go to and say, “Fix this for me”? Because you have two contractors saying—

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*Tacey Ann Rosolowski, PhD*

**0:44:28.9**

Not me.

*William Daigneau, MBA*

**0:44:29.6**

Not me. It must have been that guy. So it becomes a legal and financial—most owners finally give up and just fix it or go through lengthy legal battles trying to get it taken care of, which are expensive. So you want to avoid all that if you can.

So right off the bat—and then there's the whole thing of claims. If you're not making decisions in a timely manner, you hold up the contractor. It leads to the contractor coming back and saying, "This cost me money. I want you to pay me more. Because you took so long and delayed the work, I had to pay extra for workers. I got charged extra for storing stuff. I had to keep my staff on there longer when they could have been on another project. I want you to pay me this stuff." So there are claims. So we got hit with two claims on that project—one from the first contractor on the shell and core, which at the time I couldn't do much about, so we settled. Negotiated down as much as we could, but we paid a claim there.

But then we got hit with a second claim from the second contractor, and that one I could do something about because I had had my core team in place by then, and we had a lot of documentation. So we actually went to—first time ever in Texas—filed an Errors and Omissions claim against the architect. We didn't get an enormous settlement, but we got about half of the amount the contractor claimed. So when we ended up paying the contractor, very little came out of—by the time we negotiated with the contractor, very little came out of the pocket of MD Anderson. They paid a second claim, which is a story in itself because I'm telling OFPC, "Look, they're claiming delay. Well, all the delays are caused by the architect's plans. Let's file against Errors and Omissions." "Oh, we've never done that." "Then why do you have it in the contracts if you've never used it?" Well, we find that there's always something owner—"all these namby-pamby excuses. So I pressed. I said, "We're going to go to a higher level because Anderson fully believes this is an Errors and Omission claim." I finally pressed very firmly on that, and we filed the claim—the first ever by the University of Texas System—the first ever—Errors and Omission. Then of course, after that, then it became more common, but up until then they had never done it. So then on the second claim we paid very little out of our pocket on that one because we got it from the architect's insurance company.

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***Tacey Ann Rosolowski, PhD***

**0:47:30.4**

Interesting. So were you able to collapse the contracts for this project?

***William Daigneau, MBA***

**0:47:35.8**

No, it was too late. Because Jim Broaddus of the OFPC, he was relatively—he'd come from the design-build that the navy had been doing. He'd been working in the navy and had some experience with that and, let's call it, construction management at-risk contracts. He was familiar with those kinds of contracts. So he lobbied—it was interesting. It was one of the partnerships that we—you know—because I got to know him. I didn't have an adversarial relationship with him at all because he was very cooperative. He wanted to improve OFPC. And one of the things he decided was that we needed to modernize the state of Texas contracting rules. So he took it upon himself, using the power of the University of Texas, to get a law through that would allow design-build and construction management at risk. And the part that some of us played in all of that was to lobby our local representatives to support the bill. So we had our government relations folks, because they ask every year what are the list of things that you want through the legislative session. Right there, we had our modernization of the construction contracting rules. And luckily, that got passed. So from then on we could use construction management at risk and design-build as well as hard bid, and it changed the landscape dramatically for us.

***Tacey Ann Rosolowski, PhD***

**0:49:05.9**

Now, I'm kind of asking this question late in the day, but can you describe the difference between those two contract systems?

***William Daigneau, MBA***

**0:49:11.8**

Okay. Hard bid basically is what's called design, bid, and build. You retain an architect to design the project for you, and they create specifications. You then publicly bid it, so anyone in the state can submit a bid for the work. And then you, what they call, award to the lowest responsible bidder. Now, that's a little tricky. What does "responsible bidder" mean? Well, you go through their financials. You see how many times they've defaulted in the past. You get their reputation. But it's really subjective. So usually, in practice, it was the low bidder got it, whoever the low bidder was. And then you award a contractor a contract, and then you build it through that contractor. So you have one general contractor that has a contract to build your building or roadway or whatever. You have one architect or engineer that created the plans and specifications for it, and you bid it. That's the traditional way.

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The two innovations were construction manager at risk—CMR. And there, you hire a firm that doesn't necessarily build it. That firm is responsible for managing the construction for you. You still retain your own architect. They prepare plans and specs. But instead of a hard bid, or bidding it as a whole project, the construction manager basically gives you a guaranteed maximum price that says it should cost you no more than this, and I'll guarantee that. And then the construction management firm goes out and bids the project in pieces. So they'll award a contract to a foundation contractor, and they provide all the coordination. They provide all the warrant. So the construction manager—that's why they call it risk—acts like a general contractor, but you, as owner, participate with them in the bidding of the entire construction of the project to different contractors.

***Tacey Ann Rosolowski, PhD***

**0:51:41.3**

So you better really be able to rely on that group.

***William Daigneau, MBA***

**0:51:44.5**

Yeah. I mean, the selection is not based on bid. You select the construction manager based on qualifications. And then you negotiate the fee that they'll charge you. So that's the second way. And then the third way is called design-build, and that is where you hire a firm and that firm hires the architect and the contractors and you only have one contract to build the whole thing. They manage the architect. They manage all the subcontractors. They provide the warranty to the building, insurance, bonds, all of that. So those are the two additions to the contracting process. At Anderson, we almost entirely used—only on hard bid, on small projects would we use hard bid anymore. Almost entirely we relied on design-build and construction management at risk, from that day forward. So we never had a contract like that again.

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## **Chapter 9**

### **B: Institutional Processes**

#### ***Weather is Part of the Job: A Near Disaster and Developing Emergency Plans for Floods, Wind, and Hurricanes***

##### **Story Codes**

B: MD Anderson History  
C: MD Anderson Past  
B: Institutional Processes  
C: Discovery and Success  
C: This is MD Anderson  
B: Critical Perspectives on MD Anderson  
B: Building/Transforming the Institution  
B: Growth and/or Change  
B: Obstacles, Challenges  
C: Professional Practice  
C: The Professional at Work  
C: Understanding the Institution

***Tacey Ann Rosolowski, PhD***

**0:53:02.7**

So tell me about the other challenges of this Three-Building Plan.

***William Daigneau, MBA***

**0:53:11.7**

Well, what became the LeMaistre Clinic was a pretty straightforward building. The Clinical Research Building, which was pre-Allison, by the way—

***Tacey Ann Rosolowski, PhD***

**0:53:26.0**

This is Hurricane Allison, for the record.

***William Daigneau, MBA***

**0:53:28.4**

Tropical storm.

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***Tacey Ann Rosolowski, PhD***

**0:53:29.9**

Tropical Storm Allison.

***William Daigneau, MBA***

**0:53:31.4**

Where flooding occurred was not built above flood level at the time, so it was at risk. We later went back and basically created a flood wall around it. At the time, it was pretty—other than that—but it had an animal facility in the basement. So there was a large excavation made for the Clinical Research Building and the Alkek Hospital, and the foundations were being poured. We had a—I can't remember the name of the tropical storm in—by the way, I had come to Anderson in June. In October, we had this enormous rainfall. Flooded what was then just the basement of the Alkek Hospital and the Clinical Research Building. The basements were wide open, and we actually had a storm sewer break and flood the basements.

So you say, “Well, so what? You flooded the basement of a building that was just under construction, nothing down there yet. It just holds water. You pump it out. Big deal.” Well, the problem we had was Radiation Oncology—all the vaults for Radiation Oncology were below grade. The linear accelerators were all in the basement of the old tumor hospital.

***Tacey Ann Rosolowski, PhD***

**0:55:05.4**

Oh my gosh.

***William Daigneau, MBA***

**0:55:06.1**

Well, we had to basically excavate up to that foundation wall to build the new hospital and the Clinical Research Building, so the wall to all of the treatment areas of Radiation Oncology were exposed by the construction. And of course, we were adding Radiation Oncology facilities in the new Alkek, in the basement there. We had poked a few holes into that foundation wall to create the new doorways that would link the two buildings. So here we have a flooded basement, and the only thing holding back the water from our entire radiation oncology area in the hospital were these two construction doors.

***Tacey Ann Rosolowski, PhD***

**0:55:56.6**

Oh God.

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***William Daigneau, MBA***

**0:55:57.6**

Oh yeah, it was interesting.

***Tacey Ann Rosolowski, PhD***

**0:56:02.1**

I wish the listener could see the look on Mr. Daigneau's face.

***William Daigneau, MBA***

**0:56:06.9**

"Hello, Bill?" "Yes?" "You better come down here as soon as possible." So it was night. What the heck? So I drove down there, and I could see the water in the—you know—it didn't take long for me to put two and two together. I ran down in the basement, and sure enough, there are our physical plant crews. They're sandbagging. They've got pumps. They're trying to keep the water out of the radiation oncology suite. We had damage down there, but luckily nothing that completely shut us down until we got the water pumped out. But that was my introduction to rainfall in Houston and how much water could accumulate very quickly.

***Tacey Ann Rosolowski, PhD***

**0:57:06.3**

When did—? You said that Tropical Storm Allison had not come yet. When did it get on your radar that these big storms and that weather in general was really a factor and it had to be anticipated in buildings?

***William Daigneau, MBA***

**0:57:28.1**

When you read my job description—my original job description—there was a title in there which I laughingly look at now. It was called "hurricane manager." Well, living up in New York—well, now we know, though, but at the time, I didn't know anything about hurricanes. I'd worked out in Colorado. There are no hurricanes out there. So what's hurricane manager mean? So I talked to our head of Environmental Health and Safety. He said, "Oh, don't worry. I'll take care of everything in a hurricane. You just need to show up and make decisions." Now I see a flooded basement and how close we came to a major disaster, and I'm thinking—you know—this was October, so hurricane season was just about over for that year. But I said to myself, "I need to learn more about this stuff." So in the spring of every year they have these classes that are offered by the state and county on emergency preparedness for hurricanes. I said, "Well, I'll go to one of them to tell me a little bit about what these storms are like and what I can expect, etc." So I went to one. It scared the heck out of me. I came out of that course thinking, "Oh my God, I

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need to find another job.” (laughs) This is what stuck in my mind. I recited it for eighteen years at MD Anderson.

The wind is the problem, obviously. It can tear things up pretty bad, cause a lot of collateral damage, which they do. But you can board up your buildings. If the roof isn't gone, you can get back into operation. What hurricanes bring is what's called storm surges, where they push the water from the Gulf or the ocean inland—twenty-some foot storm surges—a wall of water twenty feet high, coming in ashore. So in Houston, what does that mean? That means all the bayous drain toward the Gulf. Well, if the Gulf has twenty feet of water—a wall of twenty feet of water—what's going to happen to the bayous? They're actually going to reverse flow. They're going to try and drain the Gulf. Well, we're sitting there on Brays Bayou, and there's Buffalo Bayou downtown. So Texas Medical Center, on two sides of it, has two major bayous, all of them now, in a hurricane, flowing backwards.

***Tacey Ann Rosolowski, PhD***

**1:00:38.5**

Toward the [Texas] Medical Center.

***William Daigneau, MBA***

**1:00:39.3**

Toward the Medical Center. So in my first year, I became—after having my October experience, all of a sudden I realized our fear was not wind; it was flood, and the flooding could cause serious damage that would require weeks and months to repair.

***Tacey Ann Rosolowski, PhD***

**1:01:12.3**

Now, MD Anderson had or did not have any kind of set plan to deal with this kind of thing? What was the situation at the time?

***William Daigneau, MBA***

**1:01:21.5**

Well, that caused me to look into what our emergency plan was. So one of my new goals was this was in serious deficiency. Me just showing up to make decisions? Oh no, no, no. This was not going to work. So at the time, this was before—the years before the incident command center approach, which we now have, by the way. But one thing I became convinced of was we needed to create a calling tree to get people here that can tell us what to do with some of this medical equipment. The animal facilities—we need the veterinarians on site. You know, if the animal facilities are flooding, well, I have no idea what to do. And we had radiation sources in the basement. If they're flooded—and me and the Environmental Health and Safety director, as

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much as he did know at the time, there's a lot of stuff we have no idea about. So I said, "We're getting a group of people together here, because I have no idea about this stuff."

So to make a long story short, we created this—at the time—we paid money, actually, to create these booklets, which were basically instructions and what to do in case of a hurricane. We expanded the fire safety and a whole bunch of things. And to this day, they still have the flip books, but that was the beginning of the flip books. We hired a company to basically put everything down in writing. This is what you do, this is what I do, etc.

Then in—his name was Earl Jansen. Earl left and went to work for the University of Texas at Austin, so I had to hire a new Environmental Health and Safety person. Her name was Linda Lee, and she came in, and at the time, the incident command center approach was being recommended by FEMA and other agencies. It had grown out of the military—how to deal with emergencies, shootings, whatever. So one of the things Linda Lee put together for us, and did an excellent job, was she created the whole incident command center. And the second thing that she asked me about was should we drill this? I said, "Yeah, we should drill it." We started drilling—doing actual drills.

So over the years, the whole emergency plan evolved into what was a haphazard, Lord-help-us-if-anything-befalls-us situation to one of—and we got to test it out. You know, we were able to test it out, the whole incident command center on Allison, Rita. Katrina didn't hit us, but it was in the Gulf. Anytime a storm is in the Gulf, we go on alert. So we were able to test it out on a number of actual things that happened. And finally [Hurricane] Ike—Ike, which really did—

***Tacey Ann Rosolowski, PhD***

**1:04:42.3**

Tell me how it works.

***William Daigneau, MBA***

**1:04:44.7**

Well, the innovation of the incident command center is—which I think is quite good—goes back to bringing together a group of people, all specialists in their field, and getting them in the same room to take control of an emergency. So you have a facilities person there, you have Information Technology, you have Finance, you have Purchasing people there, you have the head of the hospital. You have people not so much by title but knowledge sitting in the room. I guess Steve Stuyck [Oral History Interview] is now retired.

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***Tacey Ann Rosolowski, PhD***

**1:05:21.9**

Yeah, Public Affairs.

***William Daigneau, MBA***

**1:05:24.0**

Yeah, all your media relations because—you know—the TV channel wants to know what we're doing. Well, somebody put that together. Right now I'm worried about the flooding, so the media people would put that together. So you bring everybody into a room together, which is called the incident command center, and then you have the incident commander. Now, at the time that I left, the incident commander was the head of the hospital, which is Dr. [Thomas] Burke. If he was incapacitated, it fell to me, which I was never really comfortable with, but—you know—but I had the medical officer in the room with me, so medical decisions. And head of nursing was in the room with you. But the whole idea is you bring these core groups together, create the command center. You have your incident commander who makes decisions. But basically all the people in the room together during the emergency are there basically to manage their aspect of the emergency.

So for example, when are we going to close the clinics? Well, we have the head of the clinical operations there. So in this case, it was Gerard Colman. So Gerard would say, "Well, for us to close the clinics we have to give this much notice." He knew that because he knew about the scheduling, the patients coming in, etc. You can't wait until a patient leaves their home or gets off the plane to tell them it's closed, so you need so many hours. So things like that would come up. So he'd advise the incident commander, "Well, I need to notify everyone at least 12 hours in advance." And then if the commander said, "Okay, let's close it," then it was Gerard's responsibility to actually mobilize his group to call every patient, contact every patient, and let them know that their appointment was canceled, that the clinic would be closed.

So that's how the command center works. Issues come up. We have damage. We've got flooding here. It mobilizes people. The incident commander is there to make a decision on what to do, and then all the people who would execute that decision are sitting in the room and have at their command the people and the resources necessary to do it. So it's a nice system. It works well. We've tested it out. We've always come through everything with minimal damage. We're always one of the first hospitals to reopen. Our clinics reopened earlier than almost anybody else, and we were back in business way before—you know—the only thing that governed our ability to get back in business was it was usually getting our employees back to work, because sometimes they were affected by the flooding or damage or whatever. So the thing that really—the plant was never an issue for us to—we shipped in bottled water. We had everything.

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*Tacey Ann Rosolowski, PhD*

**1:08:51.4**

So laying in supplies was also part of it.

*William Daigneau, MBA*

**1:08:54.6**

Yeah. I mean, everything—generally, our incident command system worked. We'd drill it twice a year.

*Tacey Ann Rosolowski, PhD*

**1:09:00.7**

Oh, really?

*William Daigneau, MBA*

**1:09:01.6**

Oh yeah. Run everybody—sometimes it was just a paper drill. Sometimes we'd pull everybody into the room. Linda Lee's staff would create this fictional—sometimes it was a bombing. Sometimes it was a fire. Sometimes it was a hurricane. And every time we drilled it, we learned something new about our plan, and it got better and better and better.

*Tacey Ann Rosolowski, PhD*

**1:09:26.4**

What about technology and computer systems and all of that?

*William Daigneau, MBA*

**1:09:33.9**

In terms of the incident command?

*Tacey Ann Rosolowski, PhD*

**1:09:35.4**

Yeah.

*William Daigneau, MBA*

**1:09:36.6**

Oh yeah, communications were always important, both telephone as well as the computer systems.

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*Tacey Ann Rosolowski, PhD*

**1:09:43.6**

And I'm thinking data security and patient information, security—all of that.

*William Daigneau, MBA*

**1:09:47.1**

Yeah, we actually had—in the command center, we would close the whole institution, but there were what we called the “islands” that were still up and operational, and one was the data centers. Yeah, they were staffed, and they had food supplies there—power bars and microwavable. Yeah, they were fully self-sufficient. But to keep the data centers and the telephone system up and operational—

*Tacey Ann Rosolowski, PhD*

**1:10:12.2**

How long did it take to really get the working model of this in place?

*William Daigneau, MBA*

**1:10:18.6**

It evolved. It evolved. I mean, originally, the concept of—there was a guideline for incident command centers that was created by FEMA, but it misses a lot of the details. And the details became—every year you had to update your departmental emergency plan, which was integrated into the overall institutional plan. And every year we got better.

For example, one year we created what was called the emergency plan officers—the EPOs. Those were the people for each department, not necessarily the department head, but they were people in each department that were responsible to create and then update their departmental emergency plan. And they were responsible for communication flow, notification, things like that. They had a list—they still do—they have a list of responsibilities. So one year we thought—you know—because up until then we had relied on department heads. Well, we found out that department heads don't always communicate well with their departments, and they're not always available. But they use a departmental administrator or somebody else that does a lot of that stuff that is available, that does communicate well.

So one year we said, “We've got to create a core group of people. So we created the emergency plan officer—EPO—and asked every department to name one. And it took—you know—this did not go in place in one year. Every year it got better and got stronger, and every time we had an incident, we would make it better and correct the problem we had, and the drills would reveal deficiencies—unable to contact So-and-So. They didn't respond. Now what do you do? So every

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year we got better and better at it, and we innovated every year on something that would enhance the program, so it evolved over—yeah.

***Tacey Ann Rosolowski, PhD***

**1:12:20.5**

Good wake-up call.

***William Daigneau, MBA***

**1:12:21.6**

Just about a scary situation to one where we were pretty confident.

***Tacey Ann Rosolowski, PhD***

**1:12:26.9**

Right. Make it manageable. Yeah. Wow. Amazing.

***William Daigneau, MBA***

**1:12:31.6**

All learned.

***Tacey Ann Rosolowski, PhD***

**1:12:32.3**

All learned.

***William Daigneau, MBA***

**1:12:32.7**

All learned from a flooded basement. (laughs)

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## **Chapter 10**

### **B: Building the Institution**

#### ***The Alkek Hospital and the MD Anderson Way of Constructing Buildings***

##### **Story Codes**

A: The Administrator

B: MD Anderson History

C: MD Anderson Past

B: Institutional Processes

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

C: Understanding the Institution

D: On the Nature of Institutions

D: Technology and R&D

##### ***Tacey Ann Rosolowski, PhD***

**1:12:41.0**

Were there any other issues that you wanted to talk about with that Three-Building Plan before we go on and talk about maybe the master plan, how that evolved?

##### ***William Daigneau, MBA***

**1:12:52.7**

Well, there were two things that—experiences out of the—primarily the Alkek. The other two buildings were pretty straightforward, but Alkek gave me two lasting impressions about what not to do. That formed the basis of how we approached building in the future. And both these really had to do with time. When we got to the point of actually building out, the third floor was all diagnostic imaging equipment—MRs, nuclear medicine, things like that. So by the time we got to—we were starting to build out the third floor. We were putting in the ductwork for the heating and ventilation system. And this is how I got to know Dr. Murphy pretty well, by the way.

##### ***Tacey Ann Rosolowski, PhD***

**1:14:03.6**

And this is William Murphy, just for the sake of the recorder.

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***William Daigneau, MBA***

**1:14:08.0**

Yes. So all of a sudden, at one of these meetings, Mary Ann Newman says—core team meetings—says, “Well, Diagnostic Imaging wants to put in the latest model MR.” “Well, fine. Do we have it in the budget?” “Yeah, we can cover the cost of the machine, but there’s one problem.” “What’s that?” They won’t fit in the rooms that we designed for them.” “What?”

So to make a long story short, of course I went to see Dr. Murphy. I said, “Do you understand the problem here?” He said, “Well, I don’t know what to do, Bill. This is the latest technology. If we put in the older-style machines—you know—this is the best we can offer. Why would we open a brand-new hospital and put in the older-technology machines in it?” “Good argument, Dr. Murphy. I’ll see what we can do.” So we ended up tearing out everything we had built on the third floor. It was all throwaway construction. All that shiny ductwork above the ceilings, brand new, ripped out and put in a dumpster. Redesigned the whole floor to accommodate the new machines.

Second incident was we’re getting ready to move in. By the way, we hired—I didn’t trust anybody there yet, so I argued successfully that we’re going to hire a move manager, somebody from the outside that does nothing but manage the moves into new hospitals. That’s all they do. That’s what their career is. We’re not learning at the school of hard knocks. We’re going to meet this deadline, hire a move manager. We never used a move manager again in that context. But we hired this guy, and used his system basically as a blueprint to create our own. But we’re getting ready to move in and starting to train the nurses on the floor, and the nurse call system—well, how does this work? What do you mean how does the nurse call system work? To make a long story short, we had this very modern, technological nurse call system, but they still wanted the lights above the room. You know, so he hits a button and it glows red. It says, oh, patient in room—which was old technology.

So that taught me about technology transfer. You can’t just buy the technology and then tell people, “Well, we’ve got this brand-new system. Go for it.” These nurses were brought up under an old technology, an old system. So technology was moving at a speed faster, in some cases, than some people could accommodate it and faster than some buildings could accommodate it. So what’s the solution? Because it takes you three years, at minimum, to go from I’d like to have a building to let’s move into it. During that three-year time period, technology is marching forward constantly. So if you design that building for a certain technology, by the time you move into it, that technology may be out of date. Or vice versa, that technology may be of a kind that the people who are going to use the building are unfamiliar with because it reshapes practice or whatever.

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So what's the lesson here? Time is not your friend; time is your enemy. So what's the solution to deal with this? Well—which were two innovations at Anderson, which kept me on the public speaking circuit for a while. Number one is to reduce the time of construction as dramatically as you can. In other words, if it normally takes—by the way, the time from Dr. LeMaistre saying, “Let’s build a new hospital,” to the time we actually moved into the hospital was almost eight years. So the one solution is to build as fast as you can and compress—you know—if it takes eight years, you want to compress that by half to a third—or to two-thirds. So you want to go down to four years—between four and six years, depending on how complex the building is. If that’s normally what it took you, eight years, because technology changed so much in eight years that that new building will no longer be new by the time you get it done. So compress that time to construction.

The second thing that we innovated on was the last possible moment, or what I call “just-in-time construction.” And that is to delay anything you can in build out to the last possible moment. So a number of things evolved from that. First of all, as large a floor plate—or as open a floor plate as you can build unrestricted by columns and cores, to have a construction approach that allows you to make decisions as late as possible on critical—especially technology decisions. Things that are low technology, like waiting rooms, who cares? But any OR suites, MR suites, anything that uses technology, delay as possible. Build as many channels or paths between floors as you can to accommodate new technology—new wiring. Whatever you designed it for is not going to be enough in the future, so how are we going to try to power up this thing in the future? How are we going to get to it?

So a number of principles became laid out about how we would build at Anderson that we applied building after building after building and dictated our approach to building construction, the use of the core team, decision making, plan reviews. Everything was designed to compress the construction schedule as much as possible and to build at the last possible moment.

***Tacey Ann Rosolowski, PhD***

**1:22:05.8**

What are the strategies you used to speed up construction? I’m just having a hard time getting my head around that one.

***William Daigneau, MBA***

**1:22:12.0**

So up until Anderson did it and the law had been changed, nobody had used design-build except on a couple of dormitories—very simple buildings. Design-build offers you the opportunity to have—normally, under the old process, you’d have to have your design and specifications 100% complete so you could bid them. Under design-build, since the person in charge of the—you

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know—the company running the project managed the architect, he or she could say to the architect, “I want the foundations and structural plans completed first because I want to bid them right away. After that’s done, then you can work on the finishes and the mechanicals and other things, but right now I need the excavation plan, foundation plans, and structural plans now. And while you’re finishing off the design, I’ll start construction.” So it allows you to fast track the construction by managing the completion of the design to match your sequence of construction, so it shortens the time to construct.

***Tacey Ann Rosolowski, PhD***

**1:23:36.0**

I imagine that also means that there began to be a number of architects who knew how to work with that system.

***William Daigneau, MBA***

**1:23:43.9**

Yeah. Well, the other approach is construction management, and there the owner basically tells the—so what we would do is negotiate contracts with the architect. Even though we had the architect under contract ourselves and the construction manager running construction, we’d have the construction manager run up his whole schedule and set dates for when he needed various designs completed. Then we’d go back to the architect and tell the architect, “Your contract is based on four phases—five phases—and you need to complete these documents by this date, by that date, by that date.” So we would manage that part of it ourselves, but all the design basically to compress all of the construction schedule by allowing us to begin construction before all plans and designs are completed.

So okay, how do you do that? That led us to, well, the only way you can really do it is keep that floor plate as open as possible, because we won’t actually get to the interior partitions until later on, so we don’t want to design something in the way of laying out exam rooms, offices, whatever. So the only way to do that is minimize the number of columns. So we studied other industries and how they did that.

I used to, in my presentations, talk about where we learned this stuff from. Well, one thing is we learned about what was called the “mall developer.” So how do mall developers build malls? Well, the first thing they do is they determine what the capacity of the land is, how big it is, and how big of a mall they can build. Well, once they have that determined—which is the master planning phase, by the way—once they determine that, then they look for, well, I can accommodate four big boxes—what’s called anchors. I can accommodate, on this land, four anchor stores. So they go out and they try to find the anchors right away because anchors have—you know—Target has a certain way they build their stores. Macy’s likes this. So they get the

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anchor stores under commitment and their designs started. If you look at a mall, they start building the biggest stores first. Then everything in between the stores—all the other outlets—are built last, and they're built basically so you can divide them into 2,000 square foot, 4,000 square foot, 6,000. So Gap comes and says, "Well, I want to be between Macy's and Dillard's, but I need 6,000 square foot."

***Tacey Ann Rosolowski, PhD***

**1:26:30.5**

Oh, so you can—?

***William Daigneau, MBA***

**1:26:31.2**

Well, you can move that wall anywhere. Now, they may only leave 2,000, but then another retailer comes and says, "I only need 2,000, but I want to be next to Dillard's." "Okay, there you go." So that's how a mall developer does it.

So we started applying the same principle. We created what was called kit-of-parts. If you have a column spacing of thirty-five foot or thirty-three foot, you can fit three exam rooms in between those columns, two conference rooms, and one MR suite. Everything fits in that spacing. So we were able to tell the architects early on we want a building with thirty-three-and-a-half feet between column spaces. Tell the structural engineer to design floor slab to accommodate that. Because we knew once that floor plate was done, we could fit all these combinations in there. So we compressed it. We went to standard floor plates, wide open as much as possible, pathways between floors for future, in case we missed something. And that happened in IT. IT kept wanting larger cable size all the time. "Well, that was the old technology. We need this technology." "But that was your standard." "That was our standard last year. Our standard this year is this." I mean, that's how fast it would change.

***Tacey Ann Rosolowski, PhD***

**1:28:13.0**

Sure. And nobody was anticipating that—no one.

***William Daigneau, MBA***

**1:28:16.6**

So we had pathways, we had floor plates, and we had a procedure that could build fast to the point that I always—I took some—for our team, some pride in the fact that I was told once that as a public institution, we could build faster than anyone else in the Texas Medical Center, even the private ones.

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***Tacey Ann Rosolowski, PhD***

**1:28:50.4**

Wow.

***William Daigneau, MBA***

**1:28:53.2**

It became a joke. “Well, we don’t build as fast as you do.” I mean, you’d get these comments because—both inside the industry and just casual observers—you know—“How can you get this underway so quickly?” Now, I told you about people. To build fast like that and not make big mistakes, you have to have pretty good information flow constantly, not only amongst your construction team but with the users. So that approach only works if you can engage the people who are actually going to occupy the space all the way through because you’re making decisions on a daily basis that are paced with the construction of the building. So you don’t have to pick colors out yet. We’ll get to colors. We don’t have to worry about floor finishes yet, but I need to know the room dimensions. So you need to have very strong working relationships with, like, Radiation Oncology, Diagnostic Imaging, Surgery—you know—because those are all highly specialized spaces that only the people who actually do that stuff understand the details of.

***Tacey Ann Rosolowski, PhD***

**1:30:22.9**

Now, am I correct in assuming that for the Three-Building Plan you were not able to have good communication with users?

***William Daigneau, MBA***

**1:30:29.8**

No. It was one of the criticisms of that project.

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## **Chapter 11**

### **B: Building the Institution**

#### ***John Mendelsohn's Plan for MD Anderson and the First Building Projects— The Mays Clinic and the Faculty Center***

##### **Story Codes**

A: The Administrator

B: MD Anderson History

C: MD Anderson Past

B: Institutional Processes

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

C: Understanding the Institution

D: On the Nature of Institutions

##### ***Tacey Ann Rosolowski, PhD***

**1:30:32.4**

Right. Okay. So what was the project in which you were able to involve users from the very beginning? What was the first one that you were able to do that with?

##### ***William Daigneau, MBA***

**1:30:40.8**

Well, this goes back, again, to a little—so we opened the new Alkek. Actually, the dedication was given by Dr. [John] Mendelsohn because Dr. LeMaistre had by then retired and Dr. Mendelsohn had been recruited. So the actual dedication for Alkek Hospital was in the main lobby by Dr. Mendelsohn. So Dr. Mendelsohn had arrived.

##### ***Tacey Ann Rosolowski, PhD***

**1:31:08.4**

Alkek—let's see, that was '98—'99?

##### ***William Daigneau, MBA***

**1:31:14.7**

Uh-hunh (affirmative). So remember I told you that that was supposed to be the last building

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project. So Dr. LeMaistre believed—managed care was sweeping through California, and what happened in California, some hospitals were closing because if they weren't part of a network, then the doctors couldn't feed the hospitals with patients; you were closing. So the number of beds were dramatically—because better utilization led to—you know—under the old system, you had to have X number of beds. Under our new system that improves the utilization, all of a sudden these beds become excess. So Dr. LeMaistre saw that happening and actually had a—I can't remember the name of the group.

*Tacey Ann Rosolowski, PhD*

**1:32:06.9**

Was it the McKenzie Group?

*William Daigneau, MBA*

**1:32:08.4**

No. It began with an "s." He brought a group in from California that had seen this dramatic change in healthcare.

*Tacey Ann Rosolowski, PhD*

**1:32:21.6**

Oh, the SHARP Report.

*William Daigneau, MBA*

**1:32:22.7**

SHARP Report.

*Tacey Ann Rosolowski, PhD*

**1:32:23.6**

That's it. Yeah, the SHARP Report.

*William Daigneau, MBA*

**1:32:25.0**

The SHARP Report. And SHARP said that basically we would close a third of our beds and all these dire things—you know—our workforce would go back down to a third and all this terrible stuff would happen. Well, Dr. LeMaistre thinks this is like a tidal wave coming. It's not a matter of if; it's a matter of when. So we were started to downsize the institution. There was some criticism. Should we finish the hospital? Again it was restated, well, the hospital is a replacement. We're going to reclose the old beds not the new beds.

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So there were all those discussions going on. I sat through a number of strategic planning sessions based on the Sharp Report. Basically my role was, well, how could we downsize? I actually—somewhere sitting in the archives is a mothballing report about how we would close various facilities and mothball them. So that was the mental—the capital plan was we were doing land acquisitions in the mid-campus at the time. That came to a complete halt. The capital plan—you know—a new research building—Dr. Becker was arguing for a new research building—basic science research building. That kind of ground to a halt. All this capital plan was put on the backburner. Everything was in shutdown mode. Dr. Mendelsohn arrives. Dr. Mendelsohn looks around.

By the way, one key event happened before Dr. Mendelsohn arrived. Dr. LeMaistre was able to get through the legislature the self-referral. Up until then—that's why he was so afraid of managed care, because he said the private docs will stop referring to MD Anderson and will start referring to the other hospitals, and that will close Anderson's doors, just about. So he got through the legislature the self-referral, which allowed you as a patient to refer yourself to MD Anderson—key step—key step.

Dr. Mendelsohn arrives with this now a law. He looks at all the statistics—Texas population. We're not going to lose patients. We're going to get more patients than ever. So we had been in shutting down—basically closing-all-the-hatches mode for about a year. In the facilities business, that's really a difficult situation because of the timeline it takes to get new facilities online. If you shut everything down in the pipeline, it takes you three to four years to start a growth pattern, as far as space is concerned. Dr. Mendelsohn arrives and says, "We're going to grow. We're going to grow by fifty percent." (laughs) Okay, so where are we going to see those patients?

So one of the challenges—and it was a great experience, and I have a great respect for these people. I'll name them right off. Dr. Mendelsohn is number one. We're going to do this. How can we do it? Number two, he recruited a team—Leon Leach. How can we pay for it? That was Leon's role. Kevin Wardell, in charge of the hospital and clinical operations; Dr. [David] Callender, in charge of the docs; then there was Dr. Becker. Dr. Mendelsohn was—you know—we've got to see more patients because more patients allow us to fuel our research program. Dr. [Frederick] Becker liked that idea. Maybe he'd get his research building. More patients, who doesn't like that? More clinical trials—growth is a wonderful thing to be in, you know? So who didn't like that idea? And it was refreshing after all these doomsday—somebody came in and said, "We're going to grow."

Well, so how can we accomplish that with the facilities we have? We don't have—some lunch? Yeah.

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***Tacey Ann Rosolowski, PhD***

**1:37:16.7**

Okay, we will just kind of bring this to a quick close?

***William Daigneau, MBA***

**1:37:21.7**

So that laid out—first of all, redid the master plan. Number two is what is the strategy to try to accommodate more patients? Well, we had to improve utilization. It's what I call the period of compression. There are some exam rooms that were being used as offices. No, we're not going to do that anymore. So every exam room that had originally been designed as an exam room was put back into use as an exam room. Even to the point of shrinking some waiting rooms, compressing. Rooms that had been designed as copy rooms now became offices, negotiating new contracts with Kinkos, getting rid of the copy machine. There's one of the floor—a copy machine on the floor. We're going to share this. It required a pretty strong team effort to put a lot—but we went through the period of about four years that was called the Compression Period, where we just improved a higher utilization, moved rented space, moved every administrative office out the main complex that we could, which basically came up with the next two buildings. They were planned during that period of compression. They would relieve the compression eventually.

***Tacey Ann Rosolowski, PhD***

**1:38:59.7**

And what were those buildings?

***William Daigneau, MBA***

**1:39:01.2**

The Faculty Center and the Ambulatory Clinic Building, because we were trying to see more patients, so we had to have greater capacity. Both have interesting stories with them. Dr. [Andrew] von Eschenbach was still with Anderson. He had not left for the FDA—or what was his first—?

***Tacey Ann Rosolowski, PhD***

**1:39:29.4**

He went to the NIH, I think.

***William Daigneau, MBA***

**1:39:32.4**

NCI.

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***Tacey Ann Rosolowski, PhD***

**1:39:33.3**

The NCI, right.

***William Daigneau, MBA***

**1:39:34.2**

He had not left for that yet, so he was still kind of the head of the faculty in terms of been there a long time, well respected, very good negotiator, had strong connections throughout the institution. So we were in a meeting, and I was presenting how we could increase capacity with what was called the Facilities Steering Committee that had been created at the Major Building Program stage by Mary Ann Newman that I then built into a more comprehensive decision-making group, because I had all the executives there. And it was chaired by the president. So I'm kind of going through options, and they want to build a new—more clinical space. Where can we do that? I argued. I said, "Well, I think the Clark Clinic and the LeMaistre Clinic were built as clinics, so if we can move anything non-clinic related out of them, we can literally expand in place." "Well, what are you going to move out of them?" "Well, faculty offices." And actually, that was—in discussing the options, that was one Dr. von Eschenbach basically said, "I can get the faculty to move. If you'll give them more clinical space, I'll get the faculty to move." I mean, you know I talked about people? If you didn't have people step up like that, willing to take on difficult tasks—I mean—you could be the greatest facilities person in the world and can't solve a problem. But here we had a solution—the Faculty Center. That's how the Faculty Center was created. Because originally it was just going to be an office building to accommodate administrative things, and it evolved into the Faculty Center.

***Tacey Ann Rosolowski, PhD***

**1:42:06.3**

Cool. Do you want to take a break at this point?

***William Daigneau, MBA***

**1:42:08.5**

Yeah.

***Tacey Ann Rosolowski, PhD***

**1:42:09.5**

That sounds good. All right. So I'm turning off the recorder. We're just going to take a lunch break. It's nine minutes after twelve.

**1:42:15.7** (end of audio)

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(begin audio)

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## **Chapter 0**

### **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**0:00:03.9**

All right. We are recording again. Let me just write my things down here. We are back after a leisurely break, and it is 2:51. We were talking about the next two buildings that were built after the Three-Building Project, and you were about to tell me the significance of the faculty center, which was?

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## **Chapter 12**

### **B: Building the Institution**

#### ***The New Master Plan: Expanding the Main Campus***

##### **Story Codes**

A: The Administrator

B: MD Anderson History

C: MD Anderson Past

B: Institutional Processes

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

C: Understanding the Institution

D: On the Nature of Institutions

##### ***William Daigneau, MBA***

**0:00:32.7**

Well, originally—going back to the master plan, we had studied how you could add buildings around the main complex. There was one proposal at one time to even add to the LeMaistre Clinic—build out farther. But one of the things that came out of that redo of the master plan was the zoning of the main complex. Basically, the concept was in the front of the main complex would be all patient care activities, because for wayfinding purposes, it was easier to have one main entrance. So for patients trying to come to Anderson, they would go to, as it turned out, one of two main entrances. One was for the ambulatory operations—the outpatient clinics—which was at the front of Clark. And the second was for hospital, which was the new Alkek. So from a wayfinding standpoint, if you look at Anderson, there's that drive that comes in front of Anderson, and that drive connects both entrances, Alkek and—so from a patient standpoint—and then the two main garages were Garage 10 and Garage 2. So the patients would park in one of the two garages or valet in the front. We had two valet operations. So from a wayfinding standpoint, having that centralized location was important.

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*Tacey Ann Rosolowski, PhD*

**0:02:16.3**

Can I ask you—now, at this phase, when you were discussing the master plan—I mean—basically revisiting it in the light of Dr. Mendelsohn’s announcement that we’re going to grow by fifty percent, and you had said that a real limitation of the master plan, if it was conceived under Dr. LeMaistre, was that there really wasn’t a sense of the long, long term. So did you add your voice? How did you add your voice at that point?

*William Daigneau, MBA*

**0:02:45.6**

It was through the revision of the master plan.

*Tacey Ann Rosolowski, PhD*

**0:02:47.6**

And what were you advocating in terms of long-range planning?

*William Daigneau, MBA*

**0:02:50.5**

Well, based on my previous experience in life, I was trying to create a situation where it was easy for patients to find it. Now, employees, on the other hand, once they come to work for you, you show them where to park, you show them how to get in the facility, and then they’re good to go. But patients that are often there for the first time, they’re not well, people are scared—all of this is going on, so the thought was what we want to do is keep it as simple for patients as possible when they come to MD Anderson, because the Texas Medical Center is a big, complex place.

So when we did the revision of the master plan, there were some previous versions of that where we would use the HMB site, which was twenty-some acres, for research purposes and continue to develop the main complex of the hospitals. But there was no good—you know—other than taking building right out to the street, which some institutions had done, Anderson was unique because of the setback we had. We had the garden in front and then the entrance. And from a patient standpoint, that’s a much friendlier entry than coming all of a sudden on top of a building. So when we started revising the master plan, looking for the options for additions, there were really no good additions that could be made for outpatient activity. So then the question became, how would you expand outpatient activities?

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So we looked at adjacent to Garage 10 is Garage 5, which is on the corner of MD Anderson and Holcombe. That's owned by the Texas Medical Center. But we looked at that site because it was contiguous to the main complex and we could bridge there. So we looked at that site. We looked at behind Garage 10 was the psychiatric hospital, which was operated and owned by UT Health Sciences Center, and then around the back of the complex where Moursund is, and Baylor is on the other side of the street, there was, at that time, a big surface parking lot and the dental school. So long term, from a strategic standpoint, we identified those areas as potential development, even though we didn't own them. But from a development of the complex, it made sense. The issue was always, of course, timing. When could you get control of those sites? How fast could you get control of them? So from a practical standpoint, which is where the theoretical meets the real world, it became clear, at least to me, that future expansion for clinical operations was severely limited, but expansion for research was more likely. From the standpoint of building onto the north side of the complex for research purposes, it would allow you to maximize use of your fixed facilities in terms of the vivariums—two big vivariums there. So to support research activities, expanding to the north for research was the obvious answer.

So that left the question then of, well, if research is going to occupy all those sites you identified—other than the Garage 5 site—and you don't want to build all the way to the street, then what options do you have for ambulatory operations? So that led to, which I mentioned earlier, the concept of using all existing space in the current clinical buildings and maximizing their use. So that strategy became then moving all administrative offices out, which we had begun doing anyway. And then the big breakthrough there was move the faculty offices out. And that allowed us to basically expand clinical operations in place in buildings that had been designed for that in the first place. You already had the investment there for clinical operations, so to maximize their use for clinical operations made a lot of economic sense as long as you could convince the faculty that walking across the street every day was not that big of a challenge. And as I said earlier, Dr. von Eschenbach took the lead at convincing the clinical faculty that this was—if they wanted more space and they wanted it soon, this was the most practical solution to it.

So thus was born the Faculty Center and the decision to move clinical operations across the street, which was a major break in the history of Anderson. So with that kind of strategy now in place, you expand research to the north, expand patient care activities to the south, jumping across Holcombe to do that. That was a key turning point in terms of how we would accomplish all of this.

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## **Chapter 13**

### **B: Building the Institution**

#### ***The Master Plan Brings Special Challenges: Successes with the Faculty Center and the Mays Clinic (Ambulatory Clinic Building), The Prudential Building***

##### **Story Codes**

A: The Administrator

B: MD Anderson History

C: MD Anderson Past

B: Institutional Processes

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

##### ***William Daigneau, MBA***

**0:02:50.5**

So immediately, we put into operation the plans for the Faculty Center, and there was a parking lot there. It was an interesting parking lot because it was not owned by Anderson; it was owned by a private developer from Canada. And Texas Medical Center basically had a lease to operate a parking lot on that site which most of our faculty parked in. A lot of people parked in there. But when they had built the first Rotary House, they built a bridge across the street, and when we built the LeMaistre Clinic, we basically extended that bridge that had already been built at Rotary House, which terminated on the other side of Holcombe. We extended it right into LeMaistre. I was never real happy with that bridge, mainly because of the slope on it. People coming across from Rotary to the main complex have a pretty significant slope to get to the third floor of LeMaistre. But again, that was one of those designs that had already been put into place, and basically I was executing that. But I was never really happy with that bridge for patients. But—but the only people that were really using the bridge were people staying at Rotary House, so it wasn't too bad.

So when we were looking at all the sites for clinical expansion, we kind of ruled that out across the street for clinical purposes but ruled it in for office use—faculty office use. So we put into motion to build that and build it as fast as we could.

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***Tacey Ann Rosolowski, PhD***

**0:10:59.6**

How did you acquire the parking lot area?

***William Daigneau, MBA***

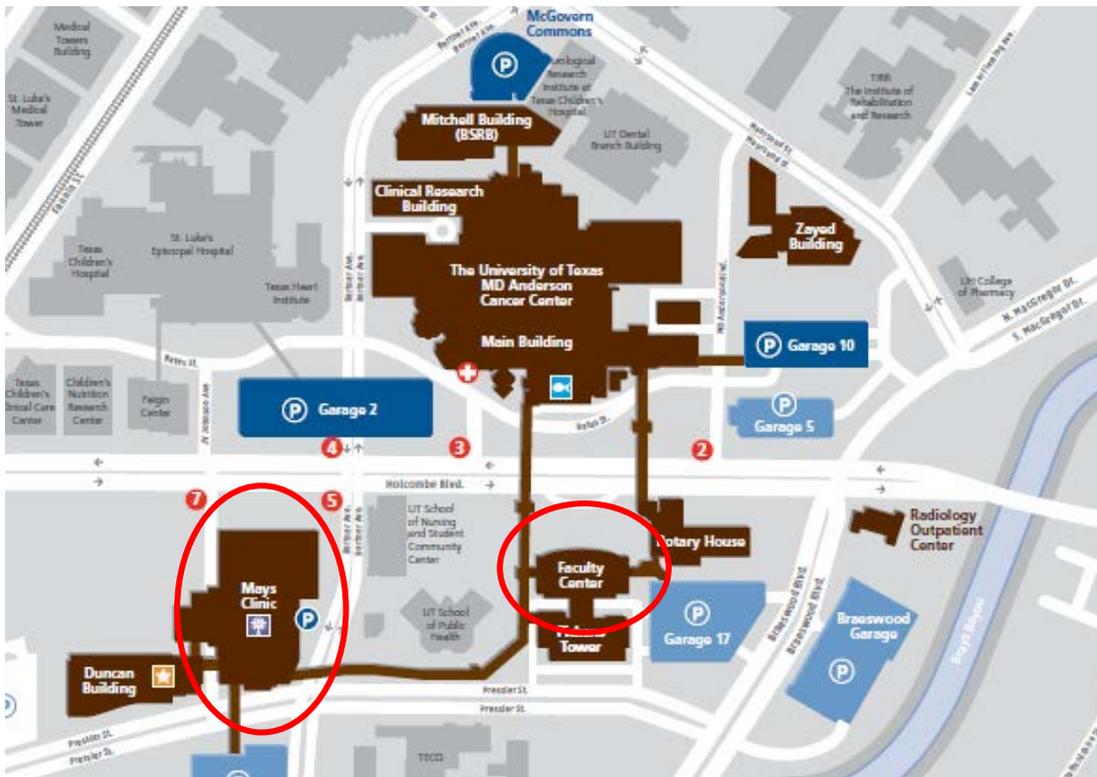
**0:11:02.7**

Well, that was my first—that was my foray into the administration with Texas Medical Center, which was led at the time—he's retired in the last year—by Dr. [Richard] Wainerdi. First of all, we had to negotiate the release of the lease with them, and then we had to acquire the land. And the Canadian developer was not—did not want to sell. Now, at the time, since we're part of the UT System—technically a part of state government—we have the power of eminent domain. The problem was nobody in the UT System administration wanted to use eminent domain because it was always public and created a lot of harsh feelings by people. But I was able to eventually convince the attorneys and the administration at UT that all we really wanted to do is threaten the use of eminent domain—go through the motions as though we were in the process of employing it to the point where we sent the developer a letter notifying him of our intentions to use eminent domain. To make a long story short—

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## The Mays [Ambulatory] Clinic and The Faculty Center



**Tacey Ann Rosolowski, PhD**

**0:12:23.5**

Can I ask you, what are the implications? Because some people who are listening might not have in mind what eminent domain is.

**William Daigneau, MBA**

**0:12:30.6**

Well, eminent domain is the use by government of acquiring private property for the public benefit. It's most often used with highways. The interstate system was built extensively using eminent domain because you'd have to go across somebody's farm in Kansas. Somebody owned that farm, but that was the route of the interstate system. The government would come in and basically the process is you pay fair market value for the property, and that is determined by independent appraisal. And there's always some negotiation that occurs, but basically you're paying that landowner for their land.

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The reason it's disliked by many people is—let's take the farm example. That roadway is going right through the middle of the farm, so now what's left for the landowner? Two pieces on each side of the highway. How are we going to get across? So it reached its peak of notoriety—the use of it—I think it was a city in Baltimore—I can't remember exactly—used eminent domain to acquire people's property in the city so that they could redevelop it for commercial uses. Now, the argument was that the city tax rolls would benefit if there was a higher and better use, but also, at the same time, a lot of people who had lived in those homes their whole life were displaced. There were lengthy court battles. It went to the Supreme Court. So eminent domain got a bad name. People could tolerate a farm, highway. We understand the benefits of putting the interstate system through, or improved road, but now you're buying it so you can turn it over to a private developer? That doesn't make sense.

So it got a bad name, so there was hesitancy to use it. And of course, in Texas—you know—very independent-minded folks, government intruding on their personal—so eminent domain, even though the power is used, was a last resort. Well, here comes MD Anderson wants to use it to acquire a parking lot to build an office building. It's hard to explain to people the logic of why this makes sense from a mission standpoint. They're just looking at you're building an office building; you're taking this poor person's livelihood away from them.

Now, this particular developer offered to build us an office building on his land and then lease it to us, but obviously we didn't want to do that. We wanted to be able to control the use and all of that. And it didn't make economic sense. He wanted to charge us an arm and a leg for it.

So we threatened it. It was enough to bring it back to the table, and we settled. I think we settled in an amicable way, where he didn't feel like he was getting deprived of things. Plus, he was very wealthy, so it's not like he didn't have a lot of resources. At one point in time, he came back to us—which we complied with—modified the terms of purchase so that the value that he could have achieved by self-development versus what we paid he could write off on his taxes as a donation to MD Anderson.

***Tacey Ann Rosolowski, PhD***

**0:16:09.2**

He got creative.

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***William Daigneau, MBA***

**0:16:10.6**

He came out all right on that. So we had—but that took a little while to get control of the land. At the same time, we decided to use design-build. And as I said earlier, this was the first time design-build had been used other than for a very simple building such as a dormitory by the UT System. That project, from the point in time where we retained the architect to the time we occupied it, was fourteen months. One of the fastest—Dr. Mendelsohn remembered the amount we paid for it—thirty-five million dollars for this building—and always, from then on, asked me why things cost so much, because he remembered how much that building cost.

But we did it in record time, and so we were able to—with the completion of that building, we were able to mitigate the compression that was occurring and see more patients, which created another series of projects which were called the Backfill Projects and the Redevelopment Projects.

***Tacey Ann Rosolowski, PhD***

**0:17:22.8**

Is that the redevelopment of the Alkek?

***William Daigneau, MBA***

**0:17:26.1**

It's going back into the Clark Clinic and the old hospital—Anderson—into Gimbel and renovating all of those older buildings to support more modern uses—expand the clinical operations, etc. So for example, the surgical suites in Alkek did not have a waiting room, so we used the Anderson—which was Anderson West. So the waiting room for the surgical suites on the fourth floor are actually in Anderson. So those kinds of things. So that led to a whole project to redevelop and what was called the Backfill and Redevelopment Projects—to go back into the older areas and expand them for clinical uses and support clinical uses. Laboratory medicine, all of that stuff occurred.

***Tacey Ann Rosolowski, PhD***

**0:18:26.3**

And about how much money did those backfill and redevelopment projects take at the time?

***William Daigneau, MBA***

**0:18:29.6**

Well, there were four of them. They were Backfill One, Two, Three, and then Redevelopment. When I left, we were talking about Redevelopment Two. But I think the total of those projects was near one hundred million dollars, just to go back in and do them. And they were named that

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way because of a couple of reasons. There were some things we knew we had to do when we opened Alkek and LeMaistre Clinic, and that was Backfill One. To make those buildings operational, we had to go back in and do things right away.

*Tacey Ann Rosolowski, PhD*

**0:19:07.3**

What were some of those?

*William Daigneau, MBA*

**0:19:07.7**

Well, like the waiting room, some projects for Laboratory Medicine on the second floor, connecting hallways, redoing the hallways.

*Tacey Ann Rosolowski, PhD*

**0:19:22.5**

Right, because these were the buildings that you had not overseen the design process, so they were ones that came out prior.

*William Daigneau, MBA*

**0:19:28.5**

Right. So they were fixes. We named them in the sequence they had to be done. Some right away—Backfill One. Some could wait a year, or because of dominoes we had to do this to be able to get to this space—move somebody. That required, for example, the opening of the Faculty Center, so that became Backfill Two projects. Then there were the Backfill Three projects related to the research areas. So they were named in the sequence that the work had to be done, and it was easier for us because we could put better numbers. Because one of the things that was my hallmark, and I never broke it except one project, was we never went back to the regents because we had a budget problem. So once we got approval by the regents of a project, we would never go back and say, “Oh, we missed it. We need a little more money approved.” Never did that. So by breaking the backfill projects, we went from projects we were pretty sure about and could estimate more accurately to projects that were more what-ifs. So the backfill went both in the sequence of execution as well as our ability to accurately estimate the cost of doing the work.

*Tacey Ann Rosolowski, PhD*

**0:20:51.7**

Let me ask you one other detail about the faculty tower. That was—you didn’t mention—you talked about the design-build, but the other piece of your kind of new system was also to

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anticipate technology by delaying decisions. I'm wondering—I mean, that was office space, but did you use the same logic in that space as you would in a clinical or patient care delivery space?

***William Daigneau, MBA***

**0:21:21.0**

There were two things that I was clear about with the president and the executives: That we would build this that fast and at this cost if it was forever used as an office building. It would be basically classified by building code as an office building. The way it was going to be built, it could never be used for any clinical activity. And going in, they had to understand that. And it was built for an office purpose. What we did was we looked at the most efficient office buildings constructed mostly by developers. The floor plates were between twenty-five and thirty-five thousand square foot, center core, and the most adaptable because of that design. For a developer who has an office building, they want different tenants, so they want maximum ability to change configuration on every floor to meet different tenants' needs. So other than the restriction that it could never be used for clinical purposes—so the infrastructure, the mechanical, the electrical infrastructure could never be upgraded for a more heavy-duty use other than office use—we followed basically the same principles employed in commercial real estate of how to build an office building rectangular in shape—which the president was always very interested in architecture and the way things looked—but basically rectangular in shape with a center core of elevators—most efficient layout. So that allowed us to move forward. Architects across the state as well as Houston were very familiar with us because they'd built tons of these types of buildings. It was not rocket science—simple in design, straightforward. Builders had built a lot of this stuff in Houston. So we were following a template that was well understood, well known, and time tested for its adaptability for office-type use.

So the Faculty Center went forward. About the same time, of course, was the second piece of this, and that was to eventually expand clinical capacity—outpatient clinical capacity. So I mentioned earlier we had acquired HMB—Houston Main Building—in the seventies from Prudential. Houston Main Building, very advanced office building at the time in terms of amenities—big cafeteria, tenth floor was all executive suites, had tennis courts, swimming pool, a big parking area. It was basically on twenty-some acres of land. In the facilities context we called it the legacy site because that was the biggest piece of land we owned in proximity to the main complex that could be developed for the future.

The site had been studied as a future research building, and estimates had been made to expand research across the street. That was the previous master plan. I resisted that because, as I said earlier, to me it made more sense to capitalize on the infrastructure we had in place by developing research on the north side of the main complex and use that where the main vivariums were located.

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***Tacey Ann Rosolowski, PhD***

**0:25:22.2**

Where was the Houston Main Building located—or the Prudential building located?

***William Daigneau, MBA***

**0:25:29.6**

It was on the corner of Fannin and Holcombe, and, at the time—you know—it was built in the fifties, and it was viewed as a state-of-the art office building at the time. It was a significant—it was one of the tallest buildings in Houston at the time. It was built on the Texas Medical Center campus, or across the street from it, and there was a significant—I mean, it occupied the skyline for many, many years.

When we redid the master plan, we looked at the legacy site for future expansion. For what, unsure, but—so at the time, I reported to Kevin Wardell, who was the chief operating officer. In devising this strategy of how to expand patient care, looking at all the options, we determined the clearest option was to expand across the street on the Houston Main Building site.

I talked about just the cultural issue of faculty now not being located next to their clinics and having to walk across a bridge. There was a much bigger step of convincing the faculty to actually move some clinics across the street. And the question was how fast could we do that? So the first question posed to me was, how fast can you build a 250,000 square foot ambulatory building, and do you have a site? And the answer was yes, we could use the HMB site for that, and it would take thirty-six months to build about 250,000 square foot clinical building. Great. So Kevin went back to the executives and said—this was occurring at the same time the Faculty Center was—these discussions—“We can have another 250,000 in thirty-six months. If the Faculty Center is done in eighteen months, that provides us some cushion. Then the new ambulatory comes online, and that allows us to meet projections for—”

So as it evolved, the 250,000 went up to 350,000 because Diagnostic Imaging said, “Well, if you’re going to move across the street, we don’t want people going back and forth, and we don’t have the capacity now. We don’t want to use the satellite facilities. So let’s add some diagnostic imaging space there.” So all right, 350,000. Then Radiation Oncology weighed in, and they said, “You know, we’re almost at capacity in our vaults. We’ve been looking at all these options. We’d really like to add some radiation oncology capacity over there.” Now, these are two heavy-duty uses. These are very specialized facilities. They’re not easy and fast to build. All right, 450,000. And I’ll talk more about this. Dr. Callender, who was at that time in charge of basically all the faculty, believed that the future would be more day surgery. Now, there was a lot of resistance within surgery about that. But he wanted to build another surgical suite across the

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street for in-and-out. Now, the argument against that was—from the faculty—from the surgeons—was that the type of surgery they were doing is not guaranteed day surgery, because once they get in there, something that was planned to be a two-hour surgery may be an 8-hour surgery. So there was no such thing in their mind as day surgery, like a hernia repair or cataract removal or whatever. There was nothing like that in the cancer business, so there was a lot of resistance to the thought of a surgical building, but Dr. Callender thought that increasingly there would be some types of surgery. That was his personal opinion about this and about the direction things were going in.

So to make a long story short, we went from 250,000 up to over 600,000 square foot within a period of months. That's what, in my business, they call "piling on." Now, the story about that is nobody remembered we started at 250,000 square foot. All they remembered was it would take thirty-six months to build. So all of a sudden comes back the news, "All right, we're going to go ahead with the building—600,000 square foot, thirty-six months." "Well, who's going to occupy the building?" "We don't know yet. All we know is we have Diagnostic Imaging, Radiation Oncology. We may have a surgical suite, and we definitely want outpatient exam rooms, but we don't know who will occupy it." "So other than those ones that you know of, we have no clients to work with?" "No, not yet, but get started." (laughs)

So the first thing we did was we had a general master plan, but we didn't have a specific site planned for Houston Main Building. So what we decided to do was, in order to shorten the time, we went out and retained an architectural firm for the design of the ambulatory clinic building. Part of the services that we requested of that firm was a site master plan. So that was the first task to be accomplished. So we eventually studied that site and got approval for basically four buildings of about two-and-a-half million square foot total.

Now, I got, over the years, many questions. Why only two-and-a-half million square foot? Can't you build higher? Instead of nine stories up there, couldn't you go up twenty stories? One of the studies we did was what was the capacity of the site in terms of transportation. So you could build an Empire State Building there if you wanted. The question is could you get people in and out based on the surrounding roadways to use that building. Office workers are one thing. They come in at 8:00 in the morning. They go home at 5:00. So it takes them thirty minutes to get out of the parking garage. Patients are a totally different thing. They want to be able to drive in in the morning, find a parking space, go to their appointment—or in the afternoon—and leave. They're not going to come to a cancer center, no matter how famous it is—unlike Sloan-Kettering, we don't have a subway system. We don't have hordes of taxis to take you somewhere. In Houston, we're dependent on private automobile. I mean, that's ninety percent of how people get to and from MD Anderson Cancer Center. So the question became what would the surrounding street network support in terms of traffic volume in and out of that site? For patient care activities, that

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set the size of the complex—two-and-a-half million square foot. Now, you could fudge a little bit. You could go up to three million, but roughly it was in that range.

***Tacey Ann Rosolowski, PhD***

**0:35:03.0**

Let me ask you a quick question so I'm clear in my mind. So this four-building master plan that the architect developed, they took the total footprint of what Houston Main—

***William Daigneau, MBA***

**0:35:15.3**

Twenty acres.

***Tacey Ann Rosolowski, PhD***

**0:35:15.9**

Okay. And then they divided—all right. So I just wanted to make sure I'd understood that. So we're still working with the footprint of the old Prudential Building?

***William Daigneau, MBA***

**0:35:23.3**

Right, of the old Prudential site, so twenty acres of land. How much can you build there? And for people to be able to get in and out—you know—get into a parking garage and then leave without being dumped into gridlock—constant gridlock. So that determined—we did the traffic studies of Fannin. We looked at other people's plans for expansion. We did projections on the street capacity then started testing—because we had these statistics—how many visits per day, how many hours per visit. We did all those calculations and said you could support two-and-a-half million square foot with X number of parking spaces on that site. So the master plan was now done. We now knew the exact site of the Ambulatory Clinic Building.

***Tacey Ann Rosolowski, PhD***

**0:36:37.9**

And what year was this when you figured this part out?

***William Daigneau, MBA***

**0:36:41.5**

This was all occurring in the early 2000s, because we'd opened Alkek, and we were—Dr. Mendelsohn arrived. So around the beginning of 1999 and working through the early 2000s, all this was going on simultaneously.

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So we had that in place now. That allowed us then to move ahead with plans for the Ambulatory Clinic Building. Dr. von Eschenbach, he had now left, convincing the faculty that they would be happier moving across the street. Now it fell into Dr. Callender's hands. He was integral to the master planning process, because we involved the section heads in that. It was a very inclusive process of looking at different options, which, frankly, Dr. Mendelsohn demanded. He demanded that people that were going to be running these programs have a very key role in making decisions, so a very inclusive process. We had a strategic planning group composed of all the section heads. Dr. [Helmuth] Goepfert was part of it. Dr. [Raphael] Pollock was involved—Dr. Murphy. There was a whole cast of characters involved in all of this. Dr. Callender chaired it, led the discussions. One thing that came out of it, while we could agree on the development of the site, there was no agreement on who would go over there—who would make the jump across the street. So that laid on Dr. Callender's shoulders, to eventually be able to tell us who would move across the street. Secondly, was there going to be a surgical suite over there?

*Tacey Ann Rosolowski, PhD*

**0:38:39.5**

Now, just so I am clear, is this all operating according to that project core team model that you were talking about earlier?

*William Daigneau, MBA*

**0:38:47.1**

Yes.

*Tacey Ann Rosolowski, PhD*

**0:38:48.3**

Okay, so Dr. Callender was the executive who had to make the final decision if there was gridlock.

*William Daigneau, MBA*

**0:38:54.2**

Right. He was key part in all of that. I mean, literally, when the building was done, he had left Anderson at that point. I actually had a picture of the original concept of the ambulatory and the finished product. Here was the sketch, and here was the finished product side by side. I dedicated that to him, because, really, he played such a critical part in dealing with the section heads and the faculty and planning that facility. Without him, we would have never finished it at the speed that we—because we had to make decisions. They had to be made, and you couldn't say, "Well, give me twelve months to think about it." Unlike the gridlock you see in DC, "Well, let's just go ahead and shut things down." No, if we want to occupy this, we need to have this decision by such-and-such a date. So he was critical in playing that part of getting those decisions.

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***Tacey Ann Rosolowski, PhD***

**0:40:01.3**

So what was his logic in terms of deciding who would cross the street to the new clinic?

***William Daigneau, MBA***

**0:40:07.1**

Well, it's interesting. Of course, I was not part of—I mean, I'd make presentations for him. I'd go with him sometimes to meet with the heads of some of these departments, where we'd have just kind of these generic—but there were a lot of behind-the-scenes meetings that I was not part of. He knew what he had to do and the time that he had to do it. And almost everyone that I worked with at Anderson, they were good to their word. That's the nice thing, working in the medical environment; they understand the importance of time. Time is important in patient care. It's critical in research. So there's an understanding of that, that you don't have all the time in the world. You've got to do something now. So there's an urgency in medical environments that doesn't exist in the strictly academic university. So that was good. Dr. Callender stepped up to the plate; otherwise we wouldn't have been able to complete that building in the time we did it.

The second major issue for us was we had, again, negotiations with Texas Medical Center because we were building that roadway that goes behind the Ambulatory Clinic Building. That was all going to be a new roadway, and it would connect to existing roadways, so we had negotiations going on with the Texas Medical Center about the design of that roadway, its capacity, the future, how it would connect into the various other roadways, traffic generation, all of these things. Those were all going on at the same time. And then we had to build this building in, of course, thirty-six months. Not going to happen.

So a couple key decisions, again, were made there. Number one decision was we were going to use design-build. Well, we just finished getting approval for Faculty Center, which was now moving ahead with construction under design-build. Now we wanted to do the total square footage of the Ambulatory Clinic Building, the Mays Clinic now. The total square foot is over a million square foot because it includes the underground parking garage. The actual occupiable area is more than the 600,000, but the total building came in roughly a million square foot. One of the biggest projects in the UT System ever—bigger than the original Major Building Program, just for this one single building—all to be built in a timeline half of what the Major Building projects were. So we chose design-build because there was no way we could ever meet those time requirements under a more traditional process. And we had to convince, at the time, UT System and OFPC to allow us to—because it'd never been used on a complex building on this. Office building—that was a stretch. Now you want to build an ambulatory clinical building with specialized facilities using design-build? How are you going to do this? It was a hard—I mean,

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we even went to—of course, we have the Board of Visitors, which the president would brief. Even some of them raised questions about using design-build on this. Is that going to work? There were a lot of questions.

To all of the credits, from the president on down—by then I'd been there long enough that trust had now been earned, and there was a big leap of faith. The president, even though he got questions from Board of Visitors, a lot of second guessing going on at System, who knows what he heard? He came back and said, "Is this going to work?" And I kept on telling him, "That's the only way we're going to do this. I can use other methods, but if you want it this fast, that's the only way I can have any hope of doing it." So they supported it, and it turned out well. (laughs) But at the time, it was a real leap of faith. Big project—biggest project ever in the system and you're using an untested method. So that was one key thing. Got support for that and backing for that.

The second critical issue was how to build this building, and I mentioned earlier the anchor approach. We knew we had some anchors. We had Radiation Oncology going in. We knew we had Diagnostic Imaging in. We weren't sure if we were going to have any surgical suites, and we didn't know the occupants for the outpatient clinics. So that's where maximum flexibility starts to play. So how can we build this building?

Mays Clinic is unique in that it's actually two buildings. There's the north end of the building and the south end of the building. The north end of the building is basically all Radiation Oncology and Diagnostic Imaging. Heavy floor loading in it, vibration proof, built to very tough standards to accommodate specialized equipment. The south side of the building was designed in a more generic, clinical fashion. Work with the architects—because of the master plan, there was circulation of the whole site was planned, where the parking garages would all be in the future, all of that had been planned out—how the four buildings would be interconnected. Remember I told you about the ramp that goes? We wouldn't have those kinds of ramps ever. How would we move materials around the site? The loading material delivery, all of that worked out. Emergency power generation—where would that be placed? We ended up putting it in the garage across the street. That has the emergency power for the whole building, expandable to provide it for the whole complex someday. All those things had been worked out, so we knew where everything was going to go, how it all fit together, both now and in the future.

We divided the building into two halves—one that we knew who the occupants would be. We could plan that, build it. The second half—well, we didn't know who was going to be there, but it would be used for clinical purposes—for outpatient purposes. That allowed us to move ahead with design. Knowing who the anchors were, by subdividing the building, allowed us to—and we made a lot of decisions that were critical for the future. For example, all the heavy

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mechanical equipment is at the two ends of the building, because I didn't ever want to be trapped where I was trying to fix things on the interior that I couldn't get to. So it's a pretty unique building in terms of its design.

Several political issues had to be solved. One was with Dr. Murphy. This was the first time that Diagnostic Imaging was on multiple floors of a building, so the question is, can your faculty go up a flight of stairs, down a flight of stairs? And your technicians, can they move vertically through the building instead of just on a floor? Because if you look at the main complex, all the diagnostic imaging is on the third floor. So Dr. Murphy sold that to his faculty. "Yeah, we can do that." See, that allowed us to basically break the building into two halves. If he would have said, "I want an entire floor like I do in the main complex," we couldn't have moved ahead with design. So a critical decision was made there. It allowed us to move forward.

Radiation Oncology had to make some decisions, especially about—they're always buried in the ground. That's the first ever radiation oncology suite that actually has some windows in it. (laughs) Bring light in instead of being sunk in the ground. So all these decisions were going on, critical to our moving forward. That bought Dr. Callender time. Once we got some of those things in place, we moved forward to design big, open floor plates. Staff circulation on the interior court, all of the patient circulation and the front of the buildings facing out where there's plenty of light, where there's way-finding. You can see across the street. You have a sense of where you're at all the time. So all those decisions were made, and basically we were able to move forward with design and get underway with construction with this principle, as I said earlier, last possible moment, giving Dr. Callender the last possible moment on decisions on surgical and the occupants.

Well, as it turned out, he got two volunteers. One was obviously Breast Oncology—and was going to make that the major—and there was a lot of support within the faculty to do that because, number one, they had a chance to create this thing that was really designed for this particular disease and this particular patient population in mind. Unlike the constraints in the main complex, they could basically have a clean slate to design it the way they wanted.

***Tacey Ann Rosolowski, PhD***

**0:51:12.1**

And I was going say—and I know because I've talked to Dr. [Gabriel] Hortobagyi—they had had discussions, and he certainly was a great advocate of multidisciplinary care. They had been trying to institute that in spaces that were not in any way suited to fostering the bringing together of the different specialties, so that was a challenge for you, I'm sure, or was an issue you had to take into consideration.

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***William Daigneau, MBA***

**0:51:39.6**

Yeah, there was—you know—pros and cons and all of this. The other critical decision that was made—and it had been started with Dr. Murphy's question about I don't want patients to go back and forth between two complexes—how self-sufficient would this site and the building be? So that led to the decision basically to put a lot of patient amenities that were across the street in the complex, so—you know—a cafeteria. Laboratory Medicine would have a presence there. So the original design and the master plan for the complexes, specifically the Mays Clinic, was that it would be almost self-sufficient—that a patient going there for an appointment, except for referral to another specialty, would not have to go anywhere else. All of the amenities would be there—educational facilities, chapel. All of that was planned into the complex.

I could go on and on about the details of that design—how we move patients in and out, the concept of the parking garage, no more than 150 feet of walking distance for a patient to the elevator core. I mean, a lot of thought in a very short period of time using the best minds, the best experiences we had had that worked and didn't work, new concepts in the layout of the exam rooms with the long corridor, flexibility in mind—maximum flexibility. So all of that—you know—thousands of details went into planning that building. Probably one of the best planned in terms of patient experience attempted.

***Tacey Ann Rosolowski, PhD***

**0:53:42.7**

The other specialty that went in was?

***William Daigneau, MBA***

**0:53:45.9**

Gastro—no. Prostate—what's—?

***Tacey Ann Rosolowski, PhD***

**0:53:56.6**

Genitourinary?

***William Daigneau, MBA***

**0:53:58.1**

Yes. What's the center called, though? I've only been away for a year and a half, and I've forgotten all the—I'll get back to you on that. I'll remember it.

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***Tacey Ann Rosolowski, PhD***

**0:54:15.1**

I'm sorry. I don't remember.

***William Daigneau, MBA***

**0:54:16.3**

You'll know the doctor's name when I reconnect it in my brain. But it was basically prostate cancer and breast. Those were the two major—

***Tacey Ann Rosolowski, PhD***

**0:54:32.7**

So you're saying that Mays Clinic was one of the best planned facilities from the perspective of the patient experience.

***William Daigneau, MBA***

**0:54:37.5**

Uh-hunh (affirmative). Totally, from the moment they—wayfinding, now they recognized the building. That project spawned a lot of issues because we were moving across the street for the first time. So the whole wayfinding project was spawned by that, because how does a patient know which entrance to go in? Remember I told you earlier—try to get down to one entrance? Well, now they have, clearly, two entrances. So how do we minimize confusion if you're driving for the first time to MD Anderson about which entrance to go in? Where's your clinic? Where do you park? Once you park, how do you get there? All of that led to the major wayfinding design that we—

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## **Chapter 14**

### **B: Building the Institution**

#### *Developing the Wayfinding System*

#### **Story Codes**

A: The Administrator  
B: MD Anderson History  
C: MD Anderson Past  
B: Institutional Processes  
C: Discovery and Success  
B: Building/Transforming the Institution  
B: Growth and/or Change  
B: Obstacles, Challenges  
C: Professional Practice  
C: The Professional at Work  
B: Institutional Mission and Values  
C: Understanding the Institution  
C: Patients, Treatment, Survivors  
C: Discovery, Creativity and Innovation

*Tacey Ann Rosolowski, PhD*

**0:55:29.3**

Is now a good time for you to tell me about that project? I didn't want to interrupt your story about the different buildings, but I had on my list of other questions wayfinding. Do you want to talk about that now, or would it be better to wait?

*William Daigneau, MBA*

**0:55:42.8**

Well, once the decision was made to move across the street—and there were other decisions going on. Dr. Mendelsohn was very keen on developing a research park on the south campus. So all of these things, while we were working on the Ambulatory Clinic Building and under negotiations and development design for the Mitchell Building, which was the basic science expansion with a major vivarium underneath it—so a lot of these things were going on at the same time, so we were facing a lot of critical issues. We had master planned the—but now we had two entrances for patients. Well, how are we going to—? And then we've got to tie these facilities together somehow. A bridge system. How would we do a bridge system here? We studied different routes for a bridge system, some wrapping around Garage 2, going into the

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front of Alkek. Some, which is the one that we finally adopted, which went along the back of the Mays Clinic, connected Faculty Center, and went across the street to the front of Clark. So all these issues were coming up. How do we move patients about? Once they're in here, how do they tell where they're at, where they're going, which entrance are they coming in? So all these questions started to emerge, and that initiated the wayfinding project—a whole team devoted to that. They worked on nothing but the wayfinding project. Hired a consultant. Looked at ones that had worked for Disney.

***Tacey Ann Rosolowski, PhD***

**0:57:30.8**

Oh, really?

***William Daigneau, MBA***

**0:57:31.2**

Well, some of us had been to Disneyland. If you think about it, big park, right? They had these gates that you go in, where to park. You have line-of-sight on some things. There's the monorail station. That's where I need to walk to. So you have visual cues. You have information that goes from very general to very specific. So there were a lot of principles in Disney World that were now—though I never use that term because I figure—you know—comparing us to Disney World is not like the right thing to do here, but some of the same issues and moving large volumes of people around.

So we looked for consultants, and we finally—I can't remember the name of the firm, but we picked them—they had good experience in those types of things—of all things, amusement parks, and sports facilities.

***Tacey Ann Rosolowski, PhD***

**0:58:45.6**

So what were some of the solutions that they came up with for the particular problems and challenges of Anderson?

***William Daigneau, MBA***

**0:58:53.3**

Well, basically they were picked because of—early in my career, when I worked for the city of Peoria, I had taken some courses in transportation engineering, and one of the things was signage—you know—how signs are created on highways. They tell which exit to get off, how much information you need to know. Route numbers, street names—all of that is part of transportation engineering. Now, we've all been around the country, and we've seen experiences of good transportation engineering and bad transportation engineering. So it's like everything

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else. You can go to a restaurant and get a good steak and another restaurant, a bad steak. It's the same with engineers. But there were some principles that made a lot of sense to me in traffic engineering. Well, I applied those same principles in terms of guidance to the consultants, what we were going to try to achieve, and that was—one thing I'd learned was from the general to the specific. In other words, at some point in the journey you get the person into the right area. Once you get them into the right area, you supply them with more information to get them headed in the right direction. And then once you have them headed in the right direction, you give them more information about their destination. But you don't load up this enormous sign that says, "For the breast clinic—da, da, da, da." You can't put that on a sign. It makes no sense to them. They can't absorb the information. They don't have time to read it. You don't put signs up—Dr. Mendelsohn likes signs at the top of the building, so we agreed we'd put MD Anderson up there and the benefactor's name. But down at street level, which is where you and I are looking, you put Breast Center. (laughs) Not So-and-So Breast Center, just Breast Center. That's all they need to know. Okay, I must be getting close. So keep the signage very simple. Go from the general to the specific. Create routes that are identifiable. Create recognizable cues along the way as to, "Well, they told me to expect to see a fountain. Is a fountain there? Yeah, there's the fountain. I must be on the right way."

***Tacey Ann Rosolowski, PhD***

**1:01:22.1**

It also makes it easier to ask for directions if you're lost. Where's the fountain?

***William Daigneau, MBA***

**1:01:27.2**

Yeah, exactly. So use visual cues combined with signage combined with routing systems. When you send a patient a letter, send the—you know—from the general to the specific of how to get here. So come to Houston, take one of two routes in, get on Holcombe, look for—and this was the gateway, the beginning of the gateway signs—entrance five—which was borrowed from Disney—entrance five, entrance three, entrance four. Once we get them there, you make a right turn in, or you turn into that entrance, valet, go in the lobby, take the elevators to the left, go up to the fifth floor, and you're there. (laughs) General to specific. And the lobby has this big piece of artwork. You'll know you're in the right lobby. Look for the big tree of life. "Do you like art?" "No, it was actually part of the wayfinding system." The gazebo—I mean, all these things—the aquarium—everything was part of visual cues. "Oh, I must be—here's the tree of life." To reconfirm, reduce anxiety, keep people on the trail.

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***Tacey Ann Rosolowski, PhD***

**1:03:07.4**

And the process is also doing double duty. Like the Tree of Life, it is a wonderful addition to—I mean, it’s functional, but it also adds to the aesthetics.

***William Daigneau, MBA***

**1:03:17.5**

And we didn’t know we were going to have the Tree of Life. All we said was we need something big that’s recognizable.

***Tacey Ann Rosolowski, PhD***

**1:03:28.1**

Interesting. So how long did it take to work out those details of way-finding?

***William Daigneau, MBA***

**1:03:34.1**

Well, they’re still being worked on. It’s one of those things that you learn—but for example, the gateways—the gate signs. That was adopted by the Texas Medical Center. I mean, we went to them and said, “We’re going to put up this sign, and we want to put one up in front of Mays. We want to put one up in front of the main complex—actually, two of them—one on MD Anderson and the other on Bertner—that say gate three.” Well, if you’re going to do that, we’ll have to think about it.” Well, the next thing we know they’re coming back saying, “We’re going to do that across the medical center.” So everybody got MD Anderson’s gate system.

***Tacey Ann Rosolowski, PhD***

**1:04:20.4**

It’s a great solution to the maze down there.

***William Daigneau, MBA***

**1:04:23.5**

Yeah. It makes it easier. People looking for a little sign—Bertner—do I turn right? Do I turn left? You see the gate signs and you say, “Well, I turn into the gate sign. That’s where I’m headed.”

**CLIP**

**B: Institutional Mission and Values**

**C: Understanding the Institution**

**C: Patients, Treatment, Survivors**

**C: Discovery, Creativity and Innovation**

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C: Professional Practice

B: MD Anderson History

A: The Administrator

*Patients Have Input Into the Wayfinding System*

***Tacey Ann Rosolowski, PhD***

**1:04:35.6**

Well, there are just millions of details. I remember when I was first coming to MD Anderson and making my way from the parking deck under the Mays clinic all the way across the sky bridge to Pickens Tower, where Research Medical Library is. It was unbelievably confusing, and I so appreciated, when I got into the elevator waiting area to take the elevator up, those little-bitty cards that I could pick one up so I could remember was I in parking level two or three. I mean, I can't even imagine a patient coming in upset, frightened, and having all that going on in their mind, and then they have to worry, "Oh my God, I've lost my car." I mean, please, we don't need this. And that's just, I'm sure, one of those millions of details that came out of that wayfinding project.

***William Daigneau, MBA***

**1:05:29.4**

Everything—and tracked a patient from the airport, coming from Austin, all the way into the complex and what would make sense to them. What were their fail-safes? The kiosks were created. All the maps were created. The instructions to new patients were created. Room signage, naming the clinics to keep it somewhat simple.

***Tacey Ann Rosolowski, PhD***

**1:06:02.9**

Now, when you said you tracked patients, was that part of your—?

***William Daigneau, MBA***

**1:06:06.8**

We had focus groups of patients, not only asking them what the problems were but tried out things with them. Actually—I didn't mention this—we had focus groups on every design of every building. The users would create groups. We talked to patients. What's your frustration? We had employee groups. We extensively used focus groups to test out ideas as well as—not only discover problems but to test out ideas. We tried out furniture. We put furniture out in the lobbies and asked people to try it out and rate it—if you like it, don't like it. We're not building for ourselves. The end result is—you know—I always remind our people that these are not our buildings. We're not building for ourselves. We're building for our patients, our faculty, and our staff. Either they find these facilities

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easy to use, reliable, comfortable, or they don't. We don't want the latter. We want the former, so we need to involve them, make sure we test every—some architect says, “Oh, I've done this fifty places.” Yeah? Well, you haven't done it at Anderson.

Until you show us—and that's one thing that Dr. Mendelsohn—you didn't go into Dr. Mendelsohn without data. If he was convinced you had done your research—and I'll give you an example of that.

We built Faculty Center, right? Had the bridge system in place. Nobody was using the bridge. The docs, especially the surgeons, were walking right across Holcombe at grade level, not using any of the crosswalks. Shortest distance—the front door of Faculty Center to the front door of Alkek, that's the path they were taking because they were in a hurry. Time is important to them. “I'm getting there as fast as I can. I'm not going to use that bridge. I'll have to walk all through Clark Clinic to get over to Alkek. I'm not doing that. I'm walking right across the street.” Well, we had a few close calls. So next step—

***Tacey Ann Rosolowski, PhD***

**1:08:33.8**

Yeah, I read about some of those near accidents on Holcombe, dangerous.

***William Daigneau, MBA***

**1:08:37.6**

—put police officers out there. We had a flashing sign—pedestrian—police officers out there slowing traffic down. The final straw was when this woman almost ran over one of our police officers. Let alone the faculty member, ran over—so I said, “We're just waiting for a major fatality here. It's not a matter of if we're going to get one; it's a matter of when we finally get one.” Because again, even if these people don't speed a lot, they're distracted, they're looking for directions, they're looking around, and all of a sudden they've run over somebody. So I went back to Dr. Mendelsohn and said, “Dr. Mendelsohn, we've got to close off the ability to walk across the street. Either people have to use one of the signalized intersections or use the bridge system. We have a bridge system in place. Let's use it.” He said, “I mean, I'm from New York City. I walk across the street all the time. People do that.” I said, “Okay.”

Next meeting—I had the research done on at-grade pedestrian deaths in Houston. (laughs) The recommendation of traffic specialists, law enforcement, overwhelmingly was even with a flashing signal, the safety of crossing between two intersections doubles the chance of pedestrian injury. I mean, there's the numbers. “Okay, we'll tell the faculty.” But it had to be supported by data.

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***Tacey Ann Rosolowski, PhD***

**1:10:48.2**

So how did you actually get people to stop?

***William Daigneau, MBA***

**1:10:51.0**

Put in a fence. When you go back to Houston, look. There's a fence that runs along the median so you can't cross. Now it's been alleviated. Once Mays was basically completed, the new bridge was completed. So now there were two bridges on either side of Faculty Center to cross the street. So even among some of our longer-term faculty who remember those days, it became a nonissue because now it was so convenient to go across the second bridge. So we solved the problem eventually, removed any reason why you wouldn't want to use the bridge—air conditioned, fast, solved the problem. So the second bridge solved that problem. But yeah, that's—big fence goes there. And again, administration trying to interfere with—well, administration trying to interfere with you keeping your life. (laughs)

So a lot of that—you know—focus groups, research, data—everything we did was—nobody walked into our door and said, “Well, this is the best thing since—” “Oh, yeah?” Baylor, when we built the new vivarium, put in an automated cage wash system. So my question was, of the consultant who recommended this to us, what happens if it breaks down? Now, if you remember, when Denver International Airport was built, they had an automated bag handling system. The thing never worked.

***Tacey Ann Rosolowski, PhD***

**1:12:51.0**

I remember newspaper articles about that.

***William Daigneau, MBA***

**1:12:53.5**

So they had to go back to a manual, throw-the-bags-around, labeling, all that stuff. So with that in my mind, I asked the consultant, “So what happens if this thing doesn't work?” “Oh, it will work. It's guaranteed by the manufacturer.” “No. Let's say the manufacturer comes back to us and says, ‘It doesn't work. We just can't do anything about it,’ what's our fallback position?” “Well, you don't need one.” “No, no, no.” (laughs)

***Tacey Ann Rosolowski, PhD***

**1:13:31.3**

That's a weird answer.

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***William Daigneau, MBA***

**1:13:33.5**

Yeah. "It works. It works. Baylor bought it." I said, "We're not Baylor. Baylor may have chosen to jump off the bridge. We're not going along with them." So we didn't put it in. As it turned out, Baylor spent a lot of money on their system, trying to get it to operate.

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## **Chapter 15**

### **B: Building the Institution**

#### ***The Mitchell Basic Sciences Building; Vulnerable Systems, Tropical Storm Allison, and the Flood-Protection System***

#### **Story Codes**

A: The Administrator

B: MD Anderson History

C: MD Anderson Past

B: Institutional Processes

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

B: Institutional Mission and Values

C: Understanding the Institution

#### ***Tacey Ann Rosolowski, PhD***

**1:13:54.8**

Where do you want to continue the story now? You said that there were discussions about south campus and then the Mitchell Building.

#### ***William Daigneau, MBA***

**1:14:01.9**

Well, so we're in the throes of Faculty Center is under construction, master planning the Ambulatory Clinical Building, kicking off the wayfinding project so we have something in place by the time Mays opens. Two other things emerged at the same period of time. Dr. [Bernard] Levin—"So where am I going to expand my prevention clinics to?" There's no room left in—by then, Dr. Callender had gotten the two occupants. There's nothing left. They're going to consume all the space. Where's prevention going?

Well, I had two problems with Prevention. Number one, I had to get them out—they were in Houston Main Building, which is a story in itself. I had to get them out of that building because we couldn't see patients in that building. It's against code, terrible safety issues, so couldn't see patients there. Their clinic space at the time was over in the LeMaistre Clinic because Dr. LeMaistre was big on prevention. He was a big supporter of it. So their clinics were located in

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the LeMaistre Clinic. Well, like everyone else, they wanted to expand too, so where's Prevention Clinic going?

So I had two issues now: Getting Prevention out of the Houston Main Building, because they had to go somewhere, sometime, and where would their new clinic be—their expansion clinic? So we had done the master plan. It emerged that, well shoot, I could kill a number of birds with one stone here. Number one, I could solve the office problem for Prevention. I could create some clinical space for them. And oh, by the way, I have this data center that is in Houston Main Building. I could put a data center into another building. So thus was born the Cancer Prevention Building. Since this building is not going to be for heavy-duty use, other than the data center, which is on one floor, it fits perfectly in this second building that was planned for the site—right square footage, everything goes into it. Neat—neat solution.

So we proposed the construction of the second building, which Dr. Mendelsohn supported because it basically got Dr. Levin off his back. What about prevention? Don't we have a part to play in this? It's part of our primary mission. It solved his problem, solved, for me and the CIO of this, getting the data center out of Houston Main Building.

*Tacey Ann Rosolowski, PhD*

**1:17:24.5**

Now, what was the scope of the data center's responsibilities? I actually hadn't heard about that.

*William Daigneau, MBA*

**1:17:31.8**

Oh, it's the main computing center.

*Tacey Ann Rosolowski, PhD*

**1:17:34.1**

Oh, it's the main computing center? Oh my gosh.

*William Daigneau, MBA*

**1:17:35.9**

Yeah, it was the main computing—it was located in Houston Main Building.

*Tacey Ann Rosolowski, PhD*

**1:17:38.3**

Okay. I had no idea.

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***William Daigneau, MBA***

**1:17:39.6**

Yeah. It was up on the—I can't remember the floor now. Twelfth floor? Whatever. We had hurricane shutters on the windows. We had an emergency generator that was located in a floodable area by the loading docks. It scared the heck out of me. I'm thinking about this stuff. What happens? We lose our data center.

***Tacey Ann Rosolowski, PhD***

**1:18:06.8**

I'm amazed you ever got to sleep at night.

***William Daigneau, MBA***

**1:18:09.6**

I mean, it was a terrible location for it because it was up in the tower. We could significantly damage equipment up there. We had an unreliable backup power supply. So at the time, we had the service in Philadelphia that backed up all our—but they could back up our data, but if we lost some machines, they couldn't provide—they could provide all our data. We wouldn't lose our data, but if we lost all our machines, it would be a while before we could come back live with computing power. So we ended up buying—there was this old—I think it was—I can't remember—some—well, AT&T and this service that ran a bunch of servers on this building out on the northwest side of town, we ended up buying that as our backup computing center. But for a long time, it was—you know—oh my goodness.

So anyway, we kicked off the Cancer Prevention Building. Went out, ended up awarding it to the same company, Hensel Phelps, that had the contract for Mays, which solved a lot of problems for us because now there was good coordination on the two buildings. So that building—

***Tacey Ann Rosolowski, PhD***

**1:19:46.2**

And I assume you also used design-build yet again.

***William Daigneau, MBA***

**1:19:48.5**

Uh-hunh (affirmative), design-build. Mays, Cancer Prevention Building, and the parking garage both underneath Mays as well as the parking garage to the south of the Mays Clinic—all those were under construction and under design at the same time—I mean—going concurrently with one another. And the objective was since Cancer Prevention was primarily an office building with one clinical floor and the data center, it was a smaller building, so the objective was to—

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even though Cancer Prevention followed a year after Mays, the objective would be that they finish both at the same time, so we'd open both of them at the same time.

So all that's under way. At the same time, going back now, was research, because of the promise to expand basic science. Dr. Mendelsohn was firmly committed. He was firmly committed to research, supported that. So while all this stuff is going on across the street—wayfinding—we're also planning the next research building.

Now, I'll double back. So I had joined Anderson. They were looking at sites for another research building, and the plans were originally to build it over on the HMB site. They'd gotten to the point of starting to do site planning for a new research building, which as I told you earlier, I had significant reservations about jumping the street with research because how are we going to move animals back and forth? Patients can drive. We can do cars, whatever, but moving animals. So building another vivarium across the street that would stand alone, a lot of expense. So I had serious reservations about doing that.

LeMaistre wants to downsize, cancelled all the capital projects, so the research building had gotten placed on hold. Dr. Mendelsohn arrives, wants to expand research. The way he expands research is to expand patient care, but he wanted to build that research building. So at the time that Dr. LeMaistre was here I said, "You know, a really good location for another research building is right next to the Clinical Research Building—the one that is under construction. That's a great site. We can tie the two vivariums together. It gets us out of some old vivarium space. It's a nice, neat little solution." One problem is what's that bill? We don't own the site; Texas Medical Center does. They have a big parking lot there.

Now, Dr. LeMaistre said, "Bill, if you think you can get that site, go for it." So thus began a couple years of negotiations and legal work with the Texas Medical Center over that site. We promised things, swapped things, employed almost full-time an attorney out of UT System that helped us negotiate with their attorneys. Dr. Mendelsohn came. "How are we doing?" It was like the Sistine Chapel. Dr. Mendelsohn saying, "When will you finish? We need to get research expanded here."

I had started that path when Dr. LeMaistre was there. It made sense. It was a beautiful site for another research building. We could tie the two newest research buildings together, tie two vivariums together, and reduce total cost—perfect site. We just had to get past the Texas Medical Center. Dr. Wainerdi was adamant. "No, no, no. That site will be used for educational purposes." "Well, what?" "I don't know, but it's not going to be used for Anderson expansion of research." How to get around this?

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Well, the only way I could get around this one was through strength in numbers. So we worked on a master plan of the former psychiatric hospital, the dental school site, and K lot, which is the TMC surface lot there, that showed how you build six research buildings on those sites—a major research complex composed of six buildings. Then I knew my counterparts at Health Science Center and Baylor. Got a hold of them, said, “Look, Anderson, in all its wildest dreams, does not need six research buildings, but you two might, as well as Anderson. What I’m proposing is we kind of get our presidents to cosign a master plan for the development of a major research center on the north end of this campus.” Sure enough—you know—this was politically acceptable. Cooperation between three major research institutions—you know—I can’t remember Baylor’s president. Was it Butler at the time? I can’t remember. But it was the sweetest thing in the world to get those three presidents to sign this master plan. It was just a master plan. It was just a nice picture. They signed it. Each of them had one or two research buildings—you know—six, three institutions. The Health Science Center said, “Well, we’d like a research building on the dental school site. We own that site. We can put one there.” Fine. Great. There’s your building. Baylor said, “Well, we probably could go for two buildings.” That left basically three buildings for Anderson—plenty of expansion. Dr. Mendelsohn signed it, Health Science Center—Dr. [Walter R.] Lowe signed it. Baylor’s president signed it. Packaged up—three president’s signatures.

Now I went back down to TMC’s offices. (laughs) I said, “We’d like to present this master plan to the Texas Medical Center and get it approved,” showing two research buildings on K Lot. Dick Wainerdi opens that up, the first cover, sees three Texas Medical Center presidents’ signatures on it. We got K Lot. We got K Lot. Now, we had to—he wanted to put in an “educational”—and parking for it, so we got that monstrosity, the garage mahal. Now, people like the waterfall, but it wasn’t supposed to be as high as it is. He overbuilt it. It was the most expensive garage ever built in the United States. We had to give ground, but we got K Lot.

So that was the Mitchell site. That’s where Mitchell went. So we got Mitchell underway while everything else was going on. And an interesting story about Mitchell is we have a vivarium—building a vivarium—and one thing I said was, “This thing can never flood.” It can never flood because—you know—we can shut down the clinics, we can evacuate the hospital, but with animals, there’s no place—you can’t put the animals up in a hotel. So this thing will never flood. So that building is designed—that vivarium is designed absolutely—now, that’s what they said about the Titanic, right?

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*Tacey Ann Rosolowski, PhD*

1:29:09.4

Right. I was going to ask how you guaranteed that.

*William Daigneau, MBA*

1:29:12.9

Other than stupidity, downright malfeasance—like going too fast in iceberg territory—that should never flood. I mean, the only way it could flood is major human error. Structurally, it's a big bathtub, sealed—specially sealed all around it. The walls of Mitchell are five feet above high flood—five hundred year flood. I mean, it would have to be—and I told Dr. Mendelsohn the same thing. “You mean never?” I said, “It will never flood, and if it does, that's the least of your problems or Houston's problems, because the whole city will be under water for it to flood. So don't worry about the animals at that point. Lots of people are going to be dead.” It was designed before Allison.

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Now, there's a funny story about the Mitchell Building in that we were under—we were putting in the foundations. I told you this foundation was specially designed as a bathtub. So we dug down pretty deep. We had dewatering going on in the hole. We had the bulldozer down at the bottom of the hole, and Tropical Storm Allison comes along. Now, this was the first time—because my worry had always been that the bayou would overflow and we would flood from the bayou. Allison was unique in that they had what was called sheet flow that occurred from the north—water coming off of all the suburbs around University, all those paved areas around Rice and to the north—you know—the Museum District, all of that. Water coming was moving basically toward the bayou, and so there was actually sheet flow created that basically submerged the Texas Medical Center in that storm, which no one had ever seen before. I mean, it was the first ever. Kind of like some of the floods here. The wall of water, which was almost five foot—you could see the mark of water on Baylor, which was right across the street from where we were building—was almost five feet high, just the wall of water sweeping toward the bayou. Well, in between Baylor and the bayou was MD Anderson. We had this enormous excavation. That wall of water hit Baylor, knocked out its vivarium, closed Methodist, and closed St. Luke's, and the major flood of water that came across from Baylor dropped in that hole. Now, having said that, we had good people on board who had already put in our flood logs.

A couple things came out of that event. Number one is I wouldn't always have a hole. Someday I'd have a building sitting there, and when that next flood of water came, I wouldn't have that little safety valve. Number two is forget the hundred-year flood level. There are some events that you just can't plan for—I mean—that you can't predict, but you can plan for them.

So we had, from Tropical Storm Allison, a couple wet basements. It affected some of our Radiation Oncology equipment. It came through a hole that we had cut in a foundation wall to connect Mitchell into the main complex when that hole flooded. Total damage was about two million dollars. Downtime was about a day. We were back in business. Across the street—St. Luke's—gone a month.

***Tacey Ann Rosolowski, PhD***

**1:34:17.1**

Wow.

***William Daigneau, MBA***

**1:34:17.9**

Hermann, gone a month. Methodist was back operational in a couple—within about a week. Baylor's vivarium flooded. Health Science Center's vivarium flooded, dead animals floating. It was terrible. Anderson was fully operational the next day with two million dollars' worth of damage due to a big hole in the ground and some very smart people who had the foresight,

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without instruction, to put up the flood logs. They could see how much it was raining, and just on their own said, “We need to close off some of these entrances.” So I gave great credit to them because it was unexpected. We didn’t have time to activate the incident command center. It just happened. It happened on a Friday night at about 2:00 in the morning. It was supposed to rain, but nobody knew that the center of the storm was backing up. It had passed Houston, stalled, and was now backing up over Houston again. So we had the rain all day, but it was supposed to blow out that night. Instead it backed up. We got thirteen inches of rain in I forget how many hours, flash flooding, sheet flooding of roadways. Roadways were carrying water. Lots of damage in the Texas Medical Center. We came out okay.

So as a result of looking at the others, how they were damaged, we need to get electrical switch gear out of the basements. Pumps, I can replace. Electrical switch gear is specially made. You can’t find it. It’s not like you go to the hardware store and get one. All electrical switch gear out of the basements. We need a flood wall that’s almost automatic—that doesn’t require somebody saying, “You know, it looks like it’s raining a lot. I think I’ll put the flood wall up.” We need an automatic flood wall, something that if it occurs at 2:00 in the morning—because no meteorologist said this was going to happen—we’re protected here. So we applied for FEMA—we only had two million—FEMA had what was called mitigation grants. They had grants to repair damage, but they also had an amount of money set aside “to prevent damage in the future.” We applied for all of these FEMA grants. On two million dollars’ worth of damage, we got thirty-five million in federal funds to build a flood wall to protect the main complex, to raise all the electrical equipment up, and to build partitions in the basements that would isolate mechanical rooms from one another so that if one flooded not all of them flooded. It was a good lesson, and we used it to really—

So now, if you walk across—most people don’t even notice them, but when you walk into the—well, first of all, in front of Clark—the main entrance to Clark—all that glass there is aquarium glass. It’s able to withstand basically ten feet of water pressure. One the doorways—just before the doorways—are these things. If you walk across them, you can hear something. Those are automatic floodgates. They basically raise themselves automatically, and in between the floodgates you’ll see—it looks like an architectural feature. It’s actually the floodwall. The floodwall comes up on either side. There’s the entrance with these automatic floodgates that raise and lower. It doesn’t require any intervention.

*Tacey Ann Rosolowski, PhD*

**1:38:31.8**

So what turns them on?

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***William Daigneau, MBA***

**1:38:33.4**

It's basically counterweighted. What happens is the water flows over and flows into like a bucket on the other side and creates the weight to rotate it up. Now, we don't rely on that. For hurricanes, we'll manually raise them. But I wanted something just in case nobody else was there.

So I told Dr. Mendelsohn belts—improve—belt-and-suspenders approach. We have the floodwall that protects us around the entire—all the buildings on the south side of the campus are raised at higher elevation, but on the main complex—you know—it was built in a time where that wasn't really considered. So now there's a flood wall that goes all the way around, these automatic gates, and then if for some reason we should flood, we should be—I told him it's not that we're not going to be down, but we'll be able to get back into operation in a week. Even if we would flood, because all of our main electrical gears are now out of the basements and on the second floor, and the only thing down there is mechanical equipment that can be replaced and rebuilt. So Anderson's in pretty good shape.

***Tacey Ann Rosolowski, PhD***

**1:40:00.0**

Lessons learned. Would you mind if I pause the recorder for a second?

***William Daigneau, MBA***

**1:40:04.0**

No.

***Tacey Ann Rosolowski, PhD***

**1:40:04.6**

Okay.

**1:40:05.5** (end of audio)

(begin audio)

***Tacey Ann Rosolowski, PhD***

**0:00:04.3**

All right. We're back after a little break. It is 4:37. Was there anything else you wanted to tell to finish the story about the Mitchell Basic Science Research Building?

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***William Daigneau, MBA***

**0:00:20.8**

Well, the major part of that story was getting the site, which was a major success for us to secure that. I think it left a—kind of a lingering bad taste. Dr. [Richard] Wainerdi specifically directed at me because, it was perceived as though I'd "gone around him." I could see no other way to achieve this, and it made sense for Anderson. It made sense for all of research to build a complex on the north side dedicated towards research. It tied together institutions in terms of collaborative ways. Since then, of course, Baylor gave up their right to build and transferred to Texas Children's, so Texas Children's has that research building that's now next to Mitchell. It made a lot of sense. It was the right thing to do. The only issue I ever had with Dr. Wainerdi was—you know—I was employed by MD Anderson to pursue MD Anderson's interests, and it had nothing to do with Texas Medical Center or him personally. It was to further the mission of MD Anderson, and that's what I—that was my role. His problems were his problems. My problems were my problems. We had to compromise and everybody gets something, but it—"no" is not an acceptable answer for things that are the right things to do. So I wouldn't—Dr. Mendelsohn asked me about that once, and I told him—I said, "Well, I heard—I read this once that even the mightiest oak will fall in a steady wind." So you have to have some perseverance if you are doing what you believe is the right thing. You have to stay at it, and that's the way I believe on many things, even though sometimes it created significant tension personally between me and Dr. Wainerdi, but it was right for MD Anderson. It wasn't really harming anyone else. Just being stubborn and difficult was not an acceptable solution.

So anyway, it sort of left a bad taste—but the other part of the Mitchell story—there are two parts to the Mitchell story that were significant. Number one, it was the first interstitial—fully interstitial research building we'd ever built.

***Tacey Ann Rosolowski, PhD***

**0:03:13.6**

What does that mean?

***William Daigneau, MBA***

**0:03:14.7**

Well, in that building, there's basically a laboratory floor, and then right above it is what's called an interstitial floor that carries all of the utilities and mechanical, electrical, fire protection to each of the laboratory floors. Now the concept behind it is an interstitial building, which is basically developed by the federal government—NIH was a big proponent on it—is that you can go in and change a research laboratory without shutting down the whole floor, because everything is individually fed. So you can have two labs: one that is being completely renovated for a new purpose without affecting the lab next door—immense flexibility. Since the site we

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were building on was one that we would—it was not throw-away construction. The building had to be built there that we were probably going to keep for fifty years or until cancer was solved. So we wanted maximum flexibility to accommodate different types of research, and since no one could really look into the future and say, “Well, this is what research is going to look like twenty-five years from now—.” In fact, we had a site that there was no going back and “re-doing a mistake” there. We opted for interstitial. There was a lot of feeling that interstitial costs more. I’m a big proponent of it. I think it’s the right thing to do in a lot of research. You want to minimize disruption to ongoing research and yet be able to change your direction. I told Dr. Mendelsohn and Dr. Becker that they’d have a building that would—even if they came and said, “Look, we need a class three facility here.” Fine. You could put one in there. No major innovation necessary. So you’d have maximum flexibility. It was the first interstitial building—I think—built by the research building, built by the University of Texas—the first one for MD Anderson.

The second part of that story is Dr. Mendelsohn was a big believer in “growth,” as I said. So when we built the building, we could document the need for four floors of research space, but we built six for future growth. Since there was no going back to that site, this was a onetime only deal, so we put two floors of vivarium plus six research floors in that building. Plus if you’ve been over there, it has the auditorium—the Onstead Auditorium, and it has the graduate school. So we added two more research floors onto it.

Before that building was finished, we were building out those two floors. Dr. Mendelsohn said, “We’re in there. Let’s finish. Do we have the money to do that? Leon?” (laughs) By the time—the building was—finished those two floors. So anyway, it’s unique on its site, it’s unique on its construction, and I said earlier that there was only once I’d ever gone back to the Regents and said we need a budget revision. That was the Mitchell Building. The problem we encountered was we have three major facilities under construction. At the same time, they were building the Reliant Stadium, Minute Maid Park, and the airport was undergoing expansion. This was a major construction boom in Houston in this time period. Literally, you couldn’t find subcontractors. Everybody was bidding high, because they didn’t need the work. It was basically whoever bids highest is going to get our labor. So we had a terrible time on that project. There was only two choices at one point, and I told you earlier—my belief that no surprises. I went back to the Facility Steering Committee and said, “Here’s our choices. I think in about six months, the market will settle down here, and if we rebid this, we’ll get prices within our budget. Right now, if we go ahead with this project, we’re going to go over budget, because we just cannot get competitive bids.” So the decision was made. Dr. Mendelsohn and Dr. Becker did not want to wait. They wanted to the space. The premium was about ten percent. So that was the only time we went back to the Regents and asked for a budget adjustment. I tried everything—absolutely

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everything to avoid that. At some point in time, you just run out of options. That was the only time we went back.

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## **Chapter 16**

### **B: Building the Institution**

#### ***Pickens Tower, The Research Medical Library, and Rotary House***

##### **Story Codes**

A: The Administrator

B: MD Anderson History

C: MD Anderson Past

B: Institutional Processes

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

B: Institutional Mission and Values

C: Understanding the Institution

C: The MD Anderson Ethos

B: MD Anderson Culture

B: The MD Anderson Brand, Reputation

##### ***Tacey Ann Rosolowski, PhD***

**0:09:26.8**

So what's the next part of the story in terms of development?

##### ***William Daigneau, MBA***

**0:09:31.6**

Well, obviously the institution continued to grow, continued to add faculty, the migration continued moving out of the main complex—all faculty offices. The next phase of that was moving all the radiation oncologists and all of the diagnostic imaging faculty basically to evacuate everything that was in office use in the main complex and was 100% research and 100% education and 100% clinical care. So that eventually led to the decision to move forward with the academic tower—the Pickens Tower, which—again, when we had master planned, we had master planned the faculty center for a twin building—two buildings, eventually. The growth outstripped another building the size of the faculty center. Plus there were other demands in place. One was for—a long promised fitness center for the faculty, so the fitness center. We had never built any food facilities in the faculty center because people could walk across the street or use Rotary House, but when we added another building, that was too much, so we had put in a

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food facility there. So there were a lot of things that increased the size of that building. Growth, amenities, space.

***Tacey Ann Rosolowski, PhD***

**0:11:18.9**

Was this another building that was designed purely for office?

***William Daigneau, MBA***

**0:11:22.1**

Uh-hunh (affirmative). It was completion of the strategy moving all faculty offices out. So now all the faculty basically, including the president—

***Tacey Ann Rosolowski, PhD***

**0:11:32.9**

Right.

***William Daigneau, MBA***

**0:11:33.8**

(laughs) And then part of the planning was—remember I talked earlier about all of the oldest buildings were on the interior—the original Anderson, Gimbel, the basic research building—BRB was there—all of the older facilities were in the interior. So for a long time, Bates-Freeman was a big problem for us in terms of its abilities to maintain research. Plans had been put in place of how—how would we eventually get out of some of the older space, because it couldn't support modern research? With regards to the old hospital—Anderson East and West—we said, “Well, we probably could continue to use those for support spaces tied to patient care activities.” Gimbel was—we decided we'd have to keep Gimbel, but it would be primarily for research faculty offices. We undersized the faculty offices in—increased the square footage dedicated to research labs, decreased the amount for faculty offices on the research labs. In the clinical research building—we figured we'd always use Gimbel for that purpose, which was a good decision. That left Bates-Freeman and basic research building—Jones—as our oldest—some of our oldest research space, and those we could get to. We could actually go in and tear those down and rebuild on those sites.

So a lot of the—and basically when we—when we—when we had planned the Mitchell Building, we had replaced the old vivarium that used to be in Bates-Freeman and Jones, so now we had a brand new vivarium—expanded vivarium, closed the old vivarium. So now Bates-Freeman and Jones—other than replacing those research labs, that only left the library that was in that space.

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**CLIP**

B: MD Anderson History

C: The MD Anderson Ethos

B: MD Anderson Culture

C: Understanding the Institution

B: The MD Anderson Brand, Reputation

A: The Administrator

C: The Professional at Work

*Locating the Research Medical Library at the Top of Pickens Tower*

**William Daigneau, MBA**

**0:11:33.8+**

So we had to find a place to eventually put the library. The funny story about—well, I don't know if it's funny, but if you're familiar with corporate America, whenever they build an office building or office tower, who goes up on the top floor?

**Tacey Ann Rosolowski, PhD**

**0:14:25.0**

(laughs) Uh-hunh (affirmative). The president. CEOs. (laughs)

**William Daigneau, MBA**

**0:14:29.1**

So I was afraid that would happen, because we were going to basically move the president's office and—as well as all the faculty out so we could clear the—the president's office was on the top floor of Clark, and that could be used for clinical space. So I was afraid what would happen was there'd be this big push—even the Board of Visitors would argue, "John, you should have your office on the top floor," because that's what they would do. But I always feared that—what does that say about Anderson and where its values are? I was always concerned about that—what is the—that's why our philosophy when we built was—all the money went on the inside. We wanted the buildings to look attractive, but we weren't paying for a big-name architect to create some fancy architectural monument to themselves. All the money went to the inside. That's why we have pre-cast, durable, inexpensive, can be made to look good but not super fancy. Dr. Mendelsohn said, "Everybody's building these all-glass buildings. Is that more expensive?" Yes, it is. It's more expensive to build and more expensive to maintain. They looked nice, but—anyway, all of the money—one of our philosophies was all of the money goes on the inside. Everything that's outside is attractive, neat, but not flashy—not extravagant. The money people spend to go to MD Anderson is used wisely, so from an architectural standpoint, I always wanted to make sure we were making the right

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statement to the public, to the tax payers of Texas, to the Regents, to the mayor and the citizens of Houston. When they saw Anderson facilities, they knew what our business was, and it wasn't a flashy building. The money went into research. The money went into patient care, and that's—that was our priority.

So I always resisted this tendency to create something that was flashy when we were building. I was actively worked behind the scenes to make sure that we were making the right statement. Well, we come up—we're planning the academic tower, and I'm thinking, "There's going to be a strong push to put the executive offices on the top floor. This is now an empire—the MD Anderson empire. What statement is this making about our priorities?" So I'm trying to figure out, "Well, how did I broach this with the president?" Not that he was a flashy guy. He drove that old Volvo for years, but sometimes people get behind an idea, and I knew that there'd be some Board of Visitors that are CEOs saying, "This is a great chance." I'd probably lose a battle to say, "This is not the right thing to do." A lot of blocking action, you know? (laughs) It's like—we had this problem with the library. Where are we going to put the library in the future? (laughs) This is probably one of those sleepless nights like you had—(laughs)—wouldn't that be a wonderful place to put the library? Number one, even though the faculty and the students would have a—these are high-speed elevators, and secondly they get up there, and how inspiring that is to look over all of Houston. What statement does that make about our priorities? It goes to education. We save the best floor for an educational use. Our executives are on the floor below. We proposed that at Facility Steering Committee—to the credit of everyone, they did the right thing. They approved that.

***Tacey Ann Rosolowski, PhD***

**0:18:55.1**

What was the reaction when you first proposed it?

***William Daigneau, MBA***

**0:18:57.7**

It's like—when the thought came to me, it was like, "What a wonderful statement!" It was like one of those things that gains traction, because you start thinking of all the positives about it. Now the one negative was your books are now on the top floor, so if you get a big hurricane through there, it rips off the top. One thing I—we didn't want to necessarily have the most valuable things of the entire institution up there, but it's a sturdy building. The likelihood of that happening is pretty slim. Anyway, that's how it ended up. It solved the problem of what to do with the library in the old space that we had—trying to vacate it all. We had solved the vivarium problem. We knew how to replace those laboratories. What did we do with the library? So that was a nice solution

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and made the right statement to people. You can ask the library. She was pretty happy with it.

***Tacey Ann Rosolowski, PhD***

**0:20:07.5**

People still do love it. How can you not? The views are great. It is inspiring.

***William Daigneau, MBA***

**0:20:13.0**

Yeah, it's relaxing. The problem is—out of the main—but that's a good—there's good things about that and there's negatives about that. So anyway, that's how the library ended up there. (laughs)

***Tacey Ann Rosolowski, PhD***

**0:20:28.9**

So what happened next? There's the Main, Mid, and South Campus issues—South Campus Research Facilities, which you've mentioned briefly before. Maybe let's just pause for a second and kind of do some strategizing.

**0:20:46.4** (end of audio)

(begin audio)

***Tacey Ann Rosolowski, PhD***

**0:00:04.3**

All right, we are recording again. So we were just talking about what we have left to talk about, and where would you like to start with that? HMB, South Campus, new admin building?

***William Daigneau, MBA***

**0:00:24.6**

So let's finish on Pickens. So basically the library got placed where it did. Basically all of the remaining faculty offices were dedicated to Pickens. We had an issue with parking—supporting the parking for that, so at the time that faculty center was built. The Texas Medical Center had built a parking garage behind Rotary House that would support both faculty center and Rotary House. Our requirement for ten years was—we had to basically keep the garage full. When we went to build Pickens, the parking garage—the TMC parking garage would not be sufficient, so we decided to build across the street where the radiation treatment centers—not treatment—the radiation—it's called the ROC—outpatient center—Radiation Outpatient Center—Radiology Outpatient Center, I'm sorry. That's located across the street at Pressler and Braeswood. We

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decided to build a new garage there to support Pickens. That created, again, a lot of tension between us and Texas Medical Center, because they believed—since we had a template where they built the garage, and we basically committed to keep it full all of the time, they thought they should build it.

*Tacey Ann Rosolowski, PhD*

**0:02:20.8**

Uh-hunh (affirmative). I see.

*William Daigneau, MBA*

**0:02:22.3**

By then, Dr. Mendelsohn had concerns about the cost of parking, and one of the things we found was that we could build the parking garages cheaper than Texas Medical Center was building them, and secondly—since this was an auxiliary enterprise for us—not our main business. We didn't have the overhead Texas Medical Center had, so we could operate that much less expensively. That all translated to if we built it and operated it ourselves, it cost less to our employees and our patients. Bottom line. As I said, Dr. Mendelsohn had been and was always sensitive to what our patients were paying for parking and what our employees paid. Now parking costs—if you're a surgeon making six figure is not as much of an issue than a housekeeper or a secretary who's making \$20,000 or \$30,000 a year. So \$600 a year or \$700 a year has a different impact depending on how much money you take home.

*Tacey Ann Rosolowski, PhD*

**0:03:46.5**

Yeah.

*William Daigneau, MBA*

**0:03:48.4**

So we decided to go ahead and build that parking garage after some discussion with Texas Medical Center. Those kinds of decisions continued to create hard feelings between Anderson and the leadership of the medical center. Again, they were in the interests of our mission and the interest of our people and our patients. So we built that garage to accompany Pickens as well as some employee parking in the main complex, because we were looking at total density of development in the main complex. We had sufficient parking planned for the Mays Clinic and all of that development. We didn't have sufficient parking to support the development of that research campus on the north side. When we built the garage on—the Braeswood garage, we sized it at maximum size that we could build on that site and still get cars in and out all the time. So it's maximum development, even though we didn't have a defined use at that time for all of it.

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***Tacey Ann Rosolowski, PhD***

**0:05:18.1**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:05:19.4**

So that created some capacity in the garage that eventually will consume, but again, in the interest of our employees, for the first time—for the first time, I think—not in higher education but definitely in the Texas Medical Center and most other campuses, we began offering a tiered rate system based on your employment category in the institution. So basically it allowed the lowest earning employees, staff to get rates that were more in line with distant service parking but get it closer in. So that's a—that garage is unique in that—because of its size and being built for the future development. It allowed us also to provide some benefit to employees by the tiered rate system.

So that kind of wraps up the development of Pickens Faculty Center, and then the last part of that was the expansion of Rotary House. We had originally built—Rotary House was planned for at least one expansion. We looked at it and figured it could actually be expanded twice, so we did the—there was the original Rotary House. We did the first expansion, added 100-some rooms to it. We also created an enhanced food service facilities and all of that.

***Tacey Ann Rosolowski, PhD***

**0:07:22.6**

When was that first expansion done?

***William Daigneau, MBA***

**0:07:24.9**

That was done in—I'm trying to remember the year now—in the mid 2000s. So there was room, then, for the third phase, and the third phase was basically to take it from an L shape and make it into a U shape. Now when we built the big garage across Braeswood and we offered the tiered rate system, we got a lot of people from the main complex using that garage, so at the end of the day, they would leave the main complex and instead of using the bridge system—which did not take them to the garage. They would just cut across the street there MD Anderson Boulevard and Holcombe. Once again, it is the same problem we had with people crossing midblock from faculty center back to the main complex. Well, now we've—so we had a public campaign—public service campaign, using our police to tell people, “Do not cross midblock. It's dangerous. Use the intersection controlled crosswalks.” People would complain, “Well, I've tried those crosswalks, and they're just as dangerous.” So anyway—so the question then became, “How can we connect that garage by bridge system?” So the answer—the solution to that problem was the

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third addition to Rotary House, because when we constructed that addition—now we have a place to actually route people through Rotary House back to the—that bridge that goes from Rotary House over to the main complex. Well, when we had the financial difficulties a few years ago—again, the capital plan was—some projects were put on hold. That was one project that was put on hold. We never—even though the garage—when we built the garage, we planned basically for new bridge that would cross Braeswood, connect to the new addition to Rotary House, and then into the bridge system over to the main complex. So while some of our employees think that was—why didn't they think of this? We did think of it, and we did have a solution to that problem. The problem that we encountered was the financial.

*Tacey Ann Rosolowski, PhD*

**0:10:18.4**

Yeah, and that was in—around 2008.

*William Daigneau, MBA*

**0:10:20.8**

Uh-hunh (affirmative).

*Tacey Ann Rosolowski, PhD*

**0:10:21.0**

Uh-hunh (affirmative). Okay.

*William Daigneau, MBA*

**0:10:22.9**

So there was a solution there, but it's—it hadn't been—and furthermore, the other thing we studied was—I told you earlier about—we looked at various sites. We still, in the master plan, have Garage 5 as a site for a future clinical building.

*Tacey Ann Rosolowski, PhD*

**0:10:38.7**

Oh. Uh-hunh (affirmative).

*William Daigneau, MBA*

**0:10:41.3**

So it's possible that eventually from—and we did the actual routing studies—that we could actually move people from that garage into the—through the addition—Rotary addition and then a new bridge directly across to a new building at the Garage 5 site. That would be an even better solution. So all of those things have been—all that is at least—has been considered and is possible. So now moving onto—moving on—South Campus?

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## **Chapter 17**

### **B: Building the Institution**

#### ***Overview: A Plan for South Campus [Research Park]***

#### **Story Codes**

A: The Administrator  
B: MD Anderson History  
B: Institutional Processes  
C: Discovery and Success  
B: Building/Transforming the Institution  
B: Growth and/or Change  
B: Obstacles, Challenges  
C: Professional Practice  
C: The Professional at Work  
B: MD Anderson in the Future

***Tacey Ann Rosolowski, PhD***

**0:11:21.3**

Yeah, the whole Main, Mid, and South Campuses.

***William Daigneau, MBA***

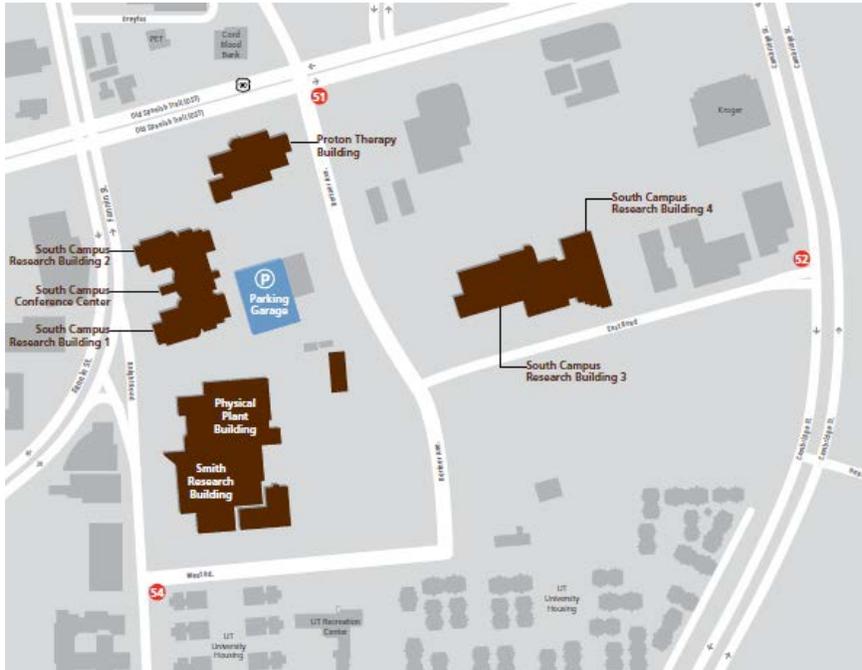
**0:11:26.9**

Okay. So let's jump to South Campus. So originally there were 100 acres purchased by the UT System, and that 100-acre parcel—part of it was used to build the RE “Bob” Smith Research Building, which housed basically Dr. [Isaiah J.] Fidler's [Oral History Interview] program, as well as—it was—at one time, Physical Plant had offices there, as well as—and the UT Police Office was there. When Dr. Mendelsohn arrived, he looked at that parcel of land and had discussions with Dr. [Walter R.] Lowe at UT Health Science Center, who operated basically graduate student housing out there, as well as had a recreation center—the possibility of using that land for a research park—not of—of the size of the ones in North Carolina, obviously, where they have 1,000 acres, but something at least would be available for research startups, et cetera. When he proposed the idea, it was obviously a great idea—how do we get it started? So one of our tasks—my task was basically to create a development plan as a research park for that 100 acres. So a couple of things evolved from that. Number one, we had—we had—when I got there, I had been talking to National Guard, because they had a corner—piece of the corner property about possibly acquiring that, and I forget where they were—but we finally did contract for that

**South Campus [also called Research Park]**

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and were able to purchase that—that corner property. Next door to the National Guard was the Army Reserve and the Navy/Marine Reserves. They both had headquarters there and their own buildings there.

***Tacey Ann Rosolowski, PhD***

**0:14:00.0**

Now was this—this was adjacent to the parcel that the Texas—?

***William Daigneau, MBA***

**0:14:03.1**

South Campus—adjacent to the 100 acres. It basically fronted—what was that—use my—Old Spanish Trail. Yeah, if you look—here’s the RE “Bob” Smith Research Building. There’s the Physical Plant Building, where I said UTPD and Physical Plant—

***Tacey Ann Rosolowski, PhD***

**0:14:39.0**

And just for the recorder right now, we’re looking at a map, and I’ll provide a copy of that.

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*William Daigneau, MBA*

**0:14:44.1**

So this was 100 acres basically—it was owned by the—here's the graduate housing for UT—

*Tacey Ann Rosolowski, PhD*

**0:14:53.8**

Okay, and that's right at the bottom of the map.

*William Daigneau, MBA*

**0:14:55.2**

Yup. There's their Recreation Center. So all of this was open land at the time, except for the Army Reserve, which was here, and the Navy/Marines Reserve, which was there—all owned by UT. So when Dr. Mendelsohn proposed Research Park, we had already had discussions from the National Guard about acquiring this corner, which we successfully got. So a number of things went on on the South Campus. Number one, we had to create a development plan for it. How would we use it as Research Park? So myself, Susan Lipka, a few others got on a plane. We looked at about four different research parks in the country, including North Carolina, but the one that kind of stood out as most practical for us that UMass/Amherst, where they had the medical center, and there they had a small research park, and we looked at the layout of the research park. It was modest. I think it maybe could support four buildings or five buildings, which they had largely built. We looked at their model for those research buildings, and it just seemed to fit well for what we were trying to do. So what happened to us was we basically had a firm—planning firm subdivide the 100 acres using the UMass model and thus was born South Campus Research Building 1. If you go to UMass Research Park, you'll see a building that looks pretty darn similar to that.

*Tacey Ann Rosolowski, PhD*

**0:17:14.3**

Oh really? Wow.

*William Daigneau, MBA*

**0:17:18.1**

And here was the concept of that building. Yeah, it was 100 acres we had, and it—like land—you're looking out there. There's all of this land to develop. Gosh, we were land rich, so let's build something substantial. Up here, we were land poor, so I told you the Mitchell Building was designed for fifty years and the fact we're never coming back and redoing that again—this building had to be very substantial and permanent—very flexible. Out here, we had wide open spaces. We don't have to build like that. The philosophy was—I use this term the twenty-year building. Dr. Mendelsohn would always say, "You mean this building's only going to last twenty

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years?” No. What I mean is in twenty years, we’ll get our maximum use out of it, and if the right decision is—because this park has been so successful, we should scrape that building and build something more substantial in it, economically it will make sense to do it. That’s what I mean by twenty-year building. So basically that was the philosophy of that first building—something that was not as costly. It was actually about half the price of Mitchell on a per square-foot basis. It was cheaper to build, less substantial, but in twenty years if you said to yourself, “You know, I want to put a building twice this size up there,” you can afford to do it, because you’ve gotten the maximum value out of the building. So that was the philosophy we followed basically in developing—if you look at the original master plan for the Research Park, all of them are footprints roughly the size of that first building laid out along this road, et cetera.

*Tacey Ann Rosolowski, PhD*

**0:19:13.7**

Interesting. Let’s pause for just a sec.

**0:19:17.8** (End of Audio Session One)

# **William Daigneau, M.B.A.**

**Interview Session Two: October 4, 2013**

## **Chapter 0** **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**0:00:00.6**

All right, so let me just—all right. We are recording again, and today is the fourth of October, 2013, and the time is 8:53 in the morning. William Daigneau and I are having our second day's session together. So we were talking—ended up yesterday talking about research building one on South Campus, and you wanted to continue the story of the development of that area.

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## **Chapter 18**

### **B: Building the Institution**

#### ***The Story of Research Park [South Campus]: Strategies to Acquire Land and Collaborators***

##### Story Codes

- A: The Administrator
- B: MD Anderson History
- B: Institutional Processes
- C: Discovery and Success
- B: Building/Transforming the Institution
- B: Growth and/or Change
- B: Obstacles, Challenges
- C: Professional Practice
- C: The Professional at Work
- B: MD Anderson in the Future
- B: Beyond the Institution
- B: MD Anderson and Government

##### ***William Daigneau, MBA***

**0:00:32.9**

So the—as I said previously, Dr. [John] Mendelsohn wanted to develop this research park in the South Campus. The land was owned by the UT System for the benefit of both Health Science Center and MD Anderson. So when he first proposed that to the Health Science Center, they were very supportive of that. There’s one part of that that I’ll talk about in a minute, but—so—we basically, in Facilities, began researching a little bit about research parks, found the one at UMass that resembled our situation, and so we based our planning on that type of a research park. So the next step, then, was to develop a master plan for it and basically subdivide the land—100 acres into various uses, one being the Research Park. So retained an architectural land planning firm and subdivided the property that we owned—that the UT System owned into developable lots based on roughly 35,000 to 50,000 square-foot buildings. That’s the first one—the pilot building was the Research Building 1. Four stories—as I said, a lower cost construction than what we had built on the main campus and based on that pilot—on land that Anderson already owned and controlled, we then—as I said—we subdivided all of them—all of the property. Health Science Center was supportive of that except for one thing; they had an ecological park that was—where they’d artificially created a swamp-like condition to mimic things that were native to Houston in the early years. Although it was completely man created—I mean, it was not natural at all. It had been—it was used by their School of Public Health for some environmental studies. That sat firmly in the middle of the property that was designated for the research park, so that initiated numerous discussions between the two institutions, beginning

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with me and my counterpart at Health Science Center about what to do with this environmental laboratory that they had constructed. Obviously, they took the position that they were willing to forgo it if Anderson would basically provide funds to recreate it elsewhere. So that little—probably it was about a five-acre parcel of land in the middle of the research park—that little issue probably took almost a year to resolve between the two institutions. Eventually, it was resolved through the intervention of a regent, so therefore the plan was then basically approved by UT System in both the components.

***Tacey Ann Rosolowski, PhD***

**0:04:34.7**

So did MD Anderson end up providing funds to recreate that laboratory?

***William Daigneau, MBA***

**0:04:38.8**

No. In effect, the intervention of the Regents said that this was not—this was a—one of those boondoggles by the institution, and that the system was basically going to approve this regardless and it was through that kind of force of will that the Health Science Center forgo the—and when you looked at—you know what I mean? It was all—it wasn't like it was a natural thing. It was—had been all created, so it wasn't like—and when you develop any piece of land, of course, you have to designate wetland—it was not natural wetland. So even the Environmental Protection Agency basically signed off because it had not—it was not a natural wetland. It had been created. So there was nothing really to stop anything other than, again, just an attempt to leverage the situation. So basically the plan was developed. The question then became—if you look at the South Campus plan, you see the roadways there. Those roadways did not exist. There was no utilities, waterline, sewer lines—nothing was—it was just bare piece of land. So then the issue became, “Well, who is going to fund those roadways and all of the infrastructure required to develop the land?” So again, took advantage of an opportunity there—at the time, state of Texas through the governor's office had a fund of money to help fuel business startups, businesses coming into the state, and so the institution—my office working with Governmental Affairs—we applied for a grant from the state of twenty-five million dollars to basically put in the infrastructure for the research park. That was approved.

***Tacey Ann Rosolowski, PhD***

**0:07:07.3**

Wow.

***William Daigneau, MBA***

**0:07:09.1**

And so the institution basically—the state funded the development of the roadway system and all of the sewer and water infrastructure. So anyway—so we were able to then develop the property,

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and it was laid out based on the UMass Amherst type model. Over the years, we'd really never—the park has never been successful in terms of attracting a third party to build buildings out there.

***Tacey Ann Rosolowski, PhD***

**0:07:50.1**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:07:51.0**

Over the years, we've attempted many different things. We were able—basically the Proton Therapy Building was located on the corner out there. That came the closest to a third party, though Anderson participated heavily in terms of providing staff to operate the proton therapy facility.

***Tacey Ann Rosolowski, PhD***

**0:08:14.0**

What was the situation? I mean, why has it had a difficulty attracting partners?

***William Daigneau, MBA***

**0:08:18.1**

Well it's an interesting problem for a lot of research parks in that most drug companies—they kind of got out of the business of developing facilities—stand-alone facilities many years ago. Even the Research Triangle [Park] in North Carolina has really kind of stalled and slowed over the years. What they would rather do—pharmaceuticals and biomedical-type firms—they'd rather fund investigative research at institutions without building anything. So even though the concept is well understood—in fact, it's been very few buildings over the years—there was a company that went around the United States and built some, but based—the recession in 2008, they basically shut down everything that they were doing. It's—not just for us, but for everyone, it's been a—it's a great concept, but funding for that concept really is never emerged in a significant way. So other than the proton therapy building, Anderson has continued to build out there, and of course we built South Campus Research Building 2, had some grant funds for that—from donors that were used. Since we're building next to it, one of the complaints of researchers out on the South Campus was that there were no amenities out there—no food—everybody had to either bring their lunch or get in the car and drive somewhere else to get something to eat. When we developed the Research Building 2, it was an interesting issue of where would we put the food service facility, for example, and where did meeting rooms go? Things like that—conference-type facilities. So one of the—in trying to figure that out, one of the ideas that I proposed based on availability funding is to tie the two buildings together with a conference center, and that's how the conference center was then created, which basically—we moved a lot of the meeting rooms from the laboratory areas themselves, put them in a separate facility, which is cheaper to do, frankly—instead of using research space that's designed around

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research for meetings rooms. It's much cheaper to build just a structure for meeting rooms only, so that's how the conference center came to be, and we're—again, our development office was able to get funding for it, and it's—that's how it got named and all of that, and as it turned out, the two-building complex now became more of a single building with the tie between the two buildings. So we built South Campus Research Building 2, and then the third building out there other than Anderson developed was Research Building 3, and that was a collaborative effort, because the institutions—both of the institutions receive grant funds to develop the advanced imaging facility out there, which include a—you know—a—shoot—I'll think of it in a minute, but anyway, that grant was given to both institutions to fund that, as well as a grant from General Electric, and so that was a collaborative effort between the two institutions. Health Science Center was going to occupy one floor. We would occupy one floor. Then there was the shared imaging facility. So that was the third building developed out there. Since then, we've added Research Building 4, and Health Science Center has built their new dental school out there, as well as a research building themselves. So the park has developed primarily through the use of the land for research purposes for both of the institutions. Now as a side story about that—as I mentioned originally, the National Guard was out there, and then there was the Army Reserve and the Naval and Marine Reserves. Anderson acquired the corner property from the National Guard probably in the middle of the 1990s, but we always had an eye on the Reserve properties, because acquiring to those two properties significantly expanded the research park. At one point in time, there was some discussions that were initiated with the Army about acquiring that property and what would it cost to do that, and the Army basically—Department of Defense said that they would relocate—actually they, unbeknownst to us, kind of had a desire to relocate to Ellington Field and relocate if basically Anderson would compensate them for the cost of a replacement facility.

***Tacey Ann Rosolowski, PhD***

**0:15:01.2**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:15:02.3**

Well, the question became, what would that cost? So by the time you looked at the list of Army requirements, it worked out that the land in effect would cost over \$200 a square foot. It was just an unbelievable price. Obviously Anderson and the UT System was not going to provide funds for that, and our development office was doubtful anyone—that any donor would contribute that much money for just land—in effect, land. So things kind of stalled for a while until some issues came up in Congress about the base closings, and one of the bases to be closed, which of course got the interest of Kay Bailey Hutchison, who was our Senator, about protecting the—that Air Force base out there. One of the arguments to keep the base was that it would be the home of the Army Reserve as well as the Navy Reserve Center, basically working with her office—of course by then, Governor Bush had become President Bush, so we had a lot of support at the highest

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levels. To make a long story short, eventually they were able to fund the creation of a new Army Reserve and Naval Reserve facility out at Ellington Field, which dramatically reduced the cost (laughs) of acquiring those properties, but I would say—I personally worked on that with our Governmental Affairs office for a good seven years.

***Tacey Ann Rosolowski, PhD***

**0:17:19.8**

Uh-hunh (affirmative). Wow.

***William Daigneau, MBA***

**0:17:21.0**

From the beginning until finally getting the funding and acquiring the actual property. So to end the story about the research park, there were a couple of things that happened. Number one was once we were able to acquire that park, Dr. Mendelsohn wanted to look at the master plan and look at a possibly greater density development out there, since we owned everything all the way up to Old Spanish Trail now. So the master plan was revised, so now the master plan created more of a campus-like setting as opposed to individual building sites. Again, for the future, if it's ever developed, it remains probably a good source of future development for MD Anderson in terms of research.

***Tacey Ann Rosolowski, PhD***

**0:18:10.7**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:18:12.0**

The other development on South Campus was—I had earlier discussed about the development of a master plan for the north side of the main complex's research. Sitting in the middle was the dental school. Well, the Health Science Center was able to get funding for a replacement dental school, which is now not located on the South Campus, and Anderson basically has acquired now the rights to the dental school. So it now controls all of the property basically other than the Texas Children's Hospital Research Facility on the north side of the campus for future research development, which one of the parcels obviously has already been dedicated to the development of the Zayed Building.

***Tacey Ann Rosolowski, PhD***

**0:19:01.5**

Right, that's the Institute for Personalized Therapy.

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*William Daigneau, MBA*

**0:19:04.5**

Right, which is under construction.

*Tacey Ann Rosolowski, PhD*

**0:19:05.5**

Right, uh-hunh (affirmative).

*William Daigneau, MBA*

**0:19:07.2**

So that basically kind of completes the story of how the South Campus came to be and its development. I don't know if I mentioned this earlier or not, but I'll restate it. One of the—one of the things that—I mentioned the Physical Plant Building is located out there. We also have a Hazardous Waste Processing Facility out there. Then one of the proposals was, of course, to expand the vivarium facilities in order to support the increased research out on the South Campus. The original vivarium was located in Smith Research Building, which was—basically supported Smith Research Building. With the addition of the other research facilities, there was not sufficient vivarium space. So the concept there was to basically take all of the Physical Plant Services, which we began to do, as well as the police department, out and use that space for future vivarium. The Physical Plant moved out into a warehouse located on what's now called the East Campus, which is off Alameda, and the first phase of the vivarium expansion occurred to support Research Building 1, 2, and 3. Eventually there are plans to further develop—move the police and further develop that to support increased research out there. Eventually, we'll have to build a separate vivarium if the property continues to expand, but at least that's the interim plan there. So the East Campus was acquired primarily because now this land had become too valuable for support functions. We were able to get—the East Campus landed roughly thirty dollars a square foot, which is a lot cheaper than the appraised value now of the South Campus. And so all of the future support service, warehousing—all of those things will over on the East Campus, which is about two blocks away from the South Campus. So that's basically—what's always been interesting is how it's like a big jigsaw puzzle—how pieces—how the dominos tend to fall and how pieces then fall into place for all of the various plans, so in large part, most of the—I mean—most of the things have moved in a way that at least have been not so haphazard as opposed to actually being planned that way, so when you look at MD Anderson, there was a lot of forethought that went into all of these things that led to its development.

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## **Chapter 19**

### **B: Institutional Processes**

#### ***Moving Occupants Into Buildings: Commissioning Buildings and Factors that Drive the Move-In Schedule***

##### **Story Codes**

- A: The Administrator
- B: MD Anderson History
- B: Institutional Processes
- A: Overview
- A: Definitions, Explanations, Translations
- C: Discovery and Success
- B: Building/Transforming the Institution
- B: Growth and/or Change
- B: Obstacles, Challenges
- C: Professional Practice
- C: The Professional at Work

##### ***Tacey Ann Rosolowski, PhD***

**0:22:11.8**

I wanted to ask you about the plans and processes that you used to actually move people from, say, laboratory and office space on the main campus down to South Campus, as well as moving patients around when that was often necessary. How did you work on that—make that happen?

##### ***William Daigneau, MBA***

**0:22:36.7**

Well all of the—we had developed over the years our process, and I mentioned the core team. The core team is responsible for managing the entire project from beginning to end. All critical decisions go through the core team. The core team is responsible for all budgetary schedule issues. One of the things that allows the core team to operate is it creates—through the various stages of the project—it creates other subgroups—sub teams that report to the core team. For example, there's one member of the core team who represents the users, and I mentioned earlier that often that person will form a user's group or a building committee that's composed of all the future users. They weigh in on basically the adjacency issues, where things go in the building. They answer questions about specific space layouts. So these subgroups will operate during the course of the project as the phase the project moves through. One of those phases will be nearing completion when occupancy—when we're getting ready for occupancy, and sometimes the names change, but usually a group is formed called the Move Team, the Building Occupancy Team, and that team is made up of both the facilities operations people, as well as users—your representatives of the actual users that are moving, as well as the project director—project

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manager, who's responsible basically to develop a move schedule and go through all the details of the move in. Separate schedules are developed for that. We often will contract for moving services. So that's all handled—telephones. A lot of people forget that every room has a telephone and a telephone numbers associated with it. All that's worked out. The keying system is all worked out.

*Tacey Ann Rosolowski, PhD*

**0:25:10.9**

What is that?

*William Daigneau, MBA*

**0:25:11.7**

The keys.

*Tacey Ann Rosolowski, PhD*

**0:25:12.7**

Oh, the key system.

*William Daigneau, MBA*

**0:25:14.2**

The locking system—because when somebody goes to move, they need to have an active phone, an active computer, and a key for the room. Room signage—we have a signing system where you can add the name of the person at the bottom of the sign, if you've ever noticed that. All of that is laid out during the move planning. A lot of work and a lot of details go into that—and that's just for occupied spaces. So when we open—we usually open floors of a hospital at a time, not the whole thing. We move by floor. The day will come where patients are actually then moved physically from wherever they're at to the new floor. All of that is developed as per that schedule and per that move plan, and one of the things I mentioned earlier that we had the Mitchell Building under construction. We had the Mays Clinic under construction. The Duncan Cancer Prevention Building under construction—all at the same time. That was kind of a problem in some ways for us, because when all the buildings were coming basically on line at similar time frames, so we were trying to active the buildings for occupancy at about the same time. It created a huge drain on facility staff, because it wasn't like we could move people from one project to the other. They were all simultaneous, so we had to create—we had actually three activation teams working at the same time for three buildings, and it create a huge impact on information services, because they were doing all the telephone planning, all the computer planning on three buildings at the same time. So we actually had to go back to the Facility Steering Committee and work out a prioritization, because there was just—there was no way to do all of this. It was peaking—all of that concurrently, and there just wasn't enough staff resources to support all that. So we went through a prioritization, got approval to basically

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sequence the buildings and—so that’s why Mitchell basically—I mean, to be honest with you, as anxious as everyone was to occupy Mitchell, it was the last one that was finally moved into.

***Tacey Ann Rosolowski, PhD***

**0:27:48.5**

Interesting, yeah. Can you tell me—what are some of the specific—some of the other issues that arise? You talk about telephones and computers and keys—signage? What are some of the other issues in moving laboratory equipment, for example, and also moving patients—people from place to place?

***William Daigneau, MBA***

**0:28:09.3**

Well, part of the activation process—a separate activity that’s going on is called the commissioning process, and that is where all the building systems—the new building systems are tested to make sure they operate correctly. It’s a lengthy process to go—to commission a building—to make sure everything—because obviously you don’t want to move in and then find out you have a problem with the fire alarm system. So all of that is thoroughly checked out, tested under various conditions, and is part of commissioning. Now, office buildings are the easiest to commission—very straight forward systems. Clinical buildings are the next more difficult, but the most difficult commissioning activity goes on in the laboratory buildings, specifically the vivariums, because the vivariums—we call them “mouse Hiltons.” It’s like a hotel for mice. So before we can move the animals—because—a lot of people don’t know this, but some of the breeds—these mice are bred specifically to test for certain things. You heard the term—maybe—nude mice.

***Tacey Ann Rosolowski, PhD***

**0:29:30.9**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:29:34.0**

Some of those mouse colonies are twenty or thirty years old, because it’s taken that long genetically, so they’re very valuable—the genetic modeling that has occurred—has taken a good while to achieve and to create a mouse that basically is susceptible to certain types of cancer so that they can evaluate drugs and various procedures, et cetera. So these mice are very valuable. Those certain breeds—I mean—there’s only one colony of them in the United States sometimes, because they’re so unique. So obviously, they have—the animal research people do not want to move it into a new facility where there’s a chance any sort of problem with it or failure of it could lead to death of those very expensive and very rare mice. So the commissioning for vivariums is—takes almost a year.

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*Tacey Ann Rosolowski, PhD*

**0:30:45.5**

Wow.

*William Daigneau, MBA*

**0:30:46.1**

They're eventually put—everything is checked out, sanitized, disinfected—I mean literally scrubbed down like an OR—almost more extensive than an OR, and then they'll put that—after that's all been achieved, then they'll put in a test colony of ordinary mice (laughs) and just see how they thrive—

*Tacey Ann Rosolowski, PhD*

**0:31:11.2**

Right.

*William Daigneau, MBA*

**0:31:13.0**

—before they actually make the move of the main colony into the new facility. So the vivariums have always been both very extensive and has generally, in occupying—a vivarium is like in Mitchell Building—if a vivarium is located in the research building, it drives the entire schedule for the building because of the fact it takes so long and it's so extensive. So all the commissioning goes on and is the most detailed in the research facilities. Then there's a safety issue, obviously, so ventilation systems are especially designed in the research buildings, checking that out to make sure that the nasty stuff is exhausted properly, that all fume hoods are working correctly. A lot of people don't know about how fume hoods actually operate, but there's a lot of fail safes build into them in terms of the air flow—basically to keep the air flow—keep whatever is hazardous inside the hood with little chance of escaping where a researcher would breathe it while they were working at the hood.

*Tacey Ann Rosolowski, PhD*

**0:32:27.0**

Uh-hunh (affirmative). This is so curious. Is this also a laminar airflow system? I talked with Dr. [Gerald P.] Bodey [Oral History Interview] at length about that.

*William Daigneau, MBA*

**0:32:34.4**

Yup, yeah. Laminar air. Basically ideas—curtain—there's a curtain of air, and so you can hold your hands inside, and that curtain of air basically continues to keep whatever hazardous material inside the hood without it coming back out where you might breathe it. So there's a lot of issues going on with the hoods—whether the sashes a third open, halfway open, fully open—all different conditions for airflow.

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***Tacey Ann Rosolowski, PhD***

**0:33:10.4**

Uh-hunh (affirmative). You've got a lot of radioactive materials, too, in the Houston labs.

***William Daigneau, MBA***

**0:33:13.8**

Yeah. So they're all tested very thoroughly before researchers are able to occupy the lab. You have to create positive air pressure inside the labs so that if there's a spill or anything like that, it's contained inside the lab and it—there's a lot of details that go on in the ventilation systems and air delivery and pressurization and all of these things that are tested constantly. Now some of those—again—some of those exist in some of the hospital rooms, as well, where you're trying to quarantine a patient who might have a disease that's infectious or whatever. But they're extensive in the—that's what takes the—that's why research buildings are so expensive and take so long to actually build—because of these very sophisticated mechanical systems that supply air and pressurize various areas.

***Tacey Ann Rosolowski, PhD***

**0:34:25.9**

What's the comparison of cost between laboratory spaces of the sort that you just described and for example, operating rooms? I think people who are kind of naïve about how all these buildings work may think—might think, “Oh, yes. The operating rooms are the most complicated and expensive.” Is that really true?

***William Daigneau, MBA***

**0:34:41.2**

No. I mean, ORs are pretty specialized facilities, but not—just to give you an idea on energy costs—a research building, in terms of its utility costs—electricity, heating/cooling—is three times more expensive to operate per year than a hospital.

***Tacey Ann Rosolowski, PhD***

**0:35:10.5**

I would never have guessed that—never have guessed that.

***William Daigneau, MBA***

**0:35:15.9**

Yup—because the—in terms of building costs—construction cost, an OR—and again, these are in late—in 2010 numbers, roughly. Hospital ORs—\$350 a square foot to build. Research labs—\$500 to \$600 a square foot. Yeah. So the investment Anderson has in research facilities—even though it has more square footage in patient care, the investment in research facilities is greater than the patient care facilities because of the costs of these things.

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## **Chapter 20**

### **B: Building the Institution**

#### ***Determining Building Efficiency; Pros and Cons of Leasing Space; Mid-Campus; Unique Features of the Institute for Personalized Care***

#### **Story Codes**

A: The Administrator  
B: MD Anderson History  
B: Institutional Processes  
A: Overview  
A: Definitions, Explanations, Translations  
C: Discovery and Success  
B: Building/Transforming the Institution  
B: Growth and/or Change  
B: Obstacles, Challenges  
C: Professional Practice  
C: The Professional at Work  
B: Institutional Mission and Values  
B: The MD Anderson Brand, Reputation

#### ***Tacey Ann Rosolowski, PhD***

##### **0:36:13.1**

I had no idea. What are some measures that you've looked into and instituted to improve the efficiency of these buildings? Because obviously, given their expense, you want them to run as well as possible. Have there been energy saving measures or other things that people might not know about?

#### ***William Daigneau, MBA***

##### **0:36:35.2**

We do a couple of things over the years with the buildings. Number one is their initial design—we look at—called building efficiency—how efficient is the building? That can range from office buildings of eighty-five percent efficient to medical care facilities, which are sixty percent efficient. Now how do we define efficiency? It's the—of the gross square foot, the amount of space that's actually occupied by people. That determines building efficiency. So when you think about a building, you've got all those hallways, restrooms, elevator shafts—they're not—they have to be there, because people can't use the building without them, but they're not really occupied space. So they consume a certain amount of square footage that "is not actually employed in the mission of the institution." So when we were designing buildings, we always attempted to maximize that percentage, because that's usable square foot by Anderson for its

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mission, and the more space that is used for hallways, storage closets, telephone equipment, stuff like that, the less there is available for really productive use. So we would always look at—our goal is always sixty percent or better. Now you say, “Well, why is patient care areas less efficient?” Mainly because an office building has a certain density of people that are using it, so you size your corridors and your elevators for that. In patient care space, especially ambulatory, the density increases significantly, because you’re basically inviting a whole bunch of people into the building other than the folks that just work there. So now you’re doubling the amount of people using that space on a daily basis than what an office building might have. So what does that mean? More elevators? Wider corridors? More restrooms? So it tends to eat away at the amount of reusable space because of the number of people per square foot that the building is designed to accommodate.

***Tacey Ann Rosolowski, PhD***

**0:39:06.4**

And is—am I correct in assuming that part of what’s figured into this idea of efficiency is that even if the spaces are not actually occupied, they still have to be heated and cooled and cleaned and all of that—furnished?

***William Daigneau, MBA***

**0:39:19.2**

Correct. Right. So efficiency drives operating costs of the building, the utilities, lighting, all of that. So you try to maximize efficiency, so we always have goals established for the efficiency of the building, and some of those also were thresholds in the state of Texas for approval of buildings, et cetera, so—but just from a practical standpoint, you wanted to maximize. So a lot of people just decide—like, for example, let’s say, “Well, why did you get rid of Houston Main Building?” The building was designed in an era where energy efficiency was not important. It was terribly inefficient—less than fifty percent. So from a practical standpoint, it was—per usable square foot, very expensive to operate because of the era it was built in. So that was one of many reasons, but the layout of the floors could not support any modern—in an efficient way, so it was a very inefficient building. So all of the buildings we designed—our office buildings are all highly efficient in terms of usable square foot per gross, and then that effects utility costs. Now after a building was occupied, there was a procedure we would follow called post commissioning, where—because what you’re trying to do is you’re trying to anticipate how people use a building—and why you might get it eighty percent right, there’s still that twenty percent. So through the first year or so of actual operation of the building, after people are using it, you find it out where you were right and where you were wrong in terms of how the building—the hours of use, the intensity of use, the characteristics of the programs, how they use the building—you find all of that out. So we used post commissioning basically to go back in and fine tune the mechanical systems to really reflect how the building is used. So we thought well maybe the library was going to be used intensively eight—twelve hours. We find out it’s intensively used eight hours. So we’ll go in and basically reschedule the setbacks for the

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temperatures and the space to reflect how it's actually being used, and that achieves significant cost savings through that fine tuning. We also do what's called post-occupancy reviews—PORs. We go back in and ask the users what they think about the building about a year afterwards, and then we use that information to improve the next one, make sure there's something—some characteristic that we attempted. We did extensive reviews of the Mays Building to see how it actually worked for patients—actually participated in a research study—a design research study that was sponsored by Health Design Initiatives or whatever and did a post-test of the building in terms of how patients fared in the new building compared to our existing ambulatory facilities, so there's actually a research study that was done on Mays about the design of it.

*Tacey Ann Rosolowski, PhD*

**0:43:15.4**

And how did it fare? Just—what were the results of that study?

*William Daigneau, MBA*

**0:43:17.3**

Excellent! It became kind of the new standard. It was the best combination of our thinking about patients in an ambulatory setting—cancer patients. So we surveyed both the staff in the building—the physicians, the nursing staff, as well as patients about what their experience was inside the facility and compared it to data—kind of a baseline data that was collected in the old existing clinics. So we had a before and after comparison, and it fared very well in terms of productivity, in terms of satisfaction—so it was—I think it got several awards—national awards. So the building—so yeah. We put in place a lot of—there was nothing—minimal amount of guess work about buildings. As I said earlier, they were designed to be very efficient. All the money went on the inside of the buildings to maximize their utilization and their attractiveness to users, and the least was spent on the outside.

*Tacey Ann Rosolowski, PhD*

**0:44:31.6**

I want to make sure that you've finished your story about the development of South Campus and all the campuses. Is there anything else that you'd like to share or observe about that evolution?

*William Daigneau, MBA*

**0:44:46.9**

I think we talked about everything except HMB and the Mid-Campus Building—I mean, we just talked about the Mid-Campus Building.

*Tacey Ann Rosolowski, PhD*

**0:44:55.8**

Sure.

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***William Daigneau, MBA***

**0:44:58.0**

Anderson was one of the largest leasers of space in the Texas Medical Center, because as I said, in the early 2000s, the strategy was—while we were building new buildings—was to move all administrative offices out of the main complex. So for example, we leased space from Texas Medical Center out on their Nabisco Building development for HR. HR was out there for years. We leased space in almost every building around basically for administrative-type functions that were—that had been or were going to moved out of the main complex to allow expansion of clinical space.

***Tacey Ann Rosolowski, PhD***

**0:45:44.0**

Not it may seem obvious, but I just want to make sure there's not something not obvious, but why does—what are the pros and cons of leasing vis-à-vis owning space?

***William Daigneau, MBA***

**0:45:55.6**

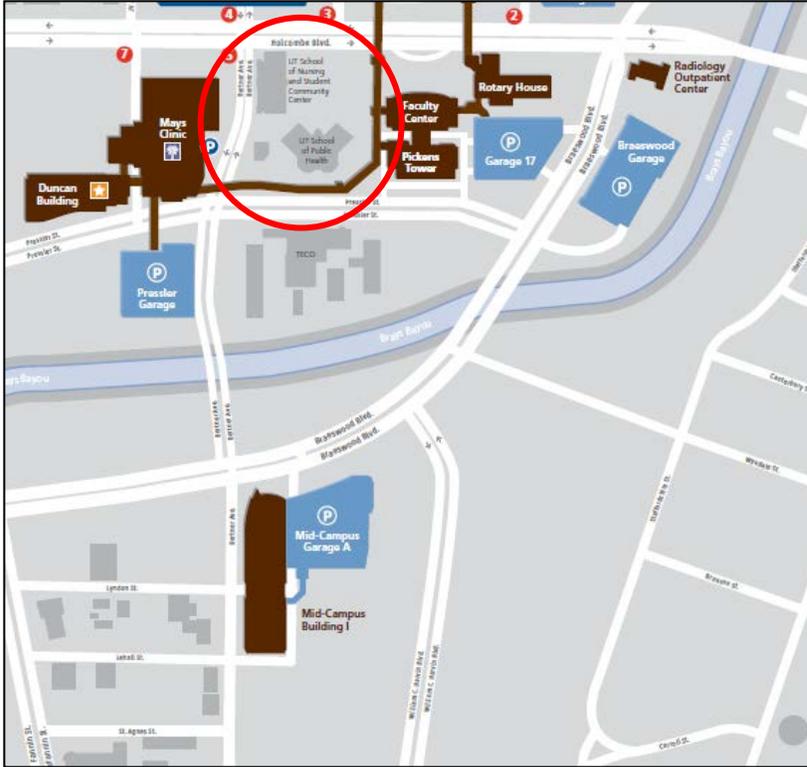
Well, two things. Well, the pro is—and we use leasing basically as a buffer, but it's not a long-term solution because of two factors. Number one is—the most important is economics—the cost of it, which is basically paying someone for square footage. You're paying all of their operating costs. You're paying all of their capital costs. Then you're paying for some of their profit objectives. So when you build for yourself, you pay all of those things except for the profit objective. So when you cut out—and that means the profit on some buildings is in the thirty percent range. So when you cut that out, you automatically just begin saving money. So long term, you want to own. I mean, if you're going to be there and in the case of a non-profit, there's no tax advantage. For corporations, they have tax advantages, because they can claim that leasing expense as a—as part of their expenses that—and get tax benefits from it. A non-profit gets no tax—we pay no taxes, so there's no tax benefit to us to lease. It's just an expense. Expenses detract from the uses of those funds for other purposes, primarily research or education or whatever. So in the long term for a non-profit with no tax benefit, you should own. Now, what you want to do is own, and when you get to the point where you no longer need that building, you want to be able to sell it. So you want to—that's why we always try to follow commercial footprints on our buildings, because we figured if we ever solve the cancer problem and we didn't need that building anymore, it would be attractive to somebody else other than ourselves. That was always called our exit strategy. Build something that can be used other than for one single purpose. So we'd always try to follow commercial-type layouts because of that exit strategy. So what happens—we were leasing everything, so we're paying a premium for that space, and then the other—the second factor of why you don't want to lease is there are few commercial building that really could hold all of our functions in one location that were close—in close proximity to the main complex. So our range of options was very limited to smaller buildings. So in our maximum leasing years, we were leasing space in about twenty-five

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different buildings around, and you'd say, "Well, so what?" Well, you've got to get mail there. You've got to extend your telephone system to those twenty-five different locations. You have to provide some support for them—flu shot season—so—I mean, all of these things multiply, and we have so many different locations—shuttle systems moving employees between the buildings—back and forth to the main complex, out to HR. We operate—at one point, one of the most expansive shuttle systems in the Texas Medical Center just because we were trying to move mail and people between twenty-five different locations. So your operating costs grow, so you have the expense of the leasing plus increased operating costs, so to minimize all of those, you want to—which was part of our plan—was to consolidate everything—all the administrative functions and support functions into a single location. Simplify—reduce shuttling cost, ownership costs, all of that went down. Actually did an economic analysis of building the Mid-Campus Building versus continuing to lease and the payback was something like—I forget—kind of like—in seven years, we paid back the cost, so obviously to own is—for long term. Now if you just need that square footage for a couple of years, you'll want to lease. You don't want to build something for that. But Anderson was going nowhere. I mean, we were located in Houston. We were going to be located in Houston until the cancer problem is solved. So for us, long-term ownership was the way to go. So that's what led to the Mid-Campus Building. Originally, because of that exit strategy, what we wanted to do was we originally wanted to use the property to create two separate buildings. Theoretically, one could be sold. So if you downsized and you

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The Mid-Campus Building

didn't need that space, you could sell one of the buildings. As we progressed in the design of the buildings, it became obvious that the executive team felt like we should—because we always seemed to run out of space. No matter what we built, we always occupied all of it—used all of it. The institution, as I said, was always—continued to grow, and we absorbed every square footage that we seemed to build, so there was some hesitancy to undersize the construction

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of the Mid-Campus Building. So as it—between the original concept of the separate buildings to the final building grew from roughly 750,000 square foot to 1.3 million. About the top third of the building is all shell space for future use. Two buildings are interconnected—would be very difficult to subdivide the building into two separate buildings at this point, though you could have a leasing strategy where you can—the building was—is separable by floor, so you could lease a floor out if you wanted to. So there are some things that create flexibility in the building, but it was primarily designed to—it has the second data center in it, all stand-alone utility systems for that data center, so it can operate independently of anything else, so that solved that problem I mentioned earlier about being scared to death that we'd lose our data center. Now we have two data centers; each one backs up one another. They're designed basically to operate twenty-four hours under any type of weather conditions. So we're able to do that. One of the things—the most efficient building is a rectangular shape, so the original plan was two rectangular shapes. Dr. Mendelsohn did not like that stark appearance—thought that we should have something that kind of signaled the fact that the Mid-Campus connected the South Campus, so we ended up with the bow shape. Some viewed it as “cutting edge technology.” Others viewed it as the gateway. So whatever your feeling is about the appearance of the building, it was the last major facility in terms of its design. Of course, the Mid-Campus was all—we bought—began buying all that land in the Mid-Campus to connect the South Campus to the main complex back in the 1990s. It was slowed during the reduction, then we picked up and—so we acquired basically a whole strip of property, worked with the city of Houston basically for the construction of Bertner, paid the electric utility to bury the electric lines through that property. So a lot of extensive infrastructure work went on, including the bridge over the bayou, which didn't exist—again, working with the city of Houston—reconstruction of all of Bertner to tie to the South Campus—all of that was both developed and planned as part of the Mid-Campus master plan.

***Tacey Ann Rosolowski, PhD***

**0:55:07.0**

Wow.

***William Daigneau, MBA***

**0:55:09.6**

So that's the story of the Mid-Campus. The Zayed Building is unique. That was the last building that was approved and planned while I was at MD Anderson. It's unique in that it's actually four towers in one building. Two of the towers are primarily office. Two of the towers are dedicated to research laboratories. You say, “Well, why have different buildings for offices than research?” Well, one of the issues that occurred—that we always attempted to do is—to lower the cost per square foot of these research buildings is you don't have the ventilation requirements in offices that you require in labs, so if you can take all the office space out of the research labs, that lowers the cost. The problem with doing that is then the researchers aren't adjacent to their labs. It's not like—I guess it's like cooking in some ways. You can't leave the kitchen. You've got to stay

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there and watch how things—so even if you want to go back and work in your office on a paper or documenting your stuff, you want to be very close to that lab all of the time. So the design of

### The Zayed Institution for Personalized Care



Zayed was basically an attempt to resolve that issue, to separate the offices from the labs but keep them very close. So basically it's a clover leaf type building pattern. You walk into a lab floor. You walk out into an office floor. So it's unique. It's the first time we attempted that.

**Tacey Ann Rosolowski, PhD**

**0:56:45.0**

And where did you come up with that design?

**William Daigneau, MBA**

**0:56:48.1**

Well, you know—over the years, we studied what everybody else was doing. We looked at everything anyone else had done. The Center for Disease Control obviously has lots of laboratories. They experimented. They did interstitial space on their buildings, so we looked at their buildings for—on interstitial design. There were some buildings where they basically created external corridors separate from the labs. We looked at those. Zayed has some of those characteristics about it. So part of our—we didn't try to reinvent the wheel. We tried to take the best practices that people had used; at the same time, we found out what didn't work—what didn't work well, so we didn't go down that road. All in an attempt to make sure—once we spent money, it was wisely spent. So when we looked at the clover leaf design, it was based on a building that wasn't the same but had certain concepts related to it. We talked to the building owners about what their experiences were, took the best from that, and created the design for Zayed.

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*Tacey Ann Rosolowski, PhD*

**0:58:05.5**

Now what was the building you were looking at?

*William Daigneau, MBA*

**0:58:08.1**

It's CDC.

*Tacey Ann Rosolowski, PhD*

**0:58:08.6**

CDC—okay.

*William Daigneau, MBA*

**0:58:12.2**

It had external corridors on it. We were really attracted to that. We thought, “Well, should we put the corridor on the outside of the building when it usually goes down the center?” Let's call it double loaded. But they used the external corridor basically to increase the efficiency of lab spaces and use it to run all the utilities through it. It was what's called a vertical interstitial as opposed to—interstitial above every floor. This building had a vertical interstitial that went on the entire face of the building, and they used it for a corridor. Ran all the pipes through it and everything. It was an interesting design. Now some aspects of it didn't work very well, so we revised the design in the Zayed to counter those negatives of it. So that's how we got Zayed.

*Tacey Ann Rosolowski, PhD*

**0:59:03.2**

Interesting.

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## **Chapter 21**

### **B: Building the Institution**

#### ***The Houston Main Building (The Prudential Building): Its Drawbacks and the Implosion***

#### **Story Codes**

- A: The Administrator
- B: MD Anderson History
- C: MD Anderson Past
- B: Institutional Processes
- A: Overview
- A: Definitions, Explanations, Translations
- C: Discovery and Success
- B: Building/Transforming the Institution
- B: Growth and/or Change
- B: Obstacles, Challenges
- C: Professional Practice
- C: The Professional at Work
- C: Controversy
- B: Critical Perspectives on MD Anderson

***William Daigneau, MBA***

**0:59:05.8**

And the last story is Houston Main Building.

***Tacey Ann Rosolowski, PhD***

**0:59:10.1**

Yeah.

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***William Daigneau, MBA***

**0:59:10.3**

Obviously that building—personally took a lot of heat on that one. If you Google my name, what will pop up is the Houston Main Building. Yeah. So here's the story of the Houston Main Building. Beautiful building. If I could—if I thought there was any way to justify keeping that building, I would have. I would have argued for it, but here's the problem with that building. A. An old mechanical system—was built in the '50s, so to reuse that building, you're faced with replacing all of the heating and cooling system. B. The exterior of the building. It was—all of the stone panels were attached with metal clips. Over the years, all those joints leaked water, rusted the metal clips. We actually had pieces of the stone fall from the building, so how do you repair that? What you do is you go in and take all of those stone panels off and replace them with something or reattach them or repair them or—very expensive work. All of those windows were steel frame windows—rusted shut over the years, costly to try to reopen. So you have to replace all of the windows in the building. So that's just starters. There was no sprinkler system in the building. It was built in an era—it was a high rise building with no fire protection sprinklers. If you had a fire in that building, you had two problems: Nothing to stop its spread, other than firemen. Now you're in the high rise, so how do you get all of those firefighters up through the building? Stairs—because it's too high for a ladder, so that means the only way to get up and fight the fire is go up the stairs. So anyway, just that one thing alone—the lack of sprinklers in the building kept me up most nights, thinking about what would happen. We had our data center there. We had lots of people in the upper floors. That always scared me—we'd get a fire—flash fire or something to that building, and we'd have fatality, because the firefighters—it would just take them too long to get into the building and try to fight the fire. So that was a problem—big problem. Then we discovered that the foundations were settling and was causing cracking of the—actually cracked the mural—the mural had to be fixed, repaired, because the mural was painted directly on plaster attached to the wall. So when the plaster cracked, the mural cracked. The floors—terrazzo floors—beautiful terrazzo floors. They all cracked. So I had a structural engineer look at it. They actually put little gages [gauges] in the basement to measure the width of the cracks, and they said if it gets to that wide, evacuate the building. (laughs) No flood protection in the building

***Tacey Ann Rosolowski, PhD***

**1:02:58.3**

(laughs) Gosh, it goes on and on.

***William Daigneau, MBA***

**1:02:59.6**

I mean, the lower the floor—the basement was used as a loading dock, so we had whole—you had a big ramp that went down to the loading dock. If the bayous overflowed, it would just flood that, and of course, all of your mechanical equipment was exposed. So all of these things combined—the floor plan was inefficient. As I said, very inefficient building because it was built

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in an era where for an insurance company—where they weren't concerned about efficiency. Construction costs were low. Energy costs were low. Who cares? So all of these factors—the settling foundations, the condition of the exterior, the aged mechanical systems, the inefficient—all of these factors said—we had that building studied by three different groups. The conclusion of everyone was regardless of what the critics say, even the developer came in, looked at it, and we asked him, “If you were buying this building, what would you do with it?” The conclusion was to tear it down. It just—other than for a historical reason—now they said, “Well, it was one of the first high rises in Houston.” Well, I researched that. True—outside the downtown, it was one of the first, but the building was never, never listed in any architectural texts as a symbol of something you want to—it was never said, “One of the greatest buildings ever build was the Houston—” No. You never see that in any architectural texts. The architect, while somewhat recognized, was not of the Frank Lloyd Wright caliber—was never recognized as—if the building had been designed by Frank Lloyd Wright—for goodness sakes, you'd probably want to preserve it, because it was—he was such a world-renowned architect. Not the architect of HMB. Then it wasn't—no one had—up until we decided it could serve no use or purpose, it was never listed on any historical list. I mean, it was an insurance building. Nice to see but never recognized as an architectural gem. So when you look at all the facts, there was—you weren't taking something down that was one of a kind—the only one like it or anything like that.

***Tacey Ann Rosolowski, PhD***

**1:05:38.4**

What do you think created the controversy? Why did people start coming out of the wood work and saying you have to save it?

***William Daigneau, MBA***

**1:05:44.6**

Well—and rightfully so—Houston had a reputation of not preserving any of its legacy, of just ripping everything down, so there was a sensitivity within the city of Houston itself—among certain circles that we were destroying all remnants of legacy—of the past, but though Houston's been around a long time—as a big city it wasn't, for many, many years. Galveston was bigger than Houston for many, many years until they had the flood. (laughs) So unlike the eastern cities, where there was some very, very old stuff—when you look at it, Houston Main Building was constructed in the '50s.

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***Tacey Ann Rosolowski, PhD***

**1:06:32.7**

Uh-hunh (affirmative). Not all that old.

***William Daigneau, MBA***

**1:06:33.5**

Not like it was 100 years old, you know? But there's a sensitivity there. Of course, there's also sensitivity to just preserving things for the sake of preserving things. So there's this—a certain group in any city, including Houston, that wants you to preserve it, even though the overwhelming evidence may say it was a nice building, not historically significant, the charter or constitution of Texas was not signed in this hallway. It was an insurance building, and other than a few features of it—the mural was the primary one, had no significance at all in historical, architectural—whatever. Unfortunately, it was a safety hazard that was falling apart. So the story about Houston Main Building was that in—I think it was in 2003, the state fire inspector came through and said—wrote us a letter and said, “You need to sprinkle that building. It's high rise occupancy. That building needs to be sprinkled.” I argued that we should put no more money into that building—that in fact, we should take it down, because the overwhelming evidence was that it was beyond its usable life. So everyone agreed with me—the executive, Dr. Mendelsohn. I said, “We could put another building in its footprint that's more efficient, designed for our purposes that we can use at less cost than to try to convert that building into some other use.” So the conclusion was yes. So I wrote a letter to the state fire inspection and said we would not install a sprinkler system, because our intent was to tear the building down within two years. So the clock is now ticking. When did we actually demolish the building? Not in 2005!

***Tacey Ann Rosolowski, PhD***

**1:08:49.8**

No, certainly not!

***William Daigneau, MBA***

**1:08:52.9**

So you ask me what kept me up at night? Number one was the knowledge that I had letters sitting in a file somewhere that said we were going to tear this thing down within two years and the building was still standing. So I'm—even though I had it—

***Tacey Ann Rosolowski, PhD***

**1:09:11.6**

When did it actually—was it actually imploded? Was it 2010? 2011?

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***William Daigneau, MBA***

**1:09:15.4**

In 2011. So anyway, so personally, I was—and I decided that if we didn't get the building down before Dr. Mendelsohn left, there was a chance we might never get it down.

***Tacey Ann Rosolowski, PhD***

**1:09:35.0**

Oh, wow. Yeah. So why were you not able to take it down in 2005?

***William Daigneau, MBA***

**1:09:38.3**

Like I'd said earlier, we had—first of all, we hadn't moved [the Division of Cancer] Prevention.

***Tacey Ann Rosolowski, PhD***

**1:09:42.4**

Right. Okay.

***William Daigneau, MBA***

**1:09:43.7**

We got rid of the data center. The School of Nursing built their building, so we had to wait until they built their building next door. The building was used to Health Science Center, as well. They had their data center, and they had to move their data center. So over the years, it just took us longer to get everybody out of the building—find space for where those people—HR would eventually move down to Nabisco. They used to be in HMB. My office used to be in HMB up until 2005. (laughs) The year it was supposed to come down! It took us awhile to get everybody out of that building. Part of the space was used by diagnostic imaging research—Dr. [William A.] Murphy. He had a program in there. We had to find an alternative location for them. We moved them out, eventually, to the South Campus. So it just took a long time to find alternative space to actually vacate the entire building. Steve Stuyck was one group that moved—he's on the ninth floor. We finally moved him in the Fannin/Holcombe Building. The new Pickens Tower allowed us to move Governmental Affairs out, which occupied the eighth floor. So it just took—every building that we put up, we moved somebody out of HMB, but as it took us years, basically, to create the alternative space to actually vacate the building. So—but we were finally successful, and I said, “Before I retire, if I have to go over there and knock it down myself, that building's coming down.” My fear was I would retire, a new president would come in, and the preservationists would start in on the new president, and there would be weakening of the will. We'd get stuck with trying to renovate that old building. So one of my objectives was to make sure it came down before I left, and I am proud to say we were successful.

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***Tacey Ann Rosolowski, PhD***

**1:11:49.2**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**1:11:51.3**

So that's about—I mean, there's a lot of details to go into, but we want to keep this within your maximum eight hours. (laughs)

***Tacey Ann Rosolowski, PhD***

**1:11:59.9**

(laughs) Well, there were a few other questions I wanted to ask you. Actually, do you mind if we pause just for a second? Okay, I'm pausing at five minutes after ten.

**1:12:07.4** (end of audio)

(begin audio)

***Tacey Ann Rosolowski, PhD***

**0:00:00.5**

All right. Well let me—okay, we've back after a brief break. It is about 10:12, and the last little bit of the story—the Houston Main Building is how it was actually taken down. So maybe you can talk a bit about that—whatever you want to share that's important.

***William Daigneau, MBA***

**0:00:20.6**

Well, long before Mays Clinic existed, from a Facilities Management standpoint, the right thing to do was take—eventually take Houston Main Building down. So when the Mays Clinic was planned, as well as the Duncan Cancer Prevention Building was planned, the architects were told that we were going to demolish Houston Main Building and that we needed to protect both Mays and Cancer Prevention when that day came. So distance between the buildings was a factor, utility interconnects—anything that could possibly be disrupted during the demolition of Houston Main Building was routed in a way that it would not be an issue when that day came. So there had already been forethought gone into how are we going to take that building, and how to we protect Mays and Duncan?

***Tacey Ann Rosolowski, PhD***

**0:01:26.4**

I just want to say right now (laughs) I am so impressed! You know, you said it was—this was a jigsaw puzzle, but nothing was done haphazardly. It was all planned, and this is another one of those amazing things! I mean, you hadn't even gotten the permission to take it down, but you

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were already looking ahead to taking it down and making sure that the institution and its function was preserved. So I had no idea, and I think there are a lot of people who don't understand the care and foresight with which the planning has done. I just really felt the need to say that. (laughs) Bravo!

***William Daigneau, MBA***

**0:02:03.9**

Yeah, a lot of interconnecting pieces.

***Tacey Ann Rosolowski, PhD***

**0:02:07.6**

Absolutely.

***William Daigneau, MBA***

**0:02:08.6**

So finally the day came where we able to get everybody out of the Houston [Main Building] and we could actively get approve of both the Regents and our Facility Steering Committee to demolish the Houston Main Building. Both were obtained, so both our executives as well as the Regents understood that this was the prudent thing to do, even in the face of certain criticism about it. So we got this approval, so the planning began in earnest. Now one of the issues was can we implode the building, or do we have to basically deconstruct it—dismantle it? This means cranes operating in the sky, taking the building down in reverse order in which it had been constructed. Two factors weight in on us in terms of making that decision. How long would that activity go on, and how long would it take to deconstruct it versus the dangers of imploding the building. Everyone had seen pictures on the Internet of buildings that fell the wrong way, you know? So we're careful in the selection of demolition contractor. We started actually working on that building almost two years before it was actually imploded, removing all hazardous material, like lead, asbestos, cleaning the building up, so that either—either in deconstruction or in implosion, hazardous materials would not be released into the air.

***Tacey Ann Rosolowski, PhD***

**0:03:46.9**

Who was the demolition contractor that you selected?

***William Daigneau, MBA***

**0:03:49.8**

CDI—Controlled Demolition, Incorporated. Now you say, who are they? They have done every major demolition/implosion, including old casinos in Las Vegas, old sports venues, office towers, industrial towers/parks—you name it, they have experience doing it. So we selected what we felt was one of the best in the world to work with on this demolition. They have their own structural engineering department, so they understand the structural components of the building

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and what is likely to happen when certain—where explosives should be placed, how the building will come down, so they had their own structural engineers that worked on this. They don't rely on anybody else. We had one of the best individuals personally supervise the demolition and its very complex structures involved with our projects. So I think we—we didn't pick a novice on this, you know? We had buildings that were close. Across the street from us was Texas Children's Hospital. We needed to protect them. Up the driveway was St. Luke's Hospital, the Heart Institute—we needed to protect them. So there were a lot of surrounding folks that have had an interest in what we were doing. So I—now I won't go into all of the details of the planning of it all of that, but it was extensive—talking to everybody in the Texas Medical Center, using curtains—steel mesh curtains to protect buildings, all of that, but it—in summary, what happened was we looked at both options, and we chose the implosion because of two factors. Number one was the believe of the demolition contractor that they could drop the building into its basement. In other words, directly down—collapse the building directly down on itself as opposed to falling over—and believed that was the way to do that building, and that they could do it. Secondly was implosion reduced the amount of dust in the air. Now you say, how is that possible? Because while there's a lot of dust on the day that it comes down—afterwards, it's just a pile of rubble, and that—you can keep sprayed down with water as you actually load it into dump trucks and take it off the site, so it's in wet form. Other than the one day where you have a big dust cloud, there is no dust. On deconstruction, you dust every day, because you can't spray down a tower every day, keep it wet. So you've got noise, dust, everything. As you well know, dust for cancer patients is very dangerous.

***Tacey Ann Rosolowski, PhD***

**0:07:01.5**

Yeah, as well as for patients in the entire Texas Medical Center.

***William Daigneau, MBA***

**0:07:06.0**

That's true. So for that reason, we figured if we took the building down, we'd have some dust in the air for one day—likely a weekend day, minimal amount of patients around. We could close off all our intakes for the brief period that it was actually in the air—so could the surrounding hospitals, and then we'd have minimum impact. But that doesn't make it necessarily worry free, you know? There's a certain amount of—do these people actually have—they've done the calculations correctly—and will that building fall directly straight down? So until that detonation occurs, there's always a certain amount of trepidation. So obviously I was very relieved when I watched that building fall directly down into its foundation—into its basement. So that's how it came to be.

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*Tacey Ann Rosolowski, PhD*

**0:08:06.4**

How long did it take to remove the rubble from—because I was interested in what the time comparisons were for demolishing the building—taking it down piece by piece versus dropping the building and then removing rubble from the basement.

*William Daigneau, MBA*

**0:08:20.5**

Well, it took us about—roughly to clean the site up—everything from demolition to cleaning the site up and restoring it was about six months. Now could it have been done faster? Yes, but we restricted the contractors operations basically to night time, because we were seeing patients during the day, so a lot of their activities—a number of hours they could work kind of was restricted, so it took longer because of environmental concerns.

*Tacey Ann Rosolowski, PhD*

**0:08:49.2**

Uh-hunh (affirmative). How long would it have taken if you had reverse constructed the building?

*William Daigneau, MBA*

**0:08:53.3**

Oh, it would have been over a year. Fourteen months.

*Tacey Ann Rosolowski, PhD*

**0:08:57.0**

Yeah, so it was a time and cost saver to do it this way. Yeah. Well, congratulations on that! (laughs) You could sleep well after that! (laughs)

*William Daigneau, MBA*

**0:09:08.2**

(laughs) Yeah, anyway!

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## **Chapter 22**

### **B: An Institutional Unit**

#### ***Transforming Facilities Management in Theory and Practice: Creating the Design Group, Defining Products, and Initiating the High-Performance Management Program***

#### **Story Codes**

- A: The Administrator
- B: Institutional Processes
- A: Overview
- A: Definitions, Explanations, Translations
- C: Discovery and Success
- B: Building/Transforming the Institution
- B: Growth and/or Change
- B: Obstacles, Challenges
- C: Professional Practice
- C: The Professional at Work
- C: Understanding the Institution

#### ***Tacey Ann Rosolowski, PhD***

**0:09:09.2**

That's great. Well, the next question I wanted to ask you was about how Facilities Management and Operations evolved as the department during the time you were at MD Anderson, because there was all of the expansion plus all of the complexity of the support that you began to provide, giving the new kind of approach to development and oversight that you were bringing to the institution. So tell me that story.

#### ***William Daigneau, MBA***

**0:09:37.4**

Well, as I said, when I arrived—basically there were separate groups that had a part to play in managing facilities and the campus operations. So one of my tasks, as I said, was—challenges—was basically combined all of those into a cohesive management group that would talk to one another, cooperate with one another, and try to maximum benefits to MD Anderson. So as I told you earlier, I formed—one of the first things I did was I formed what was called the Facilities Management Design Group. Their task was basically to come up with a new structure for Facilities Management. Now, I gave them certain—we worked through certain key concepts. One is what—actually wrote a paper about this called product-based management. You can look it up. You can Google it. Basically, one of the things I asked them to do was—what are our core products? In other words, what—why does Anderson have a department like us? What do they expect from us? What do we specialize in? What's our product?

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So the group came up with what we call the three core products. Basically, it was the planning, designing, construction—the creation of space, which included renovation—taking old space, making it newly adaptable, creating new space—whatever it was, space was one of our products, and that’s what they would—people would come to us for. “I need some space.” So that was one core product.

Our second core product was basically the operation and management of that space—space assignments, utilities, lights, cooling, heat, finishes—whatever it is—to keep it operational every day. Every day you come into your office, you flick on the light—it works! My computer work! It’s comfortable in here! It’s safe! I don’t feel like my life is at risk here. We have smoke detectors and fire alarms that work, and my trash is gone. The space is clean. It’s a nice place to be. That was another core product.

Another core product was all of our logistical things to make the campus work every day. “Hey, I got my mail!” You know? “Shoot, I think I need to go over and talk to so-and-so. Instead of getting in my car, trying to drive over there, find a parking spot, I think I’ll get on the shuttle bus to go see him.” All of those things that just—mail, hazardous waste, security—see a friendly face that’s carrying a revolver to protect me, you know? So all of those things that just make a campus work was one of our core products. So we had the three core products: facilities and operations, capital development, and logistical services.

So with that decided then—structurally, how should we organize ourselves? Well, one thing I’ve become a believer in—especially at the University of Rochester—was that there are different organizational models. You can read them in any text. One is along product lines. One is along geography. For example, Prudential Insurance—they had the southwest zone. They had the eastern division. They had the western division. That’s a geographical alignment. Product lines are where you basically organize yourself around your core products. I decided we would combine the two, but primarily the product alignment.

Basically to manage the capital portion of it—the space development part of it, we created what we call capital management, basically. It had a couple of different names over the years. It was basically organized—everything that had to do with the creation of space, whether it’s renovation or new construction, all building records, all space records—anything—leasing, real estate, land acquisitions—anything that had to do with creation of space was assigned to that unit.

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On the facilities and operations, this is where I kind of combine the two, because I discovered—as I said, at the University of Rochester, there’s really unique needs—different needs between a researcher and a physician. They have truly different needs in terms of space. So we basically split the facility operations side of things into two groups: One dedicated towards patient care, and one dedicated towards research. If you look at our organization, we have—now there were other parts of the mission, so I added prevention to Patient Care, and I added Education and Research. So now we have basically research and education facilities and patient care facilities, and those two groups are responsible for the day-to-day needs of space—operation for those four mission areas. So that was kind of a mix, even though they have—they share the same product line—as I said, geography was more mission division. That has worked very well over the years—created that back in ’94, and it withstood even a different vice president. (laughs) So—and then lastly, we created basically what’s called Campus Operations, which basically combined all of the logistical things—housing.

Now besides those core groups—at the time in ’94, there was one group they did report to directly. It was Campus Police. They reported directly to David Bachrach, my boss at the time. When David Bachrach left, they didn’t know quite what to do with the police, so Dr. Mendelsohn assigned it to me.

***Tacey Ann Rosolowski, PhD***

**0:16:58.5**

Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:16:59.5**

Now I did have experience at Rochester and my other campuses with managing security and police, so it wasn’t like it was something I hadn’t done before. So I was comfortable with it, and Campus Police reported to me, as well. Of course, the last group, which has a specific mission, was Environmental Health and Safety. They were always a unique product line, so we retained them as a coherent group to manage all fire safety, hazardous material management, chemical safety, radiation safety, all of those aspects that go on. So that’s—but when you look at the structure, you will see those three core services plus police. Police has now since moved from Facilities Management, but at the time I left, all the core services—with Research and Education sharing one of them—and Patient Care, and then UTPD and Environmental Health and Safety. So that was the structure.

Over the years, we continued to fine tune it. For example, Capital Management and Development—I found was getting bogged down with small, minor remodeling projects, so we reassigned small remodeling projects to the actual operations area—Patient Care and Research and Education. So you need a coat of paint, a couple of cabinets removed, a door moved—those kind of things that we’d just take care of, as opposed to going through the more extensive

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program in Capital Management and Development. But Capital Management and Development, over the years, basically has continued to—with some tweaks—for example, originally had real estate reporting directly to me. I reassigned that to Capital Planning Management. So there were some tweaks in that structure over the years, but basically it's remained intact, according to that original design.

*Tacey Ann Rosolowski, PhD*

**0:19:06.5**

What are some big lessons that you learned from reorganizing and reintegrating facilities in this way at MD Anderson?

*William Daigneau, MBA*

**0:19:17.2**

Well, the biggest barrier to really high-level performance in an organization is the organizational boundaries. It's not just the fact that the heads of those units don't talk to one another or won't share information, but everything through the organization does that.

*Tacey Ann Rosolowski, PhD*

**0:19:36.3**

Yeah, you were talking about the silos—yeah.

*William Daigneau, MBA*

**0:19:38.5**

Yeah, when I first got to Anderson, Facilities Management consisted of 500 people. When I left Anderson, we were over 1,700 just because of the growth of facilities over the years. So when the organization started getting that big—I mean—Leon Leach would often kid that my budget was larger than the gross national product of many third-world countries. (laughs)

*Tacey Ann Rosolowski, PhD*

**0:20:08.5**

Well, it's amazing, though—wait for—answering the phone. It is like a small city. It really is—and very self enclosed.

*William Daigneau, MBA*

**0:20:18.5**

Yeah, fourteen million square foot. So anyway, so—so—that's always the challenge. So the silos get—when you don't report to the same person, the silos get more rigid, you know? Because there's nobody—one person standing there, saying, "I want to hold you accountable for this." So the strength of an integrated Facilities Management function is that it reports to a single individual who sets the expectations and tone for cooperation and coordination. So whenever we're planning buildings or trying to decide how to solve a problem, all the major players

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responsible for some aspect of facilities were sitting at the same table with me. So it was a more comprehensive solution than if I had only controlled a little piece of it, where you rely on cooperation and good will. In an organization, you can rely on it, because the expectation people will share and will work together. So it really—it improves facilities outcomes by having everything under one roof, because everybody has to—nobody can say, “Well, it was so-and-so’s decision.” Oh, no! We all sat at the same table together. If you didn’t speak up, whose fault is it? So don’t blame so-and-so. So it’s that kind of reality of, “Oh, my goodness. I guess I really need to work out a better solution here.” (laughs) There’s no finger pointing happening here.

***Tacey Ann Rosolowski, PhD***

**0:22:08.7**

What were some changes that took place? You mentioned that basically the staff of Facilities Management more than tripled during the time you were there. What were some challenges that arose because of enormous growth within facilities management as well as enormous growth within the institution?

***William Daigneau, MBA***

**0:22:29.5**

Well, I think I began this interview by saying that my objective was that there would be no more than three levels between me and the customer. I was one of those levels. As the organization grew, we were unable to maintain that ratio, because the organization was getting so big. So we started getting some middle management layers in there. Frankly, if I would have stayed at Anderson, I was probably going to try to track—tackle that problem, because what happens as the organization grew was that information starts getting—you get a lot of noise in the information channels. They start breaking down, so you get less connected with your customer. So in order to combat that, you had to do more delegation, and there has to be higher levels of training and trust so that people can make decisions lower down in the organization without necessarily getting approval and that you’re comfortable making those decisions. That’s where the training comes in. So larger organizations have more complex communication problems and have to begin—in order to make sure that there is—that is remains responsive and it correctly interprets the problem and applies its best resources to solve it, you have to compensate for that—those lengthy communication channels that start occurring. I believe the solution to that is you have to have greater levels of knowledge lower in the organization, and you have to have greater delegation—more empowerment of workers to make the right call and do the right thing without it moving for various approvals through an organization.

***Tacey Ann Rosolowski, PhD***

**0:24:31.8**

Uh-hunh (affirmative). Was that something you began to do as the facilities expanded? I noticed that you had some training programs.

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***William Daigneau, MBA***

**0:24:39.6**

Yeah. We had a program called High Performance Management.

***Tacey Ann Rosolowski, PhD***

**0:24:42.6**

Tell me about that.

***William Daigneau, MBA***

**0:24:43.7**

It was basically designed to improve people's ability to basically manage themselves as well as manage others. It had a number of key components to it. One was a greater awareness of one's self—what your tendencies are, what you're inclined to do under stress—recognition that exists in every human being so that you're able to deal better with distraught people without feeling like they're picking on you. Yes, they may be upset, but there's a reason they're upset, and just like you get upset about things, there's a productive way to handle it, and there's unproductive ways to handle it. So there's—that program was basically just how to better manage one's own stress and reaction to things, as well as the recognition of when that's occurring in someone else, so that you have a more productive response to it. So what I was trying to do there was develop better levels within the organization of people that could—because of—normally when you contact facilities, something's wrong. If everything's right, you don't care. You're not getting on the phone just to say, "Hey, Facilities Management? I just want to tell you I'm feeling good today." (laughs) You never hear that. "Hello? It's too hot!" "My light bulb ain't on. It's flickering!" "There's a fire in this room." (laughs) That's when you call, right?

***Tacey Ann Rosolowski, PhD***

**0:26:29.6**

(laughs) Uh-hunh (affirmative).

***William Daigneau, MBA***

**0:26:30.1**

So by its nature of our operation, we get complaints. Something's wrong! So if you don't know how to productively deal with that kind of environment, you're going to get all flustered. You're going to get upset, and those are all—I mean—well, they're natural reactions. They're—in our business—they really don't help get to a stress relieving situation, which is to solve that problem. So I was trying to teach the organization better ways to deal with that—more productive ways to deal with that, as well how to set goals. I told you earlier that I honestly believe that management—most management is faulty in that it believes it has to set goals for people, whereas in a truly high performing organization, people will set their own goals within some structure where those goals further the interest of the organization. It's called a two-sided coin. One side of the coin is my personal well being. On the other side of the coin is the organization's

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well being. That's the two-sided coin. What you want to do is you can't split that coin, so how your goals that improve your well being also improve the well being and performance of the organization? So I was trying to give people tools of how to do that—accept their own goals but make sure that they—those goals have something to do with the interest of MD Anderson Cancer Center and specifically the Facilities Management Organization. Then there were just some basic tools about problem resolution, time management, things that have to do with productivity. How quickly do you get to a solution, and is it a good solution? How do you use your time—what we call gold coins. The story is that on the day you are born—in a bank account is deposited so many gold coins. Those gold coins are a minute—the total minutes in your life. Nobody knows how many gold coins you've got deposited, but there's a deposit there. From the day you were born until the day you die, which is when you exhaust all those gold coins, you make the daily decision about how you use that—every minute, it's a conscious decision. Now as a baby, that decision is, "I need some sleepy time!" (laughs) "I need some feeding time!" As you get older, you can make better and wiser decisions about that. What we teach is every day you start out with—well—eight hours times sixty minutes—your work day. You can make decisions on how you use every one of those gold coins. Question is: Are you using—investing them wisely? So we teach things like that. My whole objective is to try to move to improve decision making, interpersonal management relations between customers as well as with one another—the teams, team management—all of that—better throughout the organization so it was less reliant on me or my direct reports and was basically pushed down in the organization, so that was the purpose of High Performance Management—was to try to resolve this issue of the large organization—making better decisions at lower levels in the organization that were consistent with the best interest of MD Anderson, all the time.

*Tacey Ann Rosolowski, PhD*

**0:30:35.8**

When did you start this High Performance?

*William Daigneau, MBA*

**0:30:39.1**

I first—I took a course when I was at University of Rochester, and when I moved to Anderson, I believe that some of its principles definitely could benefit that organization, and so I imported it from Rochester—the High Performance Management called Integrated Management Development or something like that. It was a small consulting firm that ran the course. So I had brought them down, had them set it up, develop it for MD Anderson. We had our—it was specifically designed around MD Anderson.

*Tacey Ann Rosolowski, PhD*

**0:31:18.7**

Oh, interesting.

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***William Daigneau, MBA***

**0:31:20.1**

There's videos—there's a whole bunch of stuff to go on with it.

***Tacey Ann Rosolowski, PhD***

**0:31:23.9**

So how did you evaluate the results and how this program was having an impact on people's performance?

***William Daigneau, MBA***

**0:31:30.4**

Well, they're very big in that. You can't just—what is the return on investment in this? What we did basically was—we—you know—I mean—there's—if you know the balanced scorecard, there's four components to the balanced scorecard. One is financial. One is product. Third is process. Fourth is learning and development. So you look at your returns on four areas. Well, learning and development is how much have I invested in my people, and how much time have they invested in themselves enhancing skills? So that's one measure of it. In terms of process is efficiency. Cost per square foot. So if you look at our metrics—they still exist at Anderson. What is our cost per square foot? What is our energy—BTUs per square foot? So the ratio is efficiency based basically. On the product or customer, it's customer satisfaction. What's your scores? Are you moving up? Are you moving down? Now we used—the hospital uses—I can't remember the company that runs the patient satisfaction scores, but there's a component about the environment that we use, as well as—people get upset about that—we always send out these little—

***Tacey Ann Rosolowski, PhD***

**0:33:00.4**

How did I do kind of—?

***William Daigneau, MBA***

**0:33:01.0**

Yeah, because I expect everybody to measure customer satisfaction. I want to know—are we trending up or are we trending down? I don't care what the score is. I'm just interested in the direction of those scores. Of course, financial is always budget compliance. Finance used to create—it was plus or minus five percent was green light. We had plus or minus two percent, because how well have you been planned for the year? No, there were mitigating factors. A hurricane comes along. Hey, I missed the budget. Big deal. But I also used—besides—in terms of financial, besides the budget performance was also—it was part of goal setting—cost savings, either through revenue enhancement or through reduction in expense. Reduction in expense, dollar for dollar, drops the bottom line. Revenue enhancement may cost you more money in expense, but the idea is you're still making—there's still some contribution to the bottom line. Obviously, the biggest area of—for us—the biggest opportunity always is utility savings—

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energy savings, and patient care has been very successful in that. Fine tuning the facilities, reducing the costs. They've actually got an Energy Department award in terms of what they were doing to re-commission buildings, reducing cost—big dollars—a couple million dollars a year. So that's the biggest opportunity, but I also ask people to look at lease cost savings. Could we post audit the lease and make sure we're paying a fair amount? We generate saving there. So there are a lot of things we did over the years to try to reduce costs. My measure was always go back and look at what our cost per square foot was. Was it trending up or trending down? So that basically was our attempt to maintain highly satisfied operations at small cost. (laughs)

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## **Chapter 23**

### **A: View on Career and Accomplishments**

#### ***Gratified to Serve the Institution's Growth***

#### **Story Codes**

A: The Administrator

A: Career and Accomplishments

D: On the Nature of Institutions

A: Overview

A: Definitions, Explanations, Translations

C: Discovery and Success

B: Building/Transforming the Institution

B: Growth and/or Change

B: Obstacles, Challenges

C: Professional Practice

C: The Professional at Work

B: MD Anderson Culture

C: Patients

C: Patients, Treatment, Survivors

C: The Life and Dedication of Clinicians and Researchers

B: MD Anderson Snapshot

C: Understanding the Institution

C: Healing, Hope, and the Promise of Research

C: Giving Recognition

B: Institutional Mission and Values

B: MD Anderson Culture

B: The MD Anderson Brand, Reputation

B: MD Anderson in the Future

#### ***Tacey Ann Rosolowski, PhD***

**0:35:26.7**

(laughs) Uh-hunh (affirmative). Now when you look back at your eighteen years at MD Anderson, what are the initiatives that you set in place that you're most—you're happiest with—most contented to have seen come to their completion?

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**William Daigneau, MBA**

**0:35:46.1**

Well, on two fronts, it was obviously—I mean—anybody can build buildings. An idiot can do that. Can you build something that is lasting and works well over the long term? I spent a good portion of my career going in and fixing problems that other people had created because of lack of foresight, lack of planning, et cetera. So I personally am involved on the—on all aspects of the organization and the development of the planning side of things. That covers campus master planning, site and building planning, space planning. Once you have the space, what do you do with it? First of all, you should try to be utilizing ninety percent of it all of the time. You say, “Well, why not 100%?” Well, because ten percent of it ought to be probably be upgraded—modernized—whatever. So just like a hospital, you don’t want to be at 100% occupancy in a hospital all the time, because you don’t have an even flow of patients. All the sudden, you get an influx of patients. What do you do with them? I have no place to put them. So you have to have some vacancy just to be able to handle the highs and lows of volume all the time. Same with space.

[CLIP](#)

[A: Overview](#)

[A: Definitions, Explanations, Translations](#)

[B: MD Anderson Snapshot](#)

[C: Understanding the Institution](#)

[C: The Professional at Work](#)

*[Sophisticated Facilities Management at MD Anderson: A Square Foot of Space is About Different Users and Patient Satisfaction](#)*

**William Daigneau, MBA**

**0:35:46.1+**

You always have to have something in reserve—something held back to handle unexpected needs, unexpected growth, or to deal with modernization and maintenance and renovation. If you’re 100% full, you can never deal with those things. “Who do I move out to renovate their space?” Impossible to do. So you always hold that space. Space management is very important key to that—not let yourself get into a situation of, “Oh, shoot. I didn’t think of that.” (laughs) Well, now you’re affecting people. I used to give a course on—as I said, Facilities Management 101, 201, and 301. Facilities Management 101 looks basically at square foot—how to maintain that square foot, how do I create it—square foot. Just like in finance, it’s the—the denomination is the dollar; in Facilities Management, the denomination is the square foot. When you graduate from 101 to 201, you realize that—what a minute. What’s the square foot there for? Well, it’s for some use. It’s a hospital room. It’s an office. It’s something—it’s used by something. Well, now you say, “One square foot is not the same as another square foot.” Now we’re

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talking about different square feet. It has a different use, a different purpose. That's why you created it. Is it being used well for that purpose? Every square foot has been built for a different purpose, not just to create square feet. A lot of facilities managers say, "Oh, that's just square foot." Well, now the realization comes, "Wait a minute. I have an array of different square feet." It's like the cards in a deck. Every card has a different value. Do I want to—is my trump card an ace? (laughs) Is it a three? Different outcome! (laughs) So that's 201. When you finally graduate—when you finally get to the ultimate in your knowledge of facilities management, you realize that that different square foot is occupied by a person—a different person everywhere along the line. With people come perceptions and expectations more complex than the difference of the use now. The surgeon has a different expectation for that OR. In two different ORs, there are two different surgeons, and each of them will have different expectations. Now the complexity of that square foot just has been escalated by the variety of human beings in the world: Background, education, whatever.

So is your organization looking at square foot, types of square foot, or people? I try to push Anderson—our organization towards look at the people. The only way you can deal—you can't—if you have a standard approach per square foot—for type of square foot, you're still going to get a lot of problems, because the expectation is of the people using that space. So can we make every patient 100% satisfied? No, but our goal ought to be—Pareto's Law—probably eighty percent of them are really happy with us. We'll have to try to satisfy the other twenty percent, but probably not going to make them happy, but we definitely—our goal is eighty percent of those patients say, "This is the best thing that I've ever seen—my best experience ever." That should be our goal all of the time. Twenty percent of the value is in eighty percent of the items and eighty percent of the value is in twenty percent of the items. I figure that's our goal.

The patients are here not because of the facilities. Why do they come to Anderson? There's a doctor that knows how to treat their cancer. So physicians—I don't care what pain in the neck they might be; if we don't give them absolutely what they need, then they're not going to be able to give the best they can to the patient. So we threaten the mission of Anderson. Researchers—why did Anderson hire them? Because they believe that maybe they can unlock the secrets of this thing. So if the researcher is worrying about their fume hood or if they're safely able to use certain radioactive materials or anything related to that—why did we bring them here? Because they can't contribute—so right along the line when you start looking at people, it unlocks the secret of all facilities, and while your purpose there and what you're attempting to do and all that. So I try to teach people to look at 301. Deal with 301. When I got there, we were looking at 101. Every square foot is the same. Get in there. Wash it down. (laughs) Then 301 says, "When should I? Why should I? How do I do it?" That minimizes and maximizes—

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minimizes the impact on people and maximizes their contribution. So that was the whole goal all along the way—is to achieve that state.

*Tacey Ann Rosolowski, PhD*

**0:44:03.1**

Is there something that you wish you could have set in place during your time there but for some reason was not able to?

*William Daigneau, MBA*

**0:44:12.0**

Well, as I said earlier, there are obviously lost opportunities. Proton Facility—I wanted to move it close to the main academic—Patient Care instead of it out on the South Campus. Now in the end, it hasn't really hurt it a lot, but we have shuttle doctors back and forth and patients back and forth. There are things that obviously didn't work—to what I think would have been the maximum solution. Sequencing sometimes didn't work out. Redevelopment and Backfill is was very difficult, because it required us to vacate space temporarily to remodel it. As I said, where's the empty space to move people to, things like that. There were difficulties along the way, and there were always opportunities I thought, "Gosh, I wish I had more option than what I had at the time." But I think—the only issue that I grew to become more concerned about, especially for the structure of Facilities Management, was this issue we just talked about—the growing size of the division and problems that was starting to create in terms of decision making and response time and cooperation. The other issue that I started to deal with but had to suspend during the budget cutbacks in '08 was my—I was looking at—when I looked around at our management ranks, a lot of the people were starting to look like me in terms of age, and I became increasingly concerned that as Baby Boomers started vacating management ranks, there'd be a vacuum, and that we need to start taking steps to bring people up, identify those with management ability and interest, start developing their skills. I created what was called the Facilities Management University, which was basically an attempt to—because you have somebody—like a housekeeper. How do you know that housekeeper has more potential than—other than just doing their daily job? They may be really good with people. They may be really good planners. How can you identify that? So I worked with HR, and we actually created an aptitude test that we could give people to see if they had some aptitude towards management/supervision type skills, as opposed to just being there a long time. "Oh, I've been here eighteen years, so I ought to be a manager." That's the wrong way, you know? (laughs) You may be here eighteen years, but you have no aptitude at all—no interest in managing other people other than the money, and that's the wrong reason to come up. So I started to work on that. Unfortunately, because of the budget issues, we had to suspend that effort. I was getting closer to retirement, so I figured that was something really the next generation would pick up.

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So of all the things I look back on, other than some of the lost opportunities—because we didn't have enough options. Some of the—obviously you always look back and say, "I could have been more mature and handled this delicate situation better." There's always those, but in general I'm pretty happy that we were able to meet the needs of MD Anderson.

**CLIP**

**B: MD Anderson Snapshot**

**B: Growth and/or Change**

**C: Healing, Hope, and the Promise of Research**

**C: Giving Recognition**

**B: Institutional Mission and Values**

**B: MD Anderson Culture**

**B: The MD Anderson Brand, Reputation**

*MD Anderson Makes the Necessary Investment in Modern Research Space*

**William Daigneau, MBA**

**0:44:12.0+**

You can't understate the value of leadership. Dr. Mendelsohn had some strong feelings and a vision, and I was just happy to be part of that team that—to fill in. Is Anderson a lot bigger than it was? Yes. I think, though, size isn't important, especially going into economic. There are certain economy scales that you must achieve. Not everybody can afford a cyclotron, but you need a cyclotron for some types of research. Anderson has some of that infrastructure in place—animal research, cyclotrons, imaging equipment, specialized facilities that if somebody is going to be successful at trying to unlock some of these things, I don't think it's going to come out of a garage. I think this is so vastly complex that if you don't have certain abilities, we are not going to solve that problem. Anderson has many of those abilities now. So if anything's been achieved over Dr. Mendelsohn—that growth—besides all of the patients that were served that might not have been served, all the lives that have been saved that might not have been saved, because we were able to apply our doctors and our specialists special knowledge about these things and experience these things. It's the development of the infrastructure necessary to support very advanced research—very complex research. Anderson has that scale—ability to do that now. So I think—regardless of how you feel about the good old days or whatever, the reality of modern research is now achievable because of the growth that occurred at Anderson, and I was just happy to be able to help fulfill the physical form of that vision, but it was held by Dr. Mendelsohn.

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## **Chapter 24**

### **A: Post-Retirement Activities**

#### ***Consulting; A Book-In-Progress; an Active Outdoor Life***

#### **Story Codes**

- A: Personal Background
- A: Activities Outside Institution
- A: Career and Accomplishments
- A: Post Retirement Activities
- A: Overview
- A: Definitions, Explanations, Translations
- A: Character, Values, Beliefs, Talents

***Tacey Ann Rosolowski, PhD***

**0:50:21.6**

You're writing a book?

***William Daigneau, MBA***

**0:50:22.9**

Yes, I am! (laughs)

***Tacey Ann Rosolowski, PhD***

**0:50:24.0**

That's one of your retirement activities!

***William Daigneau, MBA***

**0:50:26.0**

Yeah, I know. Never done that! (laughs)

***Tacey Ann Rosolowski, PhD***

**0:50:28.4**

Would you like to tell me a bit about that? (laughs)

***William Daigneau, MBA***

**0:50:30.5**

Never done that one. What I have to do is get in the discipline of sitting down and working on it.

***Tacey Ann Rosolowski, PhD***

**0:50:37.3**

What are your plans for it, though? How do you envision it?

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***William Daigneau, MBA***

**0:50:40.6**

Well, it's—I have a small consulting practice I call 3P Management Consulting, and I don't—I'm trying not to do a lot of that, because obviously I retired for certain reasons, and I don't need to go back to work full time, running around the country, but I have a small consulting practice, and I called it 3P because I finally came—after forty-some years to understand that our management practices are faulty, because we look at the functions of management. You say, “Well, what are the functions of management?” Well, in business school, they teach you they're planning, directing, controlling, organizing, staffing—there are various functions that go on. So if you look at any manager—they do those functions—different ones at different points in the day or week or month or year, but somewhere along the line, they're going to be involved in giving some direction—providing direction, organizing things, picking people—the staff. They all do this. Most management practice looks at those functions. I finally realized that—so when you read books—they're always—they talk about how you can improve planning. Leadership is providing better direction with a vision. All these—they focus on the functions—each of the functions. In practice, though—in practice, though, what makes a cake a cake?

***Tacey Ann Rosolowski, PhD***

**0:52:18.1**

People eat it. (laughs)

***William Daigneau, MBA***

**0:52:20.6**

People eat it. It's a physical form. It's a finished product, isn't it? Now there's only one person who really cared about the ingredients, and that was whoever baked the cake. So I don't care what the list of ingredients are; if you don't put those ingredients together, you don't get a cake! So in management, if you don't put all those functions together in some form, you don't get an organization that performs. So in the case of management, what are the ingredients? It's not planning. It's not directing. It's not organizing. Those are how things are combined, but that's not the ingredients. What are the ingredients to a high performing organization? Three P's. You have to have a product. You have to have some processes to develop that product. You have to have people that function in those—deliver those processes. Those are the ingredients. So if you don't know how to identify and manage those three P's, you'll never get the cake—ever. I don't care how good you are in planning, how good you are in staffing—if you don't bring those three together, you don't have a cake. So my book is called *The Three P's of Management*. Three sections on it: The product, the processes, and the people. It's going to be a simple book, because obviously people have written tons of books on process management. I'm not going to talk about that. I'm going to only talk about a few things in process management that are key that you as a new manager need to be aware of. That's all you need to know. Now if you want more information, take a course in industrial engineering. (laughs) If you're not aware of those basic

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principles of process management, you're going to have problems, and that's all I'm going to write about.

***Tacey Ann Rosolowski, PhD***

**0:54:37.1**

How long have you been thinking about that book?

***William Daigneau, MBA***

**0:54:39.0**

You know, over the last couple of years, it kind of crystallized—to me—because I spent forty years reading books on management and tried just about everything, and why can't I consistently get—in the last years at Anderson, I finally saw the Facilities Management organization really performing at a high level without me. I mean, they were doing the right things well, and it was like all of the sudden, the whole thing comes together, so I looked back and said—and one of the critical things I—"How did this happen?" (laughs) I finally decided—without necessarily understanding what I was doing, I was focusing—when I started with the organization, I focused on product. Remember I told you—around the core products. We defined those products. I had everybody in the organization—there were 140 products that we delivered every day along three core product areas. So I defined the product. Everybody then could see the product. It's physical. It's real. It's not nebulous. It's not "a service." It's a real thing that's delivered every day. Then I focused on the processes. I told you about the emergency plan. That took many years, but that process that you go through in an emergency is sound now. It is—it works. It's been tested. It works. That's the whole process of emergency management. Work receipt and processing. We had what was called the Facility Asset Request—the FAR. It works well. It's a defined process. People used to complain—another form to fill out. You don't hear that anymore. It works! I can do it online! (laughs) There's a process here. It goes to the executive vice president, and the executive vice president says okay. It goes to the facilities. They say okay. Money is allocated. I get it done. If it's not okay, then you have to deal with the executive vice president. Don't talk to Facilities Management. We did our part! It works. It's a good process. It works fine. So I realize I spent eighteen years designing these processes and putting them in place. Then the people. I got good people—some I inherited, some I recruited, some they recruited. Basically a great group of people. They know their jobs well. They know what the mission of the division is. It works. So I tried to think, "Was there any other thing that—?" I could not come up with one. Those three things—and I finally realized it was those three things combined that made that cake. I said, "I'm going to write a book!" (laughs)

***Tacey Ann Rosolowski, PhD***

**0:57:59.3**

(laughs) Yeah. Well, that's the key thing—to discover you have something to say. (laughs)

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*William Daigneau, MBA*

**0:58:05.7**

To do it. I've got a publisher for it.

*Tacey Ann Rosolowski, PhD*

**0:58:08.6**

You have one?

*William Daigneau, MBA*

**0:58:09.9**

Yeah. They want a schedule from me now.

*Tacey Ann Rosolowski, PhD*

**0:58:12.6**

Oh, yeah. Well, that's going to keep you honest! (laughs) That's going to make you do it! That's good. Congratulation on that.

*William Daigneau, MBA*

**0:58:20.6**

Thanks.

*Tacey Ann Rosolowski, PhD*

**0:58:24.4**

What else are you doing with your retirement time?

*William Daigneau, MBA*

**0:58:27.6**

Well, I tell you—some people are not ready for retirement. Others are. I've decided that there's two types of people. There's people whose job is their life. There's people whose—their job is part of their life. I'm in the latter group. My job was part of my life, but it was not my life. An important part—whatever, but not my life. My life consisted of many other things I'm interested in, so I'm using retirement, because my boss, Leon Leach—I threatened retirement when I was sixty-two, and he asked me to stay on to finish basically the—some of the big projects that were underway, and—

*Tacey Ann Rosolowski, PhD*

**0:59:26.3**

Why did you threaten retirement at sixty-two?

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***William Daigneau, MBA***

**0:59:27.7**

Because I wanted time. As you grow older, you realize those gold coins are—the number are less and less in the bank, and the question is, how am I going to use the remaining ones? I wanted time. It wasn't that I disliked my job; it's just that I wanted more time. So anyway—so I stayed on, obviously, but when I came to—I was obviously—sixty-six, which is the legal retirement age for Social Security—was definitely going to be my last, and I did that. So my objective is to work on those other things—what everybody calls their bucket list. I took up fly fishing. It's a thrill. I used to golf. I gave up golfing, because it just didn't—I got bored with it. I've told someone that fly fishing is sort of like golf. The equipment and the skill are important, but the difference is—it's like—from day to day, they completely redesign the golf course. (laughs)

***Tacey Ann Rosolowski, PhD***

**1:00:45.2**

(laughs) That would be interesting!

***William Daigneau, MBA***

**1:00:47.3**

Different fish, different equipment you have to use. So it is fun. I'm doing that. Obviously we like to travel. I still keep my hand in consulting work. I got my book to write. I have my grandchildren, which I love. I want to spend time—I want to show them some of the things I've learned. They have to have somebody that takes the time to show them how to tie a knot and a fishing line. So I want to spend time with them and do those things. I enjoy that a lot. So yeah, I'm using—there hasn't been a day I'd look back. I like to ski, hike—you name it. I'm an outdoors person.

***Tacey Ann Rosolowski, PhD***

**1:01:35.5**

Is there something that most people don't know about you—some interesting that you would like to share?

***William Daigneau, MBA***

**1:01:35.5**

Jeeze, I've been asked that question before. Actually, they did a profile on me at Anderson in the magazine, so you might go back and look at that again. (laughs) I think they asked that question.

***Tacey Ann Rosolowski, PhD***

**1:02:05.3**

(laughs) They did ask that question. Uh-hunh (affirmative).

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*William Daigneau, MBA*

**1:02:08.2**

When I was running marathons, nobody really knew I was running.

*Tacey Ann Rosolowski, PhD*

**1:02:14.2**

Uh-hunh (affirmative). Because you ran a lot of marathons overseas.

*William Daigneau, MBA*

**1:02:16.1**

Yeah.

*Tacey Ann Rosolowski, PhD*

**1:02:16.9**

What were some of the most interesting places?

*William Daigneau, MBA*

**1:02:19.8**

I ran most of the major marathons. I ran the San Francisco Marathon, the Disney, the New York, the Marine Marathon in Washington, DC, Chicago. I ran marathons in Houston, New Orleans—most of the US—the big ones. I ran the New York Marathon two years before 9/11. We had dinner in the World—what was it—Windows on the World at the top of the World Trade Center. I ran the Marine Marathon the Fall of 9/11 when they decided to go ahead with the marathon. We ran by the Pentagon where it was still damaged from the—people would stop midstream in the marathon—forget your time and would say a remembrance or a prayer at that site. Washington, DC looked like a battle zone with gun emplacements. DCA was closed at the time. It was dark—helicopters in the air. It was really a memorable—in a bad way, but really a memorable experience. Then of course I decided we'd combine sight-seeing with marathon running, so I did the Paris Marathon, the Berlin Marathon, the Rome Marathon.

*Tacey Ann Rosolowski, PhD*

**1:03:54.3**

Why did you take up marathon running?

*William Daigneau, MBA*

**1:03:56.1**

Well, it was a funny thing. My daughter had graduated from college—my oldest daughter. She went to work for a consulting firm in Houston, and one day she says to me, “Hey, dad. I’m going to run 10K Rodeo Run—” I think it was called—“for the rodeo. Will you come and cheer me on?” I said, “Sure, I’ll come out.” So Carolyn [Daigneau] and I went out and stood on a bridge and watched her run by, and I’m standing there, saying, “Oh, this looks like kind of fun.” I had

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run all my life just to maintain some physical condition, but I'd run, like, two miles. That was about the extent of my running. At the same—about the same time, I had a friend in San Diego who ran the San Diego Marathon, and he was telling me about that. I said, "How was that?" He said, "It's tough, but you train for it and all that." He asked me, "Why don't you run with me next year? I'll send you my training program." I had seen my daughter running, and he wanted me to run. I thought, "What the heck?" I'm fifty years old.

*Tacey Ann Rosolowski, PhD*

**1:04:57.7**

Oh, wow. So you took it up at the age of fifty. Wow!

*William Daigneau, MBA*

**1:05:00.2**

Uh-hunh (affirmative). And what the heck? Never done one. Give it a try. So his training program almost killed me. So I bought a book on it—can't remember the guy's name. He's famous, though—for his marathon program, but I followed his program and ran my—ran the Houston Marathon. They say you're ready to run your next marathon when you forgot the last one. I was so sore and miserable. I said, "I'm never doing this again." Four months later, I got the hankering again. So I ended up running—I think it was sixteen or eighteen—I can't remember—marathons.

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## **Chapter 25**

### **B: Building the Institution**

#### ***The Alkek Hospital Addition: A Very Difficult Project***

##### Story Codes

A: The Administrator  
B: MD Anderson History  
B: Institutional Processes  
A: Overview  
A: Definitions, Explanations, Translations  
C: Discovery and Success  
B: Building/Transforming the Institution  
B: Growth and/or Change  
B: Obstacles, Challenges  
C: Professional Practice  
C: The Professional at Work  
C: Funny Stories

***Tacey Ann Rosolowski, PhD***

**1:05:43.7**

Is there anything else you would like to add?

***William Daigneau, MBA***

**1:05:46.5**

One parting building story, and that was the addition to the Alkek Tower. So the—Dr. Murphy said, “Tell him to tell funny stories.” This is the closest I’ve come to a funny story. So back in ’94—I told you I got to Anderson, and the major building projects—the original Alkek Tower was just starting construction. So they were putting in the foundation and the columns. By the way, Alkek is on what’s on a mat foundation—the mat that sits on is six-foot thick. The reason why it has a mat foundation is because in Houston, there is no bedrock like in New York. So they—in order to build high rises in Houston, they created a design of these very large mats that basically form—instead of piles form the basis of the foundation for high rise buildings. So as I said, my degree was in a combination of structural engineering and mechanical engineering. So I understand structural design. So I’m touring—arrived on campus, they’re starting to form the columns coming off the slab—just poured slab—the mat foundation, and they were starting to form the columns coming off that slab. I’m looking at these column forms, and I said to the guy—the Anderson guy, Gary Kimbrell, who’s running the project. I said, “Why are these columns so big? Is this earthquake territory?” Because normally you see them only that size—and Alkek was going to be basically ten stories tall for earthquake reasons—for a ten-story building? So Gary Kimbrell says to me, “Oh, no. The building has been designed to take another

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ten stories eventually.” I said, “Really?” Now the original Alkek, you have to know—the first phase of that building contained—on the third floor is all diagnostic imaging equipment—MRs. MRs are very sensitive to vibration. Obviously you don’t want a lot of shaking going on in the building, that’s why most MRs on the ground floor, because the higher up you go in the building, the more it shakes and the more it interferes with the operation of the imaging. On the fifth floor is all of the main operating rooms of MD Anderson that used advanced robotics and equipment—all of it extremely vibration sensitive. Well, when I arrived at Anderson, I knew enough about this building and what was going in it to recognize that if you attempted to add ten more floors on an existing building containing your ORs and all of your sensitive laboratory medicine equipment as well as imaging equipment, that that was going to be nightmare—constructing ten more stories. So at the time, I said to Gary Kimbrell, “I pity the poor son of a gun who is given that assignment to add ten more stories to this hospital!” If it had been up to me, I would have built all twenty stories at the same time and just shell the top ten. He laughed, and he said, “Yeah, I agree with you.” But goes to show you the inexperience of the original planners, because they had never constructed anything, so they thought, “Well, we’ll just put in these foundations, and we can always add on later,” not knowing how difficult that was going to be.

So fast forward—I’m still at Anderson. Up until Anderson, I had only stayed at most places seven or eight years. Basically, I got to a point where I wanted new challenges. Well, I’m still at Anderson at seven or eight years. Ten years, I’m still at Anderson. Twelve years, I’m still at Anderson. All of the sudden—oh, my goodness. How are we going to increase the number of hospital rooms? So I told everyone this story about—that was the stupidest thing to ever do—build a hospital with foundations for ten stories when you could never build on. So everyone was aware of that story. So I went to a Facility Steering Committee with our agenda. At the end of the Facility Steering Committee, Dr. Mendelsohn turns to me and said, “Bill, I’ve been talking with Dr. Burke here, and I know you’ve been working with him to look at options to increase inpatient care, but we kind of feel that probably the best choice right now is to go ahead and add those ten stories to Alkek.” (laughs)

***Tacey Ann Rosolowski, PhD***

**1:11:38.2**

(laughs) What you had—must been the early 2000s.

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***William Daigneau, MBA***

**1:11:38.2**

But—so I tried to explain to him the difficulty of doing that, and of course, he had great confidence in me by then and said, “Well, go ahead and work through some of these issues and bring them back to us.” So we actually went out—well, we hired a vibration consultant, because I was afraid—in the process of pouring concrete and erecting steel would shake the building. So we hired a vibration consultant. This guy came out of California, had done work for primarily the high-tech chip makers, where they have these clean rooms and vibration—because they work with very small pieces. He had a great resume in terms of vibration studies, brought them out—actually came out to look at the hospital. We’re standing there—after I even looked at his resume, he said, “Jeeze, I’ve never done a hospital before.” (laughs) There was nobody any better. Nobody had ever faced this issue before in terms of healthcare, so it’s not like there was 100 consultants in vibration analysis on existing structure.

***Tacey Ann Rosolowski, PhD***

**1:13:01.5**

Who was the consultant?

***William Daigneau, MBA***

**1:13:02.4**

I can’t remember his name. But anyway, we put all these sensors throughout the building. They had what they called thumpers. They put them on the top of the columns of the building, and they basically bang, and we scheduled that with—coordinate that with Anderson staff when the best time to do this thumping was—surgery and all that. Measured all the vibrations through the structure. To my dismay, he concluded that we could do it. (laughs)

***Tacey Ann Rosolowski, PhD***

**1:13:38.2**

(laughs) Sorry! I don’t mean to laugh.

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***William Daigneau, MBA***

**1:13:41.5**

So next then was—we're lifting steel and concrete above an existing hospital, and you drop a load of steel, rebar—goes right through the roof like a spear, so we had to develop a plan—a safety plan of how we were going to lift things—how we were going to protect the existing building. Then there was the—the original Alkek—the idea was—they left—there was a vacant elevator shaft in the original Alkek designed where a tower crane would go up to it. Well, that's great. How do you get the tower crane in there? You have to lift sections of—you've seen tower cranes. They have the big box shape—steel box shape. You have to lift those sections up to the top of the roof, and then lower them down inside the building. So we had to work all of that out, brought one of the largest crawler cranes in the world on site to lift the sections of truck—tower crane into place.

***Tacey Ann Rosolowski, PhD***

**1:14:55.4**

What's a tower crane?

***William Daigneau, MBA***

**1:14:58.1**

It's a crawler crane.

***Tacey Ann Rosolowski, PhD***

**1:14:59.5**

Oh, crawler crane.

***William Daigneau, MBA***

**1:15:00.5**

Yeah, it's basically—has the big treads on it.

***Tacey Ann Rosolowski, PhD***

**1:15:03.2**

Oh, right, right.

***William Daigneau, MBA***

**1:15:05.7**

It looks like this. So yeah—the world's largest sitting in front of Alkek to lift this thing into place. All right. You say, "Well, that's great, but now you've built up a building that's now twenty stories tall. How do you get the thing out?" (laughs) So we worked through all those issues—every one of them—painstakingly worked through every issue. I finally went back—again, to my dismay—to Dr. Mendelsohn, to the Facility Steering Committee and said, "Well, we can do it." So that led to another—doubling the size of the Alkek Hospital.

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*Tacey Ann Rosolowski, PhD*

**1:15:49.1**

Uh-hunh (affirmative). How long did that project take?

*William Daigneau, MBA*

**1:15:50.4**

That was about two years.

*Tacey Ann Rosolowski, PhD*

**1:15:52.4**

Oh, so that's actually—for all the details you needed to work out—

*William Daigneau, MBA*

**1:15:55.6**

Well, that's after all those details—those details took about a year to work out.

*Tacey Ann Rosolowski, PhD*

**1:16:01.4**

Okay, so it was like a year for details and then a year to actually construct?

*William Daigneau, MBA*

**1:16:04.5**

Yeah.

*Tacey Ann Rosolowski, PhD*

**1:16:09.5**

Well, I'm glad you added that story.

*William Daigneau, MBA*

**1:16:11.1**

Yeah, that was my funny story.

*Tacey Ann Rosolowski, PhD*

**1:16:13.4**

That was your funny story.

*William Daigneau, MBA*

**1:16:14.2**

And I tell people, "That's the penalty of hanging around too long."

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*Tacey Ann Rosolowski, PhD*

**1:16:20.6**

(laughs) Well, is there anything else that you'd like to add?

*William Daigneau, MBA*

**1:16:23.2**

No, I enjoyed talking with you.

*Tacey Ann Rosolowski, PhD*

**1:16:25.3**

I enjoyed it, too.

*William Daigneau, MBA*

**1:16:27.7**

You're a very good interviewer.

*Tacey Ann Rosolowski, PhD*

**1:16:28.8**

Thank you. Thank you.

*William Daigneau, MBA*

**1:16:29.9**

I enjoyed having you up here in the ski resort.

*Tacey Ann Rosolowski, PhD*

**1:16:32.2**

Oh, it was my pleasure—even got my fix for snow! (laughs)

*William Daigneau, MBA*

**1:16:37.2**

(laughs) Yeah, I'll get your picture!

*Tacey Ann Rosolowski, PhD*

**1:16:38.5**

Well, thank you very much again, and it's been really a pleasure talking to you. As I said earlier, I think this is really an interesting and important addition to the interview collection, because I don't think people—like most people, they don't think of it until there's a complaint, and then they call someone—most people look at MD Anderson and they don't think about—what's the process that brought these buildings into existence and all the services that keep it running and key all of those have been to allowing the people there to serve the mission of the institution. This has really been a great perspective to add. Thank you so much.

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***William Daigneau, MBA***

**1:17:15.3**

You're welcome.

***Tacey Ann Rosolowski, PhD***

**1:17:16.9**

I'm turning off the recorder at 11:30.

**1:17:20.8** (End of Audio Session Two)