

# **Janet M. Bruner, M.D.**

Interview #17

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## **Janet M. Bruner, M.D.**

Interview #17

### **Interview Profile**

#### **Interview Information:**

Two interview sessions: 4 June 2012, 7 June 2012  
Total approximate duration: four hours  
Interviewer: Tacey A. Rosolowski, Ph.D.

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

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#### **About the Interview Subject:**

Diagnostic neuropathologist Janet M. Bruner, M.D. (b. 1949, East Liverpool, Ohio) joined the MD Anderson in 1984 as a faculty associate in the Department of Pathology and was promoted to assistant professor in 1985. She is a full professor in that department and since 1994 has also held a joint appointment in the Department of Neuro-oncology. Her clinical interests focus on brain tumor neuropathology, molecular diagnostics, and molecular genetics. Dr. Bruner served as Chair of the Department of Pathology for 12 years –the first woman chair of a clinical department at MD Anderson (appointed in 1998). She has been Deputy Head of Pathology and Laboratory Medicine since 1998.

#### **Major Topics Covered:**

Personal and educational background

Overviews of pathology and neuropathology, approach and practice in team settings

Research: molecular genetics

MD Anderson Neuropathology Laboratory: operations

Developing the MD Anderson Tissue Bank

The Department of Pathology, subspecializing

The Department of Hematopathology

Women and leadership at MD Anderson

Growth at MD Anderson, financial challenges, cultural change

**University of Texas MD Anderson Cancer Center  
Making Cancer History Voices® Oral History Project**

**Research Medical Library: Historical Resources Center**

ORIGINAL Interview Profile: Dr. Janet M. Bruner, M.D.

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

Date revised: 15 July 2014

This four-hour interview of Dr. Janet M. Bruner, M.D. (b. 1949, East Liverpool, Ohio), is conducted in two sessions in June of 2012. Tacey A. Rosolowski, Ph.D. is the interviewer. Dr. Bruner is a diagnostic neuropathologist who joined the MD Anderson in 1984 as a faculty associate and was promoted to assistant professor in 1985. She was chair of the Department of Pathology for 12 years –the first woman chair of a clinical department at MD Anderson (appointed in 1998). She has been Deputy Head of Pathology and Laboratory Medicine since 1998. She holds the Ferenc and Phyllis Gyorkey Chair for Research and Education in Pathology and, since 1994, has also held a joint appointment as a Professor in the Department of Neuro-oncology. The interview takes place in Dr. Bruner's office in the Department of Pathology on MD Anderson's Main Campus.

Dr. Bruner earned her B.S. in Pharmacy in 1972 at the University of Toledo, Ohio. She continued at that institution to earn her M.S. in Pharmaceutical Sciences in 1974 and also attended the Medical College of Ohio, Toledo, receiving her M.D. in 1979. A Fellowship in neuropathology at the Baylor College of Medicine brought her to Houston (1982- '84). Dr. Bruner has been named one of "America's Top Pathologists" in 2007, 2008, and 2009; in 2009 she received the Business and Professional Women of Texas Award from the Texas Federation of Business and Professional Women's Clubs.

In this interview, Dr. Bruner offers a detailed look at the neuropathologist's practice and into the operation of the Neuropathology (and general pathology) laboratories at MD Anderson. She discusses the evolution of her career path into administration and leadership development, and covers initiatives she undertook to build neuropathology (and support quality pathology practice in general) at MD Anderson. Dr. Bruner is candid and detailed in her explanations. Her down-to-earth approach to complex institutional question makes for a very enlightening interview.

## **Janet M. Bruner, M.D.**

Interview #17

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## Janet M. Bruner, M.D.

Interview #17

### Segment Summaries

Interview Session One: 4 June 2012

Segment 00A  
*Interview Identifier*

Segment 01  
*Neuropathology and MD Anderson's Neuropathology Services*  
A: Overview

Story Codes  
A: Overview  
A: Definitions, Explanations, Translations  
A: The Researcher  
A: The Clinician  
B: Institutional Processes  
B: Devices, Drugs, Procedures  
B: Institutional Mission and Values  
B: Devices, Drugs, Procedures

Dr. Bruner begins the first segment with a brief overview of her field and clinical service. Few patients know what a neuropathologist does (even physicians can be unclear on the role). Dr. Bruner defines neuropathology and explains the neuropathologist's activities and contributions to a patient's diagnosis and care. She also describes the organization of MD Anderson's neuropathology services, noting its strengths, some of the analyses performed (including a rapidly developing area of immunohistochemistry testing and gene-sequencing), and the methods of its accreditation.

Segment 02  
*The Young Scientist and the Pathologist's 'Eye'*  
A: Educational Path

Story Codes  
A: Personal Background  
A: Professional Path  
A: Inspirations to Practice Science/Medicine  
A: Influences from People and Life Experiences  
A: Overview  
A: Definitions, Explanations, Translations  
C: Professional Practice  
C: The Professional at Work



In this segment, Dr. Bruner sketches her love of science and her educational path. She notes her love of mysteries as a young person, and draws an analogy to pathologist as a detective solving the mystery of tissue. She traces her path to a pharmacy degree and then to medical school (as opposed to graduate school), explaining how she discovered pathology in her second year of medical training at the Medical College of Ohio, Toledo. She gives a very complete definition/description of a pathologist's "eye," on which good diagnostic capabilities rely. Dr. Bruner observes that today she sees fellows struggling to develop this "eye" –some are able to develop it, others are not.

### Segment 03

#### *In Medical School*

A: Educational Path

#### Story Codes

A: Personal Background

A: Professional Path

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: Overview

A: Definitions, Explanations, Translations

This segment begins as the Interviewer recaps Dr. Bruner's educational track, providing institution names and dates. Dr. Bruner then explains the professional and personal reasons why she left Toledo for a medical school in Ann Arbor, then returned to study at the Medical College of Ohio. She covers her experiences in a unique, year-long student clerkship at the latter institution, and offers a moving anecdote about performing an autopsy on an elderly man who had been stabbed seventy times, an experience (among many) that convinced her she did not want to enter forensic pathology, as she first thought she might.

### Segment 04

#### *Discovering Neuropathology and Houston*

A: Joining MD Anderson/Coming to Texas

#### Story Codes

A: Personal Background

A: Professional Path

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

In this segment, Dr. Bruner covers her decision to specialize in neuropathology, a decision that brought her to Houston to study at the Baylor College of Medicine. She flourished in her program, however she recalls that the process of moving to Houston from the mid-west was "just awful." Though she and her husband, Charles, had no intention of staying more than two years, they came to love the city.

### Segment 05

#### *Practicing Pathology at MD Anderson*

A: Professional Path

Story Codes

A: Professional Path

C: Evolution of Career

A: Joining MD Anderson

D: The History of Health Care, Patient Care

A: Influences from People and Life Experiences

A: Experiences re: Gender, Race, Ethnicity

A: Definitions, Explanations, Translations

B: Institutional Processes

B: Obstacles, Challenges

B: Institutional Politics

B: Controversy

In this segment, Dr. Bruner traces how she became a faculty associate at MD Anderson in 1984 (becoming an assistant professor in 1985). She had already become familiar with MD Anderson's electron microscopy service while at Baylor, working closely with Dr. Bruce Mackay (and she almost specialized in electron microscopy). Dr. Mackay helped arrange for her faculty associate position, during which she divided her time between general pathology and neuropathology (she was the only neuropathologist on staff). She was very impressed with MD Anderson pathologists, who "loved to practice," and she compares the collegiality and the unique work ethic in the pathology lab with others she had experienced. Dr. Bruner recalls two memorable cases from this period, when she had to overturn pediatric diagnoses made by senior physicians much less experienced with neuropathology than she, and notes that Dr. Batsakis eventually required that she see all the neuropathology cases.

Segment 06

*A Sketch of Pathology Research*

A: The Researcher

Story Codes

A: The Researcher

A: The Clinician

A: Overview

A: Definitions, Explanations, Translations

In this segment, Dr. Bruner briefly sketches her focus on molecular genetic research when she arrived at MD Anderson (and later the harvesting of tissue to determine how classes of invading lymphocytes might be influenced). She collaborated with researchers from other disciplines and performed studies that would have an influence on patient treatment, not merely the determination of diagnoses.

Segment 07

*The MD Anderson Tissue Bank*

B: Building the Institution

Story Codes

- B: MD Anderson History
- B: MD Anderson Culture
- C: Collaborations
- B: Building/Transforming the Institution
- B: Multi-disciplinary Approaches
- B: Growth and/or Change
- C: MD Anderson Past
- A: Contributions
- A: Activities Outside Institution
- B: Institutional Processes
- A: Overview

In this segment, Dr. Bruner describes how some MD Anderson faculty began to bank tissue – lymphoma, breast cancer, genitourinary (prostate) tissue, and some bladder cancer. She herself began banking brain tumor tissue –the origin of the Brain Tumor Program still in existence today. Originally, this tissue “bank” was in fact scattered among different researchers’ laboratories and continued to be scattered, though the records were centralized in 1998. (Dr. Bruner tells an anecdote about Dr. John Mendelsohn’s attitude toward the scattered tissue repositories.) Dr. Bruner then talks her role as Consultant for Central Brain Tumor Registry of the U.S. (1996-present). One of the Registry’s tasks is to help foster accuracy of diagnosis: the reality is, the majority of diagnoses of brain tumors around the country are done by general pathologists. The Central Brain Tumor Registry uses data from other registers to track trends in how cancers are interpreted. In cases of multiple mistakes, it creates systems to clarify the evidence that a physician must consider to reach a correct diagnosis.

#### Segment 08

*Few Women at MD Anderson in the early Eighties*

B: Diversity Issues

#### Story Codes

- A: Professional Path
- A: Experiences re: Gender, Race, Ethnicity
- A: Overview
- A: Definitions, Explanations, Translations
- A: The Clinician
- B: Gender, Race, Ethnicity, Religion

In this brief segment, Dr. Bruner touches on her research path, and notes the other women employed in the Department of Pathology when she arrived. She also recalls that she did not feel aware of prejudice against women at the time.

#### Segment 09

*The Neuropathology Lab in Detail*

B: An Institutional Unit

#### Story Codes

- A: Overview
- A: Definitions, Explanations, Translations
- A: The Researcher

- A: The Clinician
- A: The Administrator
- B: Institutional Processes
- B: Devices, Drugs, Procedures
- C: Professional Practice
- C: The Professional at Work
- C: Patients, Treatment, Survivors

In this segment, Dr. Bruner details the work of the neuropathology lab, which handles 70-80 thousand cases per year and processes over 1000 tissue blocks (tissue set in paraffin blocks for slicing) per day. She describes the measures taken to insure the accuracy and efficiency of the diagnoses, including the bar-coding of anything related to a sample to prevent mix-ups. The mechanization of various instruments (e.g. for staining slides) has aided in the service's speed. The laboratory also scans slides sent by other services, increasing the repository of examples that diagnosticians can use for reference. Dr. Bruner closes this section with interesting reflections on whether pathologists will eventually examine only digital images. She notes differences between the pathology image and images in radiology, and concludes that, for now, pathology is "an analog specialty in a digital world."

#### Segment 10

##### *Becoming the First Woman Chair of a Clinical Department*

- A: The Administrator

#### Story Codes

- A: The Administrator
- A: Professional Path
- A: Experiences re: Gender, Race, Ethnicity
- A: Obstacles, Challenges
- B: Gender, Race, Ethnicity, Religion
- B: Building/Transforming the Institution
- B: Multi-disciplinary Approaches
- B: Growth and/or Change
- B: Obstacles, Challenges
- B: Institutional Politics
- B: Controversy

Here Dr. Bruner talks about the process that ended in her becoming the first woman chair of a clinical department (Pathology and Laboratory Medicine) at MD Anderson. She began to build her administrative skills by attending courses in leadership. She applied for the position of Division Head when the Divisions of Laboratory Medicine and the Division of Pathology were combined. (Dr. Bruner talks about the administrative reasoning behind this move.) Given her qualifications she feels she was passed over because the selection committee "couldn't quite envision a woman division head." She notes that the Department of Pathology was in limbo while the search for the new division head and chair was in progress. She lists the qualities of MD Anderson that convinced her to stay at the institution: term tenure, the all-funds budget, the interdisciplinary integration of specialties, and the physicians who love what they are doing. When the new Division head came in, he chose her for the Chair of Pathology in 1998.

#### Segment 11

##### Administrative Philosophy

A: The Administrator

Story Codes

A: The Administrator

C: Mentoring

C: Leadership

A: The Mentor

D: On Leadership

In this final segment, Dr. Bruner reviews advice she received on how to prepare for administrative roles then speaks about her own philosophy of the administrator's role: to allow people to grow and reach their highest potential, even if that means they outstrip your own achievements.

Interview Session Two: 7 June 2012

Segment 00B

*Interview Identifier*

Segment 12

*Women at MD Anderson in the Eighties*

B: Women at MD Anderson

Story Codes

B: MD Anderson History

B: MD Anderson Culture

A: The Administrator

A: Experiences re: Gender, Race, Ethnicity

A: Obstacles, Challenges

B: Gender, Race, Ethnicity, Religion

B: Building/Transforming the Institution

B: Obstacles, Challenges

B: Institutional Politics

B: Controversy

D: On Texas and Texans

Dr. Bruner begins the second interview session with observations on women at MD Anderson. She reflects on being the first woman appointed to chair a clinical department, then notes that many women were hired during a period of expansion in the eighties. She notes that Dr. Clark's vision for the institution is still felt today and praises the system of remunerating faculty in a way that there is no financial incentive to order procedures that do not benefit the patient. She speculates on why the glass ceiling for women takes shape at the chair level and notes that woman (and men) need to think about leadership as a distinct aspect of their careers that must be cultivated like any other skill.

Segment 13

*Cultivating Leadership at MD Anderson*

B: Building the Institution

Story Codes

A: Professional Path  
C: Evolution of Career  
C: Leadership  
C: Mentoring  
D: On Leadership  
D: On Mentoring  
B: Education  
B: Building/Transforming the Institution  
B: MD Anderson Culture  
A: The Administrator  
C: Professional Practice  
C: The Professional at Work  
B: Institutional Processes

Here Dr. Bruner talks about leadership development at MD Anderson, beginning with the courses she took via the American College of Physician Executives. She notes that MD Anderson offered few opportunities for leadership training in the nineties, but that changed in early 2000, when the Office of Faculty Development hired the Executive Development Leadership Group to offer formal training. She talks about the courses offered and also describes how the pace of the first courses was too slow for MD Anderson's high speed culture where minds move quickly. She then talks about the creation of the Faculty Leadership Academy (in 2002/3) whose goal was to offer a curriculum of basic leadership principles that faculty aren't exposed to during professional training, but that are needed in most roles: supervisory skills, conflict resolution, evaluation, mentoring, hiring and firing, etc. At the end of this segment, Dr. Bruner gives an example of a departmental dilemma requiring complex skills: over the course of several years she worked to convince two faculty members to shift from the tenure pathway to the clinical pathway.

Segment 14

*The Pathology Department: Becoming Chair and a Controversial Move to Subspecialize*

B: Building the Institution

Story Codes

A: The Administrator  
A: The Leaders  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
B: Growth and/or Change  
B: Obstacles, Challenges  
B: Institutional Politics  
B: Controversy  
B: Institutional Processes  
A: Experiences re: Gender, Race, Ethnicity  
B: MD Anderson Culture  
B: MD Anderson History

Dr. Bruner begins this section with a problem she inherited as Chair of Pathology –more faculty than the workload demanded. She then discusses her controversial initiative to subspecialize the Department, a major departmental transformation and a controversial one at the time, though the aim was to align the knowledge bases of pathologists with the specific subspecialties they served. She notes the influence of an article that documented how Massachusetts General Hospital's pathology department divided into subspecialties. MD Anderson's Pathology Department was successfully subspecialized in September 1999, and Dr. Bruner sketches the process of this "great achievement" that required a lot of communication, planning, and mental preparation. She notes with satisfaction that the Pathology Department had visitors from Memorial Sloan-Kettering Cancer Center to see how MD Anderson managed the change.

#### Segment 15

Expansion and Transformation in the Department of Pathology

B: Building the Institution

#### Story Codes

A: The Administrator

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

A: Overview

A: Definitions, Explanations, Translations

B: Devices, Drugs, Procedures

B: Institutional Processes

C: Discovery and Success

In this section, Dr. Bruner first discusses other initiatives she undertook while Chair of Pathology. She notes the new computer system she selected for the Department; she authorized transcriptionists to work from home, a move that greatly improved their productivity and ability to meet the 2-hour deadline to transcribe reports. (She says that sometimes she wants to go back and change a detail in a report, only to find that it has already been transcribed.) Dr. Bruner has been Deputy Head of the Division of Pathology and Laboratory Medicine since 1998, and here she explains that her role is to serve as the Division's second in command, representing Dr. Stanley R. Hamilton, M.D., at meetings with upper administration. She then turns to changes made in the Pathology Department once the Mays Clinic opened. The Clinic spurred huge growth in the Department, since MD Anderson pathologists are very involved in providing information during treatment decisions and surgery. A frozen section room was built in the Mays Ambulatory Clinic. Dr. Bruner explains that it is so critical to locate some pathology services very close to operating rooms, so that information from intraoperative frozen sections (tissue samples frozen and analyzed during surgery) can be quickly communicated to surgeons as they work.

#### Segment 16

*Financial Stress, Satellite Services, and Changes to MD Anderson Culture*

B: Institutional Change

#### Story Codes

B: MD Anderson History

B: MD Anderson Culture

- B: Building/Transforming the Institution
- B: Growth and/or Change
- B: Obstacles, Challenges
- B: Critical Perspectives on MD Anderson
- B: The Business of MD Anderson
- B: Beyond the Institution
- D: The Healthcare Industry

In this short section, Dr. Bruner recalls the early nineties, when managed care put the institution under threat and the Department had to fire 25% of its employees (including some faculty). The notes how Dr. John Mendelsohn's reaction to the financial stress was different from Dr. Charles LeMaistre's, and Mendelsohn "exploded us out of the doldrums." She also admits to nostalgia for the smaller MD Anderson. She also has some questions about how well quality of service can be maintained at MD Anderson's satellite locations, where analyses are made by general pathologists, rather than subspecialists.

#### Segment 17

*Pathology: A Specialty Still Not Fully Understood*

B: An Institutional Unit

#### Story Codes

- B: Critical Perspectives on MD Anderson
- B: MD Anderson Culture
- B: Obstacles, Challenges
- B: Institutional Politics
- C: Understanding the Institution
- C: Professional Practice
- C: The Professional at Work

Dr. Bruner states that the administration seems not fully understand the role that pathology plays in patient care, nor the art that is involved in making diagnoses. She also talks about the culture of team work among this Pathology Department, noting again that the pathology dealing with cancer is still the most challenging. She notes differences between pathologists in private practice versus at MD Anderson.

#### Segment 18

*The Pathology Fellowship Programs*

B: An Institutional Unit

#### Story Codes

- A: The Administrator
- A: The Educator
- C: Leadership
- C: Mentoring
- D: On Leadership
- D: On Mentoring
- B: Education
- B: Building/Transforming the Institution
- B: MD Anderson Culture



A: The Administrator  
C: Professional Practice  
C: The Professional at Work  
B: Institutional Processes

In this segment Dr. Bruner talks about the growth of the Fellowship programs from 12 Fellows in 1984 to 14 Fellows in General Pathology and 15 divided among the different subspecialties –the largest pathology fellowship program in the country. Dr. Bruner describes the training of Fellows and the Department’s goal of tracking Fellows to academic practice (they fund Fellows’ research). While acknowledging that Fellows provide the Department with “cheap labor,” she says that the Program aims to fully educate them in this specialty. Fellows, she notes, add a vitality to the intellectual environment. Their training is very hands-on, and she describes the microscopes with multiple heads (two, six, eleven, eighteen) so many people can examine and discuss a sample. The Fellows carry MD Anderson’s reputation out into the world and they send cases back to MD Anderson for second opinions. She notes that the Department has an annual reunion.

#### Segment 19

##### *The Physician-Scientist in Pathology: A Challenging Career Path*

A: Overview

##### Story Codes

A: The Researcher  
A: Overview  
D: On Research and Researchers  
D: Understanding Cancer, the History of Science, Cancer Research  
C: Understanding the Institution  
C: The Life and Dedication of Clinicians and Researchers  
B: Institutional Processes  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
B: MD Anderson Culture

Here Dr. Bruner talks about the challenges to a physician-scientists in pathology. (Noting that they do not have the responsibility of being on call for patients.) She notes that there is a difference between the passion for laboratory work and an interest in thinking about problems that come up in the laboratory. The laboratory research career, she says, takes internal drive, and the Department of Pathology attempts to support those who have it with time and laboratory space. She mentions some young faculty members who have that drive and observes that all researchers need early support and mentoring to become successful.

#### Segment 20

##### *A New Department: Hematopathology*

B: Building the Institution

##### Story Codes

B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
B: Growth and/or Change

B: Institutional Processes

Dr. Bruner sketches how she worked with Dr. Hamilton to set up (in 2002/3) the Department of Hematopathology, a very unusual structure that links Lymphoma and Leukemia (and that serves 1/3 of the patients at MD Anderson.) She touches on the Department's fellowship training program.

Segment 21

*Current Administrative Appointments*

A: The Administrator

Story Codes

A: The Administrator

A: Contributions

C: Understanding the Institution

B: Institutional Processes

A: Career and Accomplishments

B: MD Anderson in the Future

C: Leadership

B: Gender, Race, Ethnicity, Religion

In this segment Dr. Bruner first talks about her new (one month) position as an Ombudsman, describing how she got the position and her role in creating a confidential environment for faculty and staff to talk about work issues before they approach Human Resources, Legal, or undertake a grievance process. She notes some of the issues that staff bring and describes special issues for the faculty. She next talks about her involvement with the Women Faculty Leadership Group and their aims to raise the profile of women and their involvement at higher levels of administration. She then speaks about her experience on the Promotion and Tenure Committee, describing the challenges of creating criteria applicable to faculty in many different fields. At the end of the interview, Dr. Bruner notes Dr. DePinho's enthusiasm and focus and her own optimism for the institution.

## Janet Bruner, MD Interview Session 1— June 4, 2012

### About transcription and the transcript

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

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

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

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

### Chapter 0 Interview Identifier

*Tacey Ann Rosolowski, PhD*

**0:00:02.9**

So we're starting, and I'm Tacey Ann Rosolowski interviewing Dr. Janet M. Bruner at the University of Texas MD Anderson Cancer Center in Houston, Texas. This interview is being conducted for the "Making Cancer History@ Voices" Oral History Project run by the Historical Resources Center at MD Anderson. Dr. Bruner is a diagnostic neuropathologist. She joined the faculty of MD Anderson in 1984. She was Chair of Pathology for twelve years and has been Deputy Head of Pathology and Laboratory Medicine since 1998. Do I have those dates all correct?

*Janet M. Bruner, MD*

**0:00:37.1**

Right.

*Tacey Ann Rosolowski, PhD*

**0:00:39.1**

Okay. And this I probably will need help with. She holds the Ferenc and Phyllis Gyorkey Chair for Research and Education in Pathology.

*Janet M. Bruner, MD*

**0:00:54.0**

Right.

***Tacey Ann Rosolowski, PhD***

**0:00:54.6**

Since 1994, she has also held a joint appointment as a professor in the Department of Neuro-Oncology. This interview is taking place in Dr. Bruner's office in the Department of Pathology on MD Anderson's main campus. This is the first of two planned interview sessions, and today is June 4, 2012. The time is two minutes after 2:00. So thank you very much for taking the time.

***Janet M. Bruner, MD***

**0:01:18.6**

Thank you.

## **Chapter 1**

### **A: Overview**

#### ***Neuropathology and MD Anderson's Neuropathology Services***

#### **Story Codes**

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

B: Institutional Processes

B: Devices, Drugs, Procedures

B: Institutional Mission and Values

B: Devices, Drugs, Procedures

***Tacey Ann Rosolowski, PhD***

**0:01:19.5**

And as I mentioned earlier, I wanted to start off by asking you for an overview of diagnostic neuropathology because I was in reading some of your background materials that you educated me that patients—that your role is really key—and all diagnostician's roles are really key to patient care, but most patients don't even know that individuals like you are working behind the scenes. So if you could, tell me what diagnostic neuropathology is as a field and how it contributes to a patient's treatment and care.

***Janet M. Bruner, MD***

**0:01:52.7**

Well, I think all of the pathologists really feel very strongly that patient treatment starts with the diagnosis—that unless you have the correct diagnosis or the most complete diagnosis, you can't—you don't know how to treat a patient. Neuropathology is really the specialty of pathology that deals with the brain, and diagnostic neuropathology obviously deals with making the correct assessment of what's wrong with the patient's brain. Here at MD Anderson, we deal mostly with tumors, so we receive biopsies from surgery that are done by neurosurgeons, brain biopsies of patients who have some problem with the brain, or some mass that's been discovered. It's our job to look at those with a microscope, assess them in every way that we know how through our professional eyes, and come up with a correct, complete diagnosis so that the neuro-oncologist and/or the neurosurgeon knows how to treat those patients going forward.

***Tacey Ann Rosolowski, PhD***

**0:02:59.3**

Now what would be a timeline? I mean, could there be a scenario when the sample is taken and in the midst of surgery you're actually doing a diagnostic look? Maybe you could give me a little bit of a sense of—

***Janet M. Bruner, MD***

**0:03:10.8**

Yeah. That's actually very common here at MD Anderson in all specialties, but it seems particularly so in brain. Our surgeons need to know the type of tumor and how malignant it is

because that's going to tell them what they need to do during surgery at the moment. So we are on call. There are four of us here at MD Anderson who do diagnostic neuropathology. One of us is on call whenever there's a neurosurgeon in surgery. When they call and say, "I have a specimen ready," we physically go to the area that is adjacent to surgery that we have for pathology, we freeze the tissue in order to make it hard so we can cut very thin slices, and then the slices are cut. They're put on a slide, they're stained, and we use a microscope to look at those slices of tissue. We can interpret that—not 100 percent, but we can get now an eighty percent, eighty-five percent, ninety percent idea of what's going on in that patient's brain at the time and give immediate feedback to the surgeon. Our goal is to do that within less than twenty minutes.

***Tacey Ann Rosolowski, PhD***

**0:04:22.7**

Wow.

***Janet M. Bruner, MD***

**0:04:23.7**

Then the surgeon can decide what to do—either stop surgery at that point if they don't feel additional surgery is going to be beneficial or proceed to take out more of the tumor or more of the tissue, and we then process it on a more extended schedule. Usually we have a diagnosis available within a couple of days—a much more complete diagnosis. Sometimes we need to do additional studies in order to tell them more, so sometimes those take an additional one or two days also, and those are studies that can't be done on the frozen basis. They take a little bit longer.

***Tacey Ann Rosolowski, PhD***

**0:04:59.5**

So you would collaborate. Are these studies that you would do here in-house in Pathology or do you—?

***Janet M. Bruner, MD***

**0:05:04.6**

Yes, they're studies we would do here. We have several different types of laboratories in Pathology that are capable of doing different diagnostic tests on tissue, and we send the tissue to whichever area we know does the test that we need. We really have a very complete diagnostic repertoire here that we really don't need to send out too much. There are a few diagnostic tests now that are patented so that we cannot do them here. They have to be done at a different laboratory, and those we send out. But just about everything else we try to do in-house.

***Tacey Ann Rosolowski, PhD***

**0:05:42.9**

And what are those—what are the areas in which you do the testing? You said there were four areas.

***Janet M. Bruner, MD***

**0:05:46.4**

No, there are many.

*Tacey Ann Rosolowski, PhD*

**0:05:48.2**

Okay.

*Janet M. Bruner, MD*

**0:05:49.0**

We do routine histology stains. We do immunohistochemistry. We do some fluorescence in situ hybridization, which we call FISH. We do—we can do electron microscopy although now—we used to do that here. Now we send it to St. Luke's because it's very expensive equipment to maintain, and our need is just not that great right now. What else do we do? We do other molecular diagnostic procedures, even gene sequencing on some of the tissue if it's necessary, and all that can be done here just in various areas of Pathology or of MD Anderson.

*Tacey Ann Rosolowski, PhD*

**0:06:34.0**

Where is this—is there a ranking system for pathology laboratories? I'm wondering if—where MD Anderson sits in terms of its ranking in efficiency and accuracy if there's something of that kind of standard that's established.

*Janet M. Bruner, MD*

**0:06:50.0**

Yeah, there are standards that are established. We are accredited by the College of American Pathologists, and our laboratory is fully accredited. Now, it's not really a ranking system. I can't tell you whether we rank first or fifth or twentieth, but really any hospital laboratory in the United States who's going to be examining patient tissue needs to have this type of accreditation, so we take it very seriously. We're accredited every two years. They come and actually send people to inspect us. It's like—people hear of the Joint Commission for Hospital Accreditation, the JCAHO, that the hospital undergoes every two or three years, but JCAHO doesn't pay much attention to pathology and labs because most of the pathology and lab people are accredited by the College of American Pathologists and they take that—they have what's called “deemed status.” So they take the—the JCAHO takes the CAP's word that they are inspecting us in a very strict manner.

*Tacey Ann Rosolowski, PhD*

**0:08:03.4**

And as Deputy Head of this department, what's your satisfaction level with its performance? Where do you feel you're very strong? Where do you feel maybe there are some areas that need to be improved?

*Janet M. Bruner, MD*

**0:08:17.2**

Actually, I'm the Deputy Head of the Division so the Division of Pathology and Laboratory—

*Tacey Ann Rosolowski, PhD*

**0:08:20.8**

And Laboratory?

*Janet M. Bruner, MD*

**0:08:21.6**

Right, and I think we're pretty strong in almost all areas. I know we have a particularly strong transfusion service and blood bank. It's just—we transfuse a lot of blood. We have our own donor services, which is really a good thing. One thing that we are developing now much more strenuously, if you will, is the molecular diagnostic and gene sequencing of tumors and tissues. That is a very rapidly developing area—the Human Genome Project and gene sequences—and we really are, I think, doing a great job. I actually think we're pretty far out at near the head of the field, but I don't think that's recognized sufficiently at MD Anderson. It's like you're never a prophet in your own land, and I think that we're doing a lot here in all areas that we just—we don't respect each other enough. I think we look outside and we see, "Oh, those guys are doing this," but we don't realize that they're way back behind the pack in a lot of other areas. I think we are really at the forefront in our molecular diagnostic testing particularly in—but we need to go further and faster, and we are. That's one that thing we're developing a lot. We do a tremendous amount of immunohistochemistry testing on tissues, and that's specifically for Pathology. Our panel of antibodies that we run for those tests is well over 300 antibodies, and it's huge compared with other places. And I think we can get just about any test in that area that we feel we need to have done. It seems like we can get it. Our technologists are very anxious to keep up at the forefront of the field, and so they tend to push us along, too.



## Chapter 2

### A: Educational Path

#### *The Young Scientist and the Pathologist's 'Eye'*

#### Story Codes

A: Personal Background

A: Professional Path

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: Overview

A: Definitions, Explanations, Translations

C: Professional Practice

C: The Professional at Work

*Tacey Ann Rosolowski, PhD*

**0:10:42.8**

Well, thank you for that. That's really useful. Would you mind now if we turn to some of your own background and journey into this field?

*Janet M. Bruner, MD*

**0:10:54.0**

That would be great.

*Tacey Ann Rosolowski, PhD*

**0:10:54.5**

Okay. Well, let's just start with some real basics. Where were you born and when? Where did you grow up, and how did you get into the sciences?

*Janet M. Bruner, MD*

**0:11:05.6**

I was actually born in East Liverpool, Ohio, which is a little town on the Ohio River right by West Virginia, and I don't remember that, of course. Then we moved to Cleveland, which I also don't remember, and the first place I remember living is Detroit, Michigan. We lived there until I was about five. My father was a Woolworth's store manager, and my mother was just a homemaker, so really no background in the sciences at all. But I do remember growing up that I was very interested in Sherlock Holmes and detective work and I think people—I've told that story before, but when I was about twelve, I saved my money for six months to buy this giant tome of Sherlock Holmes stories. It was the complete works of Arthur Conan Doyle, and I still have it. It was great! I read that book—I can't tell you how many times I read that book, and I compare that a lot to pathology because with pathology you've got a piece of tissue, and you have to use your intuition, your observation skills, and you are the detective trying to solve the mystery of that tissue and bring all of its—reveal all of its secrets and make a diagnosis. I think that's really a very good analogy for what pathologists do.

*Tacey Ann Rosolowski, PhD*

**0:12:50.8**

Do you still read mysteries?

***Janet M. Bruner, MD***

**0:12:52.5**

Not so much. I still love Sherlock Holmes, though. You know the new series—that new series on PBS that I’m watching, too. But I think growing up I was just good at biology and good at science. I really seemed to enjoy those and I think because they were very—the answer was there, if you will. It was not like literature where there may be several answers. It was—in the sciences and in math, it’s like there was one answer, so that was something that I liked. I went to pharmacy school. That’s my undergraduate degree, and the reason I did that was I was looking for something in the sciences. I was the oldest of three children, so my dad told me, “Okay, you’re going to go to college, but when you graduate you’ve got to have something you can do to make money, because I can’t support you after that.” He said, “You’ve got to have a trade.” I thought pharmacy school really fit that bill, and I was very happy with pharmacy school, but during pharmacy school I met my husband. He’s also a pharmacist. We got married, and I had decided that I wanted to go to graduate school. I talked to some people about going to graduate school, and also my husband had a hand in it because they all advised me that if I wanted to go to graduate school and be a scientist that I probably would want to do research that involved people. You know? They said, “You know, it’s all well and good to go to graduate school and do research, but if you want to get involved with people and medical research, you might as well go and get an MD because that way you would have access to the people you need to do the research, and you wouldn’t have to be asking a doctor, ‘I want to get your patients to do this research.’”

***Tacey Ann Rosolowski, PhD***

**0:15:08.2**

So you were convinced very early in that process that you did want to work with people—that you—

***Janet M. Bruner, MD***

**0:15:14.0**

Yes, I was convinced that I wanted to do research that involved human—the human condition and not just rats, or not just chemistry research in the lab. I wanted to do something that could help people more directly. So that’s what made me decide then to go to medical school rather than graduate school. At the time I thought I was going to go to medical school and get some—get a graduate degree in pharmacology, do something combining my pharmacy and medicine—I didn’t know what—and then about two years into medical school—during the second year of medical school I discovered pathology, and I just loved it. It was just—all of a sudden it was like, “Wow! This is really, really neat!”

***Tacey Ann Rosolowski, PhD***

**0:16:10.6**

What was it that so captivated you?

***Janet M. Bruner, MD***

**0:16:12.5**

I think it was the visual specimens and just the visual part of the body—the parts of the body that were really particularly interesting to me. Again, that was sort of hard science, and I realize that the people part of it is sort of softer science. I liked the hard science, if you will, a little bit better.

*Tacey Ann Rosolowski, PhD*

**0:16:37.7**

Doctor, when I was interviewing Dr. Frederick Becker [Oral History Interview] he talked about discovering at one point that he had what he called “the eye.”

*Janet M. Bruner, MD*

**0:16:48.3**

Right.

*Tacey Ann Rosolowski, PhD*

**0:16:49.2**

So you know what that is.

*Janet M. Bruner, MD*

**0:16:50.7**

Right.

*Tacey Ann Rosolowski, PhD*

**0:16:51.0**

Maybe you could give me your take on that and when you discovered that?

*Janet M. Bruner, MD*

**0:16:53.9**

Well, I’m not sure that I knew, but I do think that it’s something that people have, and I think you can train yourself. It’s sort of a power of observation, if you will, but I notice it today, and it’s very strange. A pathologist who’s got the eye or somebody who’s been doing pathology for a long time has these powers of observation that seem to be more acute than other people. I always thought everybody was like this, but when I’m driving down the street or when I’m in a car—I’m going somewhere with somebody—if a car goes by, somebody will say, “What kind of car was that,” and I know what it was just by—if I’ve just seen a corner of it or the back of it. I never knew that that was any different than anybody else until—my husband will do that, and he’ll say, “I don’t know how you can tell what those cars are. It just went by so fast. You hardly saw it.” But it’s just like I can see the part of it that tells me what it is, and I think that is part of a pathologist’s eye. I think there are pathologists also who are photographers and maybe have the same kind of eye. I’ve known quite a few pathologists who are birdwatchers, and I think it’s a similar type of thing. You see the flash of a bird, and they can recognize it because they have this observation. They work on it every day.

*Tacey Ann Rosolowski, PhD*

**0:18:34.3**

So you said that you can train your—you feel like—

*Janet M. Bruner, MD*

**0:18:37.0**

I think people can train themselves.

*Tacey Ann Rosolowski, PhD*

**0:18:39.5**

Did you work in consciously obtaining—?

*Janet M. Bruner, MD*

**0:18:41.3**

Not consciously. Not consciously, but I just think that you sort of develop that. Now, I've also known pathologists, sadly, that didn't have the eye, and I just felt so sorry for them. We'll get sometimes coming through our program—we have fellows in our program—clinical fellows. Once in a while you run into a clinical fellow that you know they're trying and trying as hard as they can. They read a lot, they look at slides, they look at cases. They try to do the best they can to do the analysis and make the diagnosis, but you realize that they just don't get it. They don't have it, and there have been some that have been so bad that you just say—I feel like saying, “How did you ever get into pathology? You just need to get out of it, because you're never going to be very good at it.” I've never said that to any of them, but there's a couple of them that I've wanted to say that to. I don't know what it is, but I think it's this power of observation or a way of looking at something visually and mentally analyzing what you see.

*Tacey Ann Rosolowski, PhD*

**0:19:59.4**

Yeah. And from what you're saying, the speed at which you can do it is quite extraordinary.

*Janet M. Bruner, MD*

**0:20:03.3**

Yes, and I think the speed develops as you have more experience. We notice that in young pathologists. Young pathologists will look at a slide, and it will take them much longer to finish a case their first year or so that they're in practice, and again, I feel sorry for them. We had a person start recently that—he was having such a hard time! He said, “Oh, this is much harder than I thought. I don't know if I can make it. I just don't know if I can make it here. We have so many cases. It's so burdensome.” And then I talked to him about a year, a year and a half later, and he felt much better about it. He said, “You know, I'm learning about the cases. I'm getting through them faster,” and that's what happens. I think that's what happens with all pathologists that we send out. We send these fellows out into the world, they'll call back, and they'll say, “Oh, I'm having such trouble here in practice! I've got so many cases. I'm here until eight-o'clock at night. I don't know what to do!” Then you talk to them a few years later, and they go, “Oh, you know, it's no problem now.” So I think people do—you get faster, and it's not carelessness. It's just that you look faster. You observe more quickly.

## **Chapter 3**

### **A: Educational Path In Medical School**

#### **Story Codes**

- A: Personal Background
- A: Professional Path
- A: Inspirations to Practice Science/Medicine
- A: Influences from People and Life Experiences
- A: Overview
- A: Definitions, Explanations, Translations

*Tacey Ann Rosolowski, PhD*

**0:21:18.3**

Just for the record I wanted to pick up or to note that you did your BS in Pharmacy at the University of Toledo in Ohio—Toledo, Ohio—and you were awarded that degree in '72, and then you got your Master of Science in Pharmaceutical Sciences also at the University of Toledo in 1974. I just noticed in my notes. It said you were the first student in this new program.

*Janet M. Bruner, MD*

**0:21:44.4**

(laughing) Right!

*Tacey Ann Rosolowski, PhD*

**0:21:44.9**

You were the only student in that program?

*Janet M. Bruner, MD*

**0:21:46.4**

Well, it was a small—the pharmacy is a small school. I think we had about thirty-five people in my class, and they had just started this master's degree program, and at the time I wasn't 100 percent sure what I wanted to do, where I wanted to go from there. So I signed up for the master's program, and I was the first person to receive this Master of Pharmaceutical Sciences at the University of Toledo.

*Tacey Ann Rosolowski, PhD*

**0:22:10.6**

That's neat.

*Janet M. Bruner, MD*

**0:22:11.4**

And then partway through that is when I decided to go to medical school, and I actually went to the University of Michigan for a year, which is only fifty miles away.

*Tacey Ann Rosolowski, PhD*

**0:22:22.0**

Okay.

***Janet M. Bruner, MD***

**0:22:22.2**

It's in a different state, but it's very close. I went there because it was a big school that was away from home. I had lived at home during my college years and then got married, and I enjoyed my time at Michigan, but it was difficult, personally difficult, because my husband had owned a business in Toledo. We moved to Ann Arbor, which is where Michigan is. It's fifty miles away. I was in medical school, which was fine, but he was having to drive fifty miles each way, and it's not like Houston. We don't drive that much in Ohio. So it was just really difficult for him to drive that way, and also we have to deal with the winter. We had a bad winter with a lot of snow and that year he ended up—one time driving home from work he had to leave his car on the freeway. He couldn't go any further.

***Tacey Ann Rosolowski, PhD***

**0:23:18.1**

Yeah. The commuting can be brutal with the weather.

***Janet M. Bruner, MD***

**0:23:20.4**

Yeah, it was.

***Tacey Ann Rosolowski, PhD***

**0:23:20.7**

And just for the record, what is your husband's name?

***Janet M. Bruner, MD***

**0:23:22.8**

His name is Charles. Charles Bruner. So we decided—the reason I didn't stay in Toledo to go to medical school was at that time the medical school was also fairly new in Toledo. I thought it would be better not to try that school, and then the further I got away from it, I realized that it's fine. Where you go to school doesn't mean as much as how you study and what you learn, so I transferred back then to the Medical College of Ohio, which is in Toledo, and finished up there.

***Tacey Ann Rosolowski, PhD***

**0:24:00.9**

And you received your MD in '79?

***Janet M. Bruner, MD***

**0:24:03.5**

Right.

***Tacey Ann Rosolowski, PhD***

**0:24:04.5**

But—and it was year two—that first year you had gotten back and were attending at the Medical College of Ohio—that you made your discovery about pathology?

***Janet M. Bruner, MD***

**0:24:12.8**

It was. It was. And in addition to that they had an option there, which really helped me a lot. They had an option of what they called a student clerkship in pathology. So you could interrupt your medical school education for a year after the second year and go for a year—spend a year in the Department of Pathology and work right alongside the first-year residents and essentially find out what it's really about. I think it was a good thing to do that—

***Tacey Ann Rosolowski, PhD***

**0:24:48.3**

Why did they do that? That seems like a very enlightened program.

***Janet M. Bruner, MD***

**0:24:51.4**

They did it. I think what they did—I think it's sort of a recruiting tool because if you think about it people who go to medical school—everybody knows what a pediatrician does. Everybody knows what a surgeon does. Everybody knows what an internist does because you see them, but no one knows what a pathologist does. So it's like, “Oh, I think I like pathology, but what do they do?” It really gave me a chance to find out what pathologists do every day and whether I thought I would like to do that and at the time—that was during the Quincy era. Remember Quincy, the medical examiner?

***Tacey Ann Rosolowski, PhD***

**0:25:27.9**

Right.

***Janet M. Bruner, MD***

**0:25:30.8**

So I really thought that I wanted to go into forensic pathology because I knew that program and I—the people who got me interested in pathology—the professors there happened to also be forensic pathologists. I thought, well, it's really interesting. You do autopsies. You do these medical examiner cases, you find out why the person died, and you're the hero! So I thought, “Oh, wow! I really want to do that!” I did this clerkship in pathology for a year and worked right alongside the first-year residents, and we did a lot of autopsies at that time. Autopsies then were a lot—seemed to be a lot more popular than they are today so we did that year—I don't know—300 or so total. There were about three or four of us doing autopsies and we were doing—at the hospital—we were doing the medical examiner cases. It's just the way they had it set up. They didn't have a separate—it's a small city, so they did not have a city morgue. They just sent them to the medical school, and the residents would do the autopsies. While I continued to enjoy that part of it, I realized that there were a couple of parts of forensic pathology that I really didn't enjoy. One of them was I realized that you would have to go to court and testify, which I did not think I was going to enjoy. The other one was that you had to detail every tiny little facet of every autopsy which was fine until I had a case—and it was so sad! I had a case of an elderly gentleman that was killed by stabbing. So somebody had stabbed this person, and I had to document, measure, and photograph every stab wound. The person had been stabbed seventy

times, and I thought, “How many times do you need to stab somebody to kill them?” It was just an example of man’s inhumanity to man, and I thought, “I don’t know how many times I can stand this.” So that kind of turned me off of forensic pathology, and the other thing was that you get the drug overdose suicide cases, so you get the body in, you do the autopsy, and the body is perfectly normal. I was very disappointed because you don’t have the answer. You have to wait for the toxicology to come back, and that may take a few weeks. So I thought, “I did this whole autopsy. I spent all my time and all my effort, and I’ve got a normal dead body here.” It was sort of frustrating. That was sort of frustrating.

*Tacey Ann Rosolowski, PhD*

**0:28:25.6**

I can see the detective in you.

*Janet M. Bruner, MD*

**0:28:27.5**

Yeah.

*Tacey Ann Rosolowski, PhD*

**0:28:28.6**

You wanted some of the mystery there.

*Janet M. Bruner, MD*

**0:28:29.8**

I want something. Yeah, I want to get something here. So I enjoyed that year—and I also did—during that year, I also got a chance to do some surgical pathology, and I could see what the pathologists were doing every day.

*Tacey Ann Rosolowski, PhD*

**0:28:41.9**

What does that mean—“surgical pathology”?

*Janet M. Bruner, MD*

**0:28:43.4**

Surgical pathology is this diagnostic pathology that we talked about, only it’s more broad. Surgical pathology means you do the diagnosis in every type of specimen, not limited only to brains. So right now I have subspecialized into brain and even further subspecialized into brain tumors, but when you start out in surgical pathology, you have to learn everything first so you can decide where to narrow your efforts. The surgical pathology is sort of where every pathologist starts who is going to do the anatomic part of pathology, not the clinical lab part. So it was a good experience, and it did convince me that I was in the right place. I went back and finished up medical school knowing that I had made the right choice.

*Tacey Ann Rosolowski, PhD*

**0:29:42.1**

And then you did your residency also at the Medical College of Ohio in Toledo.



*Janet M. Bruner, MD*

**0:29:47.5**

Right.

*Tacey Ann Rosolowski, PhD*

**0:29:49.5**

The Medical College of Ohio-Toledo.

*Janet M. Bruner, MD*

**0:29:50.5**

Yeah.

## Chapter 4

### A: Joining MD Anderson/Coming to Texas *Discovering Neuropathology and Houston*

#### Story Codes

A: Personal Background

A: Professional Path

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

*Tacey Ann Rosolowski, PhD*

**0:29:51.3**

And then you made a move and came to Houston.

*Janet M. Bruner, MD*

**0:29:55.6**

I did. I ran into—during my residency which is where people decide whether to be—whether to stay general or whether to specialize—I met a pathologist who became my mentor there, a man named Jim Harris, who was the neuropathologist at the Medical College, and I just decided that I really, really liked neuropathology as a specialty of pathology. It was if anything even more detailed than pathology and it was sort of a special—it has its own special language, if you will. The rest of pathology sort of has a general language that applies to most of the tissues, most of the specimens, most of the structures, and brain pathology is really very separate. It's described differently. It's the only place in the body where there are neurons and glia and the things that we work with every day, and it was something that I probably came out of medical school knowing very little about. I just didn't remember much about the brain, and I thought, "That's something that I need to study and know more about," and it seemed to be a very interesting part of pathology. I decided to specialize in neuropathology, and there really aren't many training programs. I can't remember how many there are—maybe sixty in the country. I chose a few to go and interview at. I knew I couldn't stay in Toledo because there was none there. I looked at a program in Cleveland. I looked at a program in North Carolina, and I looked at a program in St. Louis, which was a very good program at Washington University in St. Louis.

**0:32:01.2**

I can't even remember why I was looking at the program in Houston, because Baylor College of Medicine here had a neuropath program, and I don't know how that popped up on my radar screen, but it did. In going and interviewing at these other programs—when I came and interviewed at the one here at Baylor, I just felt like, "That's the one." It's not that the other ones treated me badly—and I got some offers from the other ones—but the program at Baylor seemed to be a little bit larger. They had—once you go into subspecialty training, instead of a resident, you become a fellow. Their fellowship program was—at the time it was a large fellowship. We had three or four fellows. I think we had three. That was a "large" fellowship. I liked the people. I was very comfortable with the people, and they had a very broad program, because it had different kinds of hospitals. They had a county hospital, a children's hospital, an adult hospital—so it was a good program. You could see different aspects of neuropathology, and that was my goal, to get the most complete training possible. At that time I wasn't yet particularly interested

in tumors, so I wanted to get complete training. We have Alzheimer's disease, we have brain malformations that occur in newborns, so there are a lot of different areas of neuropathology. We do muscle and nerve biopsies for muscle and nerve diseases. There are a lot of different types of neurological diseases that we are involved in and usually diagnose and deal with, and I was very happy with the program. It was everything I thought it would be, and the fellows that were there at the time I was there were great people to train with and had a diversity of backgrounds. We helped each other. It was a two-year fellowship.

**0:34:20.0**

*Tacey Ann Rosolowski, PhD*

**0:35:53.8**

Oh, my gosh!

*Janet M. Bruner, MD*

**0:35:54.2**

We never—we were very naïve. Of course, moving to Houston—Toledo—Houston is ten times the size of Toledo, Ohio. Our full intent was to come to Houston for two years in training and then go right back to the Midwest. We had no intention of staying here. We didn't know where Houston was. We had flown in. I thought Houston and Dallas were close together. We knew nothing about Texas. I didn't even know MD Anderson was here at the time. I'd never even heard of it! But we settled down, and at the time I was based at Methodist, which was part of Baylor at the time, and my husband also got a job at Methodist, so we would ride to work together and ride home together. We found Houston to be very large, very hot, and those were the two things we remember! After, I don't know, the first year went by—I had a great fellowship, I had a great time and by about the—was it the end of the first year? Yeah. By about—shortly into the second year of my fellowship we realized that we really liked Houston a lot, and we really didn't look forward to moving away. It was a really a good experience.

*Tacey Ann Rosolowski, PhD*

**0:37:31.6**

What had turned you around and come up?

*Janet M. Bruner, MD*

**0:37:34.5**

You know, I don't know! It was just so easy to live here—no winter. Now, we never minded the winter when we were there. We liked it. We liked brushing snow off our cars, and we liked driving in the snow. We never thought too much about it, but the first winter that we didn't have, we liked that a lot too!

*Tacey Ann Rosolowski, PhD*

**0:37:55.9**

Yeah, I hear you. I moved down from New York State, so my first winter without ice and snow was okay.

*Janet M. Bruner, MD*

**0:38:03.9**

Yeah, and if you really want that stuff, you can go back there and visit.

*Tacey Ann Rosolowski, PhD*

**0:38:07.4**

You can.

*Janet M. Bruner, MD*

**0:38:08.1**

But then you can get out of it.

## Chapter 5

### A: Professional Path

#### *Practicing Pathology at MD Anderson*

#### Story Codes

A: Professional Path

C: Evolution of Career

A: Joining MD Anderson

D: The History of Health Care, Patient Care

A: Influences from People and Life Experiences

A: Experiences re: Gender, Race, Ethnicity

A: Definitions, Explanations, Translations

B: Institutional Processes

B: Obstacles, Challenges

B: Institutional Politics

B: Controversy

*Janet M. Bruner, MD*

**0:38:08.1**

So by that time—by shortly after I got into my second year of fellowship, I was doing some research, and that was good too. I started thinking about where to get a job. Obviously, here was MD Anderson standing across the parking lot from Methodist Hospital at the time, and I had occasion to come to MD Anderson because there was—MD Anderson had a big electron microscopy service at the time. I really enjoyed—that’s another aspect of pathology that I enjoyed was electron microscopy. What it does is it allows you to see even higher magnification than you can with a regular microscope. In fact, I had even considered—before I decided for sure whether to go into neuropathology, I had even considered subspecializing in electron microscopy and doing it full time because I liked it that much, but I decided ultimately to do neuropathology because it’s what they call a “boarded subspecialty.” At the end of your subspecialty you take a board exam, then you get a certificate, and nobody can take that away from you. It means you are officially trained in that specialty, whereas electron microscopy was not at the time a boarded subspecialty. As it turns out, it never became a boarded subspecialty, and in fact it sort of waned. It was very popular at the time, and we used it a lot through the 1980s, I would say, and then with the advent of immunohistochemistry, which is this antibody technique that I talked about early on—a lot can be learned from immunohistochemistry, and with that, I think electron microscopy, which has a much more intensive equipment requirement—you have to have an electron microscope, which is so huge you almost have to walk inside of it. People have really gotten away from it now, so as it turns out I’m glad I didn’t do that. I’d probably be doing something else by now.

*Tacey Ann Rosolowski, PhD*

**0:40:26.3**

Yeah.

*Janet M. Bruner, MD*

**0:40:29.5**

Here at MD Anderson, there was a huge electron microscopy service and a world-famous electron microscopist named Bruce Mackay—that's M-A-C-K-A-Y—and I had read about him when I was a resident in pathology in Ohio. I thought, "Wow! Here he is," and in Ohio we used to call him the "god of electron microscopy." So I thought, "Wow! Here I am, not only on the same planet—I'm on the same parking lot with the god of EM," so I thought I could not leave Texas, and at the time I was interviewing for jobs. I was interviewing for a job in Pennsylvania and I interviewed somewhere else—I guess in Cleveland—for a job. I thought, "Okay, if I'm going to move away from Houston, I cannot leave without spending time at MD Anderson with the god of EM because that would be stupid." You know? Here I am! So I came over and talked to him, and he said, "Yeah, I do take people to rotate with me. You can come and spend"—I forget what I spent—I think two or three months—at MD Anderson as part of my electives doing work with him, really learning about electron microscopy from the guru. I enjoyed it a lot, and I met some of the people in the department then.

### **0:41:52.8**

In another sad story they had—at that time, MD Anderson had just recently hired its first neuropathologist. All the pathologists here were general pathologists. They were not subspecialized, but there was a growing brain tumor program here. It was just starting out. They had a couple of neuro-oncologists. They had a couple of neurosurgeons. Those people were demanding the services of a specialized neuropathologist, so the chairman at the time John Batsakis had been pressured to hire—I think it was on a full-time basis. He had been using the neuropathologists from the UT Medical School on a part-time basis over here and had just hired within the last year one of them to come over here and work full time as a neuropathologist. That person did—I think he covered the autopsy service, and he also did neuropathology and diagnostic neuropathology, which is what they wanted. Around the time or just before that I came here—it was an older gentleman, and he had had a stroke, and it was a pretty severe stroke as it turned out. He came back to work, but he was never quite the same and could never really function well. So I thought there might be a position, but I didn't know much about the politics of the department or anything about it, and at the time I was also interviewing for a job at the VA here and just looking at jobs in general.

### **0:43:36.1**

I was about ready to take that job at the VA here when Dr. Mackay said to me, "Wait a minute. I don't think you want to go to the VA." I said, "Well, I've got to have a job," and he said, "Yeah, but let me have some conversations and just hold off. Don't accept that job." Oh, I was looking at a job in Michigan, too. That was it. I'm remembering these things. It's coming back to me. I was looking at a job in Lansing, Michigan, at a private hospital there, and I had been to interview. It seemed like a good job, but Mackay knew something about the job and about the people there that I didn't really know. He had heard or knew through his associates that they weren't very good, nice people. Of course, I couldn't see that. I was a kid. So he said, "You don't want to take"—that was the job I shouldn't take. He said, "You don't want to take that job in Michigan." I said, "It looks like a good job, and it's in Michigan. I'm from Ohio." He said, "Uh-hunh (negative). Don't take that job. There's something wrong." So he talked to the chairman at MD Anderson, and they realized that this pathologist who had the stroke was probably never going to be able to effectively practice again, so they were in need of a neuropathologist. So they said, "Why don't you come on here, and you can do general

pathology, and also you can do neuropathology”—because there wasn’t enough volume at the time to support a full neuropathologist. That looked pretty good to me, but I said, “It’s been two years since I did any general pathology. I’ve been doing neuropathology for two years, so I probably need a chance to brush up.” So they said, “Okay, we can hire you as”—what they called at the time a “faculty associate,” which is a very junior faculty level person—“You can come on. You can do general pathology—sort of rotate with our fellows and brush up on your general pathology—and at the same time you’ll be our neuropathologist for whatever we need.”

**0:45:48.5**

So I thought that sounded like a good idea, and I took the job. During my fellowship I had also become very interested in tumor neuropathology, so MD Anderson was a good fit for me. I really enjoyed it. There were a lot—relatively a lot of pathologists here and everybody did general pathology. They had their special interests, but they didn’t exclusively practice that part of pathology. One thing that really, really impressed me with the pathology—with the pathologists and the department at MD Anderson was that they really—they loved pathology. They loved to practice. They could never get enough. They could never get enough cases. They just were like, “Give me more!” I’ll never forget, in some of the other places I had heard about—in some of the other places I heard people talk about—you sort of came in and did your cases, and the main object was to see how little you could do, how few cases you could do. The goal was to dodge the cases, so you didn’t especially want to do any more cases than the guy next to you. You wanted to do just as many. In fact, I even remembered seeing that in my residency—that the pathologists were very concerned that the person in the office next to them was doing as much work as they were. “Wait a minute! I’m doing more work than you are. That’s not right! That’s not fair.” And it was sort of—it didn’t seem very collegial to me, and at MD Anderson I noticed it was exactly the opposite, even when I was in that first year where I was a faculty associate. Dr. [John] Batsakis at the time said, “Be a faculty associate for a year, and then you’ll become an assistant professor.”

*Tacey Ann Rosolowski, PhD*

**0:47:54.5**

And in ‘85 you did become an assistant professor.

*Janet M. Bruner, MD*

**0:47:56.4**

Right. So during that first year I particularly noticed that the pathologists at MD Anderson—and I’ll never forget Mario Luna, who was one of our great pathologists. He was the head of the autopsy service. I’ll never forget Mario Luna walking into somebody’s office saying—seeing a huge stack of trays. We keep our slides in trays. I don’t have any in here right now, but they’re these big wooden trays. Oh, here! These.

*Tacey Ann Rosolowski, PhD*

**0:48:24.7**

Oh, yeah! Okay.

*Janet M. Bruner, MD*

**0:48:24.9**

Those big wooden trays. And this was the first place I had ever seen those trays. I was used to these little folders on the top of the desk there that hold twenty slides. That's the size I was used to working with.

*Tacey Ann Rosolowski, PhD*

**0:48:35.5**

And how many slides—?

*Janet M. Bruner, MD*

**0:48:36.6**

These hold fifty slides.

*Tacey Ann Rosolowski, PhD*

**0:48:37.3**

Wow.

*Janet M. Bruner, MD*

**0:48:38.9**

So Mario Luna walked into somebody else's office who had a stack of trays and folders on their desk, and he said, "Oh, you've got too many cases today. Let me take some of those for you and do them for you." I was like, "Oh, my god! What kind of place is this—where people like each other, and they want to help each other out?" It was just the greatest thing. That is truly an example of the way the pathologists work at MD Anderson, and I think that's what keeps us here is that we don't get the highest salaries, and we don't have the cushiest jobs, and we have tough cases, and we teach fellows, but I think what keeps all the faculty at MD Anderson is that they really love what they're doing. That's why we're here, and it doesn't matter whether you're a surgeon, whether you're an oncologist, pathologist, radiologist. If you like what you're doing, you're going to stay here. If you don't like it or if you're here for the money, then just go ahead and move on, because you're never going to be happy.

*Tacey Ann Rosolowski, PhD*

**0:49:54.8**

Was there a particularly memorable laboratory experience or case that you had during those first couple of years when you were first here at MD Anderson?

*Janet M. Bruner, MD*

**0:50:04.6**

I do remember a couple of cases, and they are probably cases I shouldn't talk about because they were sort of bad. Well, they weren't that bad. One thing that made me feel really good about being here was—I remember a couple of times—of course, most of the pathologists—should I say most? No, we had a cadre of about maybe a half a dozen quite senior pathologists who in fact—they must have been even more senior than I realized at the time because they retired within about three or four years of the time I started. So they must have been in their sixties at the time—very well known, very senior, very capable—just giants in the field. But they were all general pathologists. Now, some of them had interests in other areas. One was interested in lymphomas and leukemias. One was interest in skin pathology, and Dr. Batsakis was interested



in head and neck pathology. They all did general pathology, but then they had their interests aside from that. None of them—well, one or two of them thought they were interested in neuro, but they weren't really trained. So I'll never forget, a couple of different times during that first year or two that I was on the faculty, I was doing general pathology, so I wasn't seeing every brain tumor case. They were allowed to sign them out. They could consult me if they wanted to. The older pathologists were somewhat reluctant to consult me, but a couple of them did, and I think it was good. One time, I remember one of the very senior people called me. He was on frozen section that day and was doing one of these rapid—we actually have a person in our frozen section laboratory near surgery—adjacent to surgery. We have one pathologist—and we still do this—have one person who's there all day to do all of the frozen sections generally for everybody, and if they run into trouble or if they want help, they can call for it, and we immediately go and help them. Now, there are certain subspecialties that they don't even try. They just call immediately. Neuro is one of those, and I think it stems from way back when because this older gentleman was on frozen section that day. He was doing his routine cases, and he had this routine case that he was doing. I believe he had even made a diagnosis and told the surgeon, "It's this."

#### **0:53:09.4**

The surgeon was smart enough to realize that didn't sound right, so the surgeon said, "Can you call Dr. Bruner to look at that?" The guy wasn't too happy, but he did. I went up there and I said, "What did you tell him it was?" He said, "It was this, and I told him it was this because it looks"—he explained a couple of the features. I knew it wasn't the right diagnosis because it was a child. It was the posterior—back—part of the brain. Children just don't get that tumor very often, and they never get it in the back part of the brain. So I said, "In order to be what you called it, it has to have these two other features. Did you see those?" And he said, "Well, I didn't see those, but it had this other one." And I said, "Yeah, but that's not enough." So I looked at it, and instead of what he called it, which was the most malignant grade IV type of tumor—and in that situation the surgeon would just biopsy it and then stop because there's not more he can do. It was the lowest grade. It was a benign tumor in a child, and the goal would be for the surgeon to take it all out, and the kid would be cured. So I called in and said to the surgeon, "I think we're going to change the diagnosis to this, so take it out." And the surgeon said, "Thank you. I'm already taking it out because I sort of knew that's what it was." That would have just been a disaster. There was a similar incident, also in a child. I guess kid brain tumors are just more difficult, but I had actually been on vacation, and the pathologist had gotten this brain tumor. I'm not sure if he had already finished the case and signed it out or whether he was just working on it, but it was a similar thing. He was going to call it a lymphoma, and in a brain of a child, a lymphoma is vanishingly rare—vanishingly rare. It turned out to be another type of tumor—also a malignant tumor, but it turned out to be a medulloblastoma, which is very common—one of the most common—in a child. They do look a little bit similar. The cells of each one are pretty similar, but there are things you can do to differentiate between those, and it's a matter of familiarity. I think it just is an example of how the more you see, the more you know, and even though these pathologists had been in practice for years and years and years, we weren't doing much brain pathology here in MD Anderson. They hadn't seen much at all. They knew the basics, and they knew it superficially but they hadn't seen—even at their advanced stage of career, they had not seen as much neuropathology as I had already seen in my fellowship just having subspecialized in that. And each one of those pathologists did have a subspecialty interest

and was the best in their area, but it was sort of an example to me that you really do best in your area. Even in pathology—even in surgical pathology we are—at MD Anderson we see such difficult cases and so many of them that if you have an area that you really like and you’ve subspecialized, you do it best. So don’t get out of your area. Stick with what you know best, and that will serve you the best. I felt like those two cases—and I remember those cases, and it was like I saved them from really making some big mistakes.

*Tacey Ann Rosolowski, PhD*

**0:57:33.3**

That situation also brings up an issue that we’re going to touch on eventually which is—I mean, there’s a whole power thing going on there with this senior person and a newbie, as it were.

*Janet M. Bruner, MD*

**0:57:42.9**

Right.

*Tacey Ann Rosolowski, PhD*

**0:57:46.8**

And also the difference between a senior man and a young woman coming in, and I hadn’t asked you the question about the issue of how many women were in the Pathology Department and how you experienced being a woman there. We’ll talk about it more, but it seemed like I kind of asked the question.

*Janet M. Bruner, MD*

**0:58:02.6**

I think there was some of that. I think it was more the senior versus junior thing and they—yeah, they had egos. They had egos. I guess we all do. It’s funny. I used to—a few years later, one of the things I said was that the reason we got along so well at MD Anderson is because there’s no prima donnas in Pathology, and then I realized, “No, no, no. It’s because we’re *all* prima donnas.” So each of us has our own prima, and then we all have this big ego. I think the thing that really helped me out there was that the chairman John Batsakis was very supportive. He knew he needed a neuropathologist, and somehow he knew that I was the one he needed. He was very supportive of me from the beginning, and I think some others were sort of jealous of that. They thought he was maybe too supportive, but one of the things he did too which helped me a lot—and I don’t know if he knew about these two cases or if it’s just in general. I think he was getting some feedback, too, from the surgeons that they liked the way—they liked having me do their cases because they were very comfortable. They thought I was going to give them the right diagnosis. I think he was getting some pressure there, so he eventually made a rule that all of the neuro cases had to be seen by me, which was very good for me, and I think it was good for the patients. I’m not sure everybody liked it that much, and they did sort of resent it. There was at least one other more senior pathologist who thought he knew neuropathology, and so he didn’t really like that. But I think it was the best thing, and it meant that the cases were signed out, and the diagnoses were made in a much more consistent fashion. Obviously it was hard for me because I was the only neuropathologist here, so if I ran into trouble I didn’t have anybody with an equal skill set to show it to or any senior person to show my cases to, and we do that a lot. But I had the resources of the whole Texas Medical Center, so I could go back to Baylor and show

those people cases. They made it clear that it was perfectly fine with them, so I got help from them. We have a neuropathology group in Houston which has about a dozen—there's about a dozen of us in the city, which is fabulous. That's a big group of neuropathologists.

*Tacey Ann Rosolowski, PhD*

**1:00:49.0**

Does that have an official name?

*Janet M. Bruner, MD*

**1:00:51.5**

We call it the Houston Area Neuropathologists—HANP.

*Tacey Ann Rosolowski, PhD*

**1:00:57.2**

Area Neuropathologists—

*Janet M. Bruner, MD*

**1:00:58.2**

Neuropathologists. Yeah. I haven't actually gone to a meeting in a while, but there for a long, long time we met—and I think they still are meeting—about once a month just to share cases, which is really, really good. It's a huge advantage of being in a large city. Other than Houston, I guess Cleveland probably—Cleveland, Ohio, probably has a group, and New York City obviously has a big group of neuropathologists. Boston has quite a few of them and San Francisco, but other than that I don't think that most cities have that advantage.

*Tacey Ann Rosolowski, PhD*

**1:01:38.5**

Really that collegiality kind of spread beyond—

*Janet M. Bruner, MD*

**1:01:38.5**

Right.

*Tacey Ann Rosolowski, PhD*

**1:01:42.3**

—the individual lab.

*Janet M. Bruner, MD*

**1:01:43.8**

Yeah, because most places there's one or two neuropathologists at a hospital, so you just don't have that advantage, and here, of course, the other advantage is the medical center. We have so many people just around these series of parking lots here.

## Chapter 6

### A: The Researcher

#### *A Sketch of Pathology Research*

##### Story Codes

A: The Researcher

A: The Clinician

A: Overview

A: Definitions, Explanations, Translations

*Tacey Ann Rosolowski, PhD*

**1:02:00.6**

Would you like to tell me what kind of research you were doing when you came?

*Janet M. Bruner, MD*

**1:02:06.8**

I was very interactive with the other people in neuro-oncology and neurosurgery, and we were doing molecular-genetic research of that era, which is sort of different than it is today. Much more primitive, if you will. We were looking at different gene profiles and trying to see if we could either influence them—change the genetic profile or discover the genetic profile—to see if we could help influence the survival or predict the survival better for patients. I was working with a couple of people—the neuro-oncologists at that time—[Wai-Kwan Alfred] Al Yung [Oral History Interview] was here in neuro-oncology, and there was a young Greek oncologist named Athanassios Kyritsis—his last name is K-Y-R-I-T-S-I-S. He was doing a lot of work with us, and there was a fellow from Japan who was just doing research named—his last name was [Hideyuki] Saya, S-A-Y-A. He's since gone on to at least chair a department at a university in Japan, and I think he is even the head of a cancer center there now, so he's really done well. Dr. Kyritsis returned to Greece after several years and I've lost touch with him so I don't know—but I think he's still there in practice. I was working with Dr. Elizabeth Grimm here. We were doing some discovery on—she was doing immunology of brain tumors at the time, and we were doing stuff with that trying to harvest tissue and figure out what classes of lymphocytes were invading the tissue and see if they could be stimulated to fight the tumor cells.

*Tacey Ann Rosolowski, PhD*

**1:04:26.4**

So you were actually doing research that would have had an influence on perhaps treatment, not just on how do you differentiate cells so that it would serve you within the laboratory in the pathology context.

*Janet M. Bruner, MD*

**1:04:39.3**

Right. And both. Because that was—my interest was predominantly the tissue-based research but the type of research we were doing—the collaborations were good because I think everybody at MD Anderson is working on how do we cure cancer? So that's what we want to do.

## **Chapter 7**

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

#### ***The MD Anderson Tissue Bank***

##### **Story Codes**

B: MD Anderson History

B: MD Anderson Culture

C: Collaborations

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: MD Anderson Past

A: Contributions

A: Activities Outside Institution

B: Institutional Processes

A: Overview

***Tacey Ann Rosolowski, PhD***

**1:05:00.8**

Now, is that kind of unique to MD Anderson for that sort of collaboration to happen?

***Janet M. Bruner, MD***

**1:05:05.5**

I think those collaborative relationships are fairly unique to MD Anderson not only in research, but also we collaborate in patient care. Another thing we were doing which was—we had one of the early tissue banks—tumor tissue banks, and we were harvesting brain tissue as far back as 1984-1985 when I first came. We were freezing tissue—either keeping it sterile and freezing it or just freezing it down—for future research, and that gave us the advantage of having a lot of specimens. A lot of the research that you did in those days couldn't be done on tissue that was already fixed like we fix it in pathology to look at it, so it was really necessary to have frozen tissue to work with.

***Tacey Ann Rosolowski, PhD***

**1:06:02.3**

So when again did that tissue bank—? When was that program initiated?

***Janet M. Bruner, MD***

**1:06:08.4**

There was a little bit of tissue banking going on here when I came but it was mostly—there was some support for it in lymphoma, and there was a little bit of banking going on in other areas, but it was mainly at the request of a research person with a protocol. They would send a note to Surgical Pathology that said, “I need so-and-so tissue on this patient. So harvest me some tissue, and give it to me.” It wasn't centrally banked, whereas in the brain tumor program we sort of got together and said, “Let's start banking as much as we can on all brain tumors or all tumors of this type.”

*Tacey Ann Rosolowski, PhD*

**1:06:59.1**

So who was involved in that?

*Janet M. Bruner, MD*

**1:07:01.3**

It was Dr. Yung. I think Dr. Sawaya was involved with that. Dr. Richard Moser, who was one of the surgeons, and I'm trying to think whose lab it went to to freeze. I guess we had some—I had a freezer in Pathology, and that's where we stocked it and stored it. That was before the days of patient consent, and it was much easier to just do things with tissue in those days. We didn't worry so much about whether we had to protect patient privacy, and there's a lot more regulations now.

*Tacey Ann Rosolowski, PhD*

**1:07:46.1**

Sure.

*Janet M. Bruner, MD*

**1:07:47.8**

But I guess we weren't making as many discoveries either. We started that up, and I think there's probably still a freezer around here somewhere with some of those old tissues in it.

*Tacey Ann Rosolowski, PhD*

**1:07:58.0**

So how long was that active and how was it used?

*Janet M. Bruner, MD*

**1:08:02.1**

It was used in the research programs of Dr. Sawaya, Dr. Kyritsis, and people who came after them, and it's still active. Now it's expanded hugely. It's just an explosion what we're banking—

*Tacey Ann Rosolowski, PhD*

**1:08:17.3**

But you go through all of the—

*Janet M. Bruner, MD*

**1:08:18.8**

Oh, we're banking tissue in everything, yeah.

*Tacey Ann Rosolowski, PhD*

**1:08:21.8**

Oh, amazing. I'm just wondering—because in the 1980s, wasn't that the time when there was just a huge expansion in the institution?

*Janet M. Bruner, MD*

**1:08:31.5**

Uh-hunh (affirmative).

*Tacey Ann Rosolowski, PhD*

**1:08:33.4**

I was wondering if there was kind of this, “Okay, let’s really serve our research base in a new way,” and this seems like it’s part of that spirit—expanding that.

*Janet M. Bruner, MD*

**1:08:45.0**

It is, but I think it was more—it wasn’t spearheaded so much through Pathology. It was spearheaded through the interdisciplinary programs in each area. The brain people got together and said, “Let’s bank brain.” What other areas? Maybe the skin people got together and said, “Let’s bank”—well, they weren’t even doing that at the time. I guess they were banking lymphomas. I think there was quite a bit of activity in breast cancer. What other programs? I can’t remember what other programs were even here at the time. I think they were doing some banking in the genitourinary program, particularly prostate, and I think they started doing some banking in bladder.

*Tacey Ann Rosolowski, PhD*

**1:09:51.9**

So this was basically a tissue program, but it was kind of spread all over the center?

*Janet M. Bruner, MD*

**1:09:59.5**

It was. It was individual. There was no central tissue bank. It was individual tissue banks in each of these areas, because there was no central support or much coordination at the time. There just—the department was—Pathology was much smaller, and the main effort of most of the pathologists with just a couple of exceptions was really to do the diagnostic work. The pathologists really were not here so much to be interested in research. Now, there were a couple of pathologists who were more interested in research, but that was fairly unusual.

*Tacey Ann Rosolowski, PhD*

**1:10:46.5**

So at what point did that tissue bank become—? Was it ever more centralized?

*Janet M. Bruner, MD*

**1:10:55.9**

More centralized? It is now, and that really didn’t happen until 1998.

*Tacey Ann Rosolowski, PhD*

**1:11:01.2**

Oh, okay.

*Janet M. Bruner, MD*

**1:11:01.6**

When Dr. [Stanley] Hamilton came. In fact, I think it was sort of—and he doesn't—I'm sure he doesn't know this and wouldn't agree. Dr. [John] Mendelsohn [Oral History Interview] came in 1996, and he was appalled that there was no central tissue bank. He didn't seem to know about all these other tissue banks. Somehow he just ignored that. So the word got out, and Dr. Mendelsohn perpetuated this fantasy that there was no tissue bank at MD Anderson. So that was one of the things that they recruited for Dr. Hamilton for. "Oh, you must come here, because we don't have a tissue bank, and we need you to start a tissue bank." It was like, "Excuse me, we've got a tissue bank here—in brain, in prostate, in this, in this." And the really funny part about it was the area that Dr. Hamilton is interested in is GI and colon, particularly. We weren't banking colon. Nobody cared about that, so in a way he was right. There was no tissue bank in colon. He was tasked with starting an MD Anderson tissue bank, and he really started the centralized bank, but I think soon after he got here he realized that even by that time we were so huge that there just physically could never be a space that would hold a central tissue bank. You know? He's thinking of a central tissue bank as a few freezers, and we'll freeze everything, but it could never happen. It was beyond the mind's concept almost. If he had ever said, "Bring all those tissue banks back together, and we'll have this central tissue bank," it'd be impossible.

*Tacey Ann Rosolowski, PhD*

**1:13:02.7**

So they're still all separated?

*Janet M. Bruner, MD*

**1:13:04.5**

They still are all separated, but there is now a central tissue bank. There's a central repository and then distributed banks, which is the only way it could ever work here. And it's fine. It works great. I think a central nidus and a central database which they've created is now something that you have to have because of the patient consents and—it has to all be run under the—operate under the same rules and have oversight. The way it's working now is the way it has to be, but it didn't start that way, and there was plenty of tissue bank here before he came. It was kind of funny.

*Tacey Ann Rosolowski, PhD*

**1:13:52.1**

I read that in 1996 you also became a consultant for the Central Brain Tumor Registry of the U.S. You served on that continually up to the present.

*Janet M. Bruner, MD*

**1:14:03.7**

Right. Right.

*Tacey Ann Rosolowski, PhD*

**1:14:04.6**

So tell me a bit about that.



***Janet M. Bruner, MD***

**1:14:06.3**

It's like a tissue registrar. They take information from tissue registries particularly. Let's see. There's one in—is it Connecticut? There's one in New England. They use aggregate data from tissue registries in the United States to track trends in brain tumor incidents and what's happening with brain tumors across the country, and it's all aggregate data. It's not any specific patient. What they needed was—they were at the time very concerned with whether the diagnoses on this aggregate data they were receiving were correct or not. Now remember, we talked a lot about whether—is it worth it to actually try to get slides and review cases to make sure? Or which diagnoses are more likely or less likely to be correct? I mean, because out there across the United States, you have a limited number of neuropathologists. There may be 300 or 400 in the United States, but all the other brain tumor diagnoses are being made by general pathologists like these senior pathologists at MD Anderson who don't see that much. It's not that people want to make mistakes, but they don't have the experience that allows them to be correct more of the time. So they are very concerned about trying to figure out ways of categorizing brain tumor data that minimizes the chance that this aggregate data that they're working with is going to be very incorrect. So it's a lot of looking at diagnostic categories in groups and trying to stratify—if I've got this category of tumors and I get some information from a registry that says we have 500 cases of X, and we know that most of the time that tumor occurs in the front part of the brain, but here I've got four or five cases that say they occurred in the back part, then it's like, “No, it doesn't ever occur in the back part,” so you know that those diagnoses almost by definition are incorrect. So it's telling them things like that because they don't know—the people who are working with them are epidemiologists and scientists, and there are a few neuropathologists that work with them, but I think I was the first one they had that was working with them.

***Tacey Ann Rosolowski, PhD***

**1:17:07.7**

So what are some of the most difficult to diagnose, or what are some of the cancers that are the most easily misdiagnosed in the country?

***Janet M. Bruner, MD***

**1:17:16.6**

Oh, in the country? I would say brain is probably one. Another one is probably ovarian cancer. It's fairly rare, so it's diagnosed incorrectly a fair amount of the time. Here we see either incorrect diagnoses or incomplete diagnoses a fair amount of the time on breast cancer. Actually, we have quite a bit of a problem, too, with prostate, which is sad because it's such a huge—they're huge numbers.

***Tacey Ann Rosolowski, PhD***

**1:17:53.8**

What is an incomplete diagnosis? What does that mean?

***Janet M. Bruner, MD***

**1:17:57.6**

It's where there is information that you can get from the slides that you should report that would

affect the treatment of the patient that maybe the person didn't report. Like, is the cancer invading certain other structures? Some pathologists who aren't very familiar with the biology of the cancer may not recognize that that's important, so they may not report that. Another category that's misdiagnosed or incorrectly diagnosed a lot is lymphomas—leukemias and lymphomas. Again, a very specialized type of cancer. What else? Some of the more rare things. Bone tumors are probably difficult to diagnose because they're rare. And a lot of it is experience. The more you see, the more you know.

*Tacey Ann Rosolowski, PhD*

**1:18:50.1**

Yeah. Yeah.

*Janet M. Bruner, MD*

**1:18:52.0**

And it's not that people outside of MD Anderson or at small centers are bad pathologists, but they don't have as much of a chance. They see a lot of colon cancer. They see a lot of lung cancer. They see a lot of breast cancer. They don't see brain tumors. They don't see bone tumors. They don't have a chance to really get good at it.

*Tacey Ann Rosolowski, PhD*

**1:19:11.1**

I wanted to come back to your research work. We kind of—I took the opportunity to ask you about the tissue banks since it had come up. How did it evolve? The last subject you talked about was the harvesting of those different tissues to—that there were ways of influencing the invading cells. So where did you go next, and why did that evolve? How did those collaborations evolve?

*Janet M. Bruner, MD*

**1:19:38.0**

I think they evolved—unfortunately, the busier I got here with diagnostic pathology, the more I sort of got away from that. I was collaborating but not really doing as much firsthand as I had been earlier on. I think Dr. Yung has used some of that work and continued to develop and also some of the other people in neuro-oncology. We haven't made any huge breakthroughs, but we did a lot of work with some of the genes early on and toward the mid part of—into the early '90s.

*Tacey Ann Rosolowski, PhD*

**1:20:30.3**

And was that the moment when it was suggested that you become chair?

*Janet M. Bruner, MD*

**1:20:36.5**

(laughing)

*Tacey Ann Rosolowski, PhD*

**1:20:40.3**

I'm sorry?

## Chapter 8

### B: Diversity Issues

#### *Few Women at MD Anderson in the Early Eighties*

##### Story Codes

A: Professional Path

A: Experiences re: Gender, Race, Ethnicity

A: Overview

A: Definitions, Explanations, Translations

A: The Clinician

B: Gender, Race, Ethnicity, Religion

##### *Janet M. Bruner, MD*

###### **1:20:41.1**

No. It actually—the way that the work went here—oh, and you were asking me how many women were in the department and things like that, too. Actually, it seems like there were—when I think back, it seems like it was all men, but there were some women in the department. Barbara Osborne was here, and Karen Cleary, both of whom were really excellent pathologists. I'm trying to think. There must have been other women pathologists too. But I can't think of them. They were here when I came, and fairly soon after that it must've been—we started to add a few more pathologists along through the mid to late 1980s. Actually, there were a couple of cytopathologists who were here when I came: Ruth Katz and Nour Sneige—who's S-N-E-I-G-E. Both of them were here. They were in cytology, which is another subspecialty of pathology that deals with individual cells, and they had established a program of what we call fine-needle aspiration. It's not like a needle biopsy. What they do is they stick a needle into a lump or someplace where there is a lesion and they pull back on the needle and just—it doesn't cut out a cylinder of tissue. It just sucks out individual cells, and it's much less invasive than the biopsy. It causes less bleeding usually and less trauma. Then they smear those individual cells on a glass slide and look at them and can usually make a diagnosis from that. It's a technique that was started in Sweden, and one or both of them actually went to Sweden in the early 1980s to learn how to do this, and they brought the program back. So we've got a fairly good—a fairly large program. They were doing that and then we started to add—as we added more junior faculty on through the later part of the '80s—I think we hired—we started to hire more women, too. But I never really felt acutely aware of any prejudice against women. You were sort of evaluated on how good you were, which was nice because that was the way I had felt through my residency and fellowship too, but I'll talk about it later. After I became chair and around that time I started to feel—I think that's where the glass ceiling hits is when you get up that high.

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

###### **1:23:58.1**

Into leadership positions.

##### *Janet M. Bruner, MD*

###### **1:23:59.2**

Right.

*Tacey Ann Rosolowski, PhD*

**1:23:59.6**

Yeah.

*Janet M. Bruner, MD*

**1:24:00.0**

Right.

## **Chapter 9**

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

#### ***The Neuropathology Lab in Detail***

##### **Story Codes**

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

A: The Administrator

B: Institutional Processes

B: Devices, Drugs, Procedures

C: Professional Practice

C: The Professional at Work

C: Patients, Treatment, Survivors

***Tacey Ann Rosolowski, PhD***

**1:24:00.5**

And I do want to get there. Do you mind if I ask you just a couple of other lab-related things?

***Janet M. Bruner, MD***

**1:24:06.1**

Sure.

***Tacey Ann Rosolowski, PhD***

**1:24:06.8**

And then we'll turn to that. Okay. I was wondering some real technical things, like now in the pathology lab, how many cases per day does the laboratory handle?

***Janet M. Bruner, MD***

**1:24:18.8**

The lab—I can't tell you how many cases per day. We have about—

***Tacey Ann Rosolowski, PhD***

**1:24:24.4**

Whatever unit—I'm just trying to get a sense of the volume of work.

***Janet M. Bruner, MD***

**1:24:27.4**

Right. We have about 70,000 or 80,000 cases a year, and about half of those are cases from outside. We do a tremendous amount of reviewing cases from outside, because we review the slides of every patient who comes here. If you have a diagnosis outside somewhere else, we're going to review those slides before you're treated here, and it's for not only the patient's protection but also our doctors because we don't want them treating something that doesn't exist.

*Tacey Ann Rosolowski, PhD*

**1:25:04.3**

On the basis of a bad diagnosis.

*Janet M. Bruner, MD*

**1:25:05.5**

Right. Right. And we do have that. We've had cases where the patient really had an infection in the brain, and some pathologist outside called it a tumor, and they had radiation therapy to the brain for an infection. It doesn't help it. An antibiotic would've been much better. That's really a sad thing. So it's not only the difference between benign tumor and malignant tumor or a different type of malignant tumor but things like an infection that's misdiagnosed or some other inflammatory condition—an arthritis type of thing that's diagnosed as a tumor.

*Tacey Ann Rosolowski, PhD*

**1:25:50.7**

How frequently do you find that?

*Janet M. Bruner, MD*

**1:25:53.1**

We've done a study in brain, and it's about eight percent to ten percent.

*Tacey Ann Rosolowski, PhD*

**1:25:57.0**

Really?

*Janet M. Bruner, MD*

**1:25:57.9**

Which doesn't sound very high until you realize it's one out of ten people, and if you're that one person it's critical.

*Tacey Ann Rosolowski, PhD*

**1:26:05.2**

Absolutely.

*Janet M. Bruner, MD*

**1:26:05.8**

It's critical. That's the number of cases per year that we see. Our laboratory processes here over 1000 tissue blocks a day, and a tissue block is what we make the slide from. It's a piece of paraffin wax with tissue inside it, and it's where the slide is cut from. The significance of that is if you think about 1000 tissue blocks a day and about 250 working days in a year, that's a quarter of a million tissue blocks in a year. That's huge, and we have to store those! We have to store them in a controlled climate condition. We actually store them at a warehouse offsite.

*Tacey Ann Rosolowski, PhD*

**1:27:02.4**

Oh, do you?

***Janet M. Bruner, MD***

**1:27:02.5**

We hire Iron Mountain. MD Anderson has a contract with Iron Mountain so they not only store documents—

***Tacey Ann Rosolowski, PhD***

**1:27:08.8**

Is that “Iron Mountain”?

***Janet M. Bruner, MD***

**1:27:10.4**

Iron Mountain.

***Tacey Ann Rosolowski, PhD***

**1:27:11.3**

Iron Mountain.

***Janet M. Bruner, MD***

**1:27:11.6**

I-R-O-N. It’s a very well-known document control—document storage, but they also store other things.

***Tacey Ann Rosolowski, PhD***

**1:27:19.7**

Interesting. Well, I was going to ask you what you felt ensured that the pathology laboratory operates accurately and efficiently, and you’re starting to answer that question. So what else goes into that—ensuring a really high quality of diagnosis and speed?

***Janet M. Bruner, MD***

**1:27:40.3**

Well, we have benchmarks that we have to adhere to as far as turnaround time for cases, so that’s where the speed comes from. It’s not to punish people that take an extra amount of time, but we do have a benchmark goal so that it can’t take you three weeks to sign out every case, because that just isn’t acceptable. We have a lot of checks. A lot of our work now in our labs is bar code driven. We had—

***Tacey Ann Rosolowski, PhD***

**1:28:14.6**

What does—?

***Janet M. Bruner, MD***

**1:28:16.2**

It means that every piece of physical property is bar coded. The container that the specimen comes in is bar coded the cassette that—I have a cassette around here I can show you. Yeah. Of course, this isn’t going to mean much to your listeners.

*Tacey Ann Rosolowski, PhD*

**1:28:47.5**

Well this is—it's a little tiny cassette tape?

*Janet M. Bruner, MD*

**1:28:50.3**

No. It's—

*Tacey Ann Rosolowski, PhD*

**1:28:50.9**

Oh.

*Janet M. Bruner, MD*

**1:28:51.7**

It's a piece of plastic with paraffin wax.

*Tacey Ann Rosolowski, PhD*

**1:28:54.3**

Oh, okay.

*Janet M. Bruner, MD*

**1:28:54.9**

And this is the tissue.

*Tacey Ann Rosolowski, PhD*

**1:28:55.8**

Yeah. Oh, I see.

*Janet M. Bruner, MD*

**1:28:56.9**

And what we do—

*Tacey Ann Rosolowski, PhD*

**1:28:57.9**

Embedded in the wax.

*Janet M. Bruner, MD*

**1:28:59.4**

Right. Embed it in the wax as a support, and then the tissue is cut.

*Tacey Ann Rosolowski, PhD*

**1:29:08.9**

Oh—



*Janet M. Bruner, MD*

**1:29:09.4**

And see how similar that is?

*Tacey Ann Rosolowski, PhD*

**1:29:10.2**

Yeah.

*Janet M. Bruner, MD*

**1:29:10.7**

A thin section is cut. The wax is just a support to let us cut it as thin as possible.

*Tacey Ann Rosolowski, PhD*

**1:29:16.5**

Right.

*Janet M. Bruner, MD*

**1:29:16.9**

And this is cut at about four or five microns, and then it's stained. The stainer is an autostainer, so every slice is supposed to be stained exactly the same. Now these are very old. These are from 1990, both of these.

*Tacey Ann Rosolowski, PhD*

**1:29:31.7**

So they're not bar coded.

*Janet M. Bruner, MD*

**1:29:33.0**

They're not bar coded. Right now, if you saw a cassette and a slide, the cassette has a bar code printed right there, and in order to print the slide that it goes on, there's a bar code reader. The bar code reader then prints that same bar code on this slide so that I know it can never be mixed up. I only deal in the lab with one cassette at a time, one slide at a time, so there's no tissue mix up. That's a very critical issue with pathology. Obviously, if you have 1000 tissue blocks a day, you don't want to be mixing up one slide with another block.

*Tacey Ann Rosolowski, PhD*

**1:30:15.4**

Absolutely. Right.

*Janet M. Bruner, MD*

**1:30:17.1**

So that's one thing we do. We also—whenever we dictate—and we dictate a lot of the cases, and they're transcribed by offsite transcriptionists. Whenever we dictate anything regarding a patient we also always have to dictate—we require two or three identifiers. We have a surgical pathology number that we assign, a patient name and patient medical record number, and most of us I think dictate all three things. Then whoever is transcribing that dictation, if they don't hear

what matches, or if when they type in the name of the case or the number of the case another name pops up, they stop, and they go back to the pathologist and say, “Are you sure? What were you dictating here?” So we have a lot of checks and balances, and most all of our labs now are bar code driven so that we have these critical things.

***Tacey Ann Rosolowski, PhD***

**1:31:19.6**

When were those procedures instituted?

***Janet M. Bruner, MD***

**1:31:22.6**

The bar coding actually has been fairly recently. It’s been about two or three years ago with parts of it and really only within the last year that we’ve been pretty fully bar coded. Before that, we would have—and even now—in addition to the bar code on the slide, we have the surgical pathology number and the patient last name. So there are multiple identifiers on a slide.

***Tacey Ann Rosolowski, PhD***

**1:31:49.9**

I guess a related question I wanted to ask was how have various changes in technology been integrated into the diagnostic process and even altered it?

***Janet M. Bruner, MD***

**1:32:03.7**

Yeah. That’s one, computers and dictation. We’re not using voice recognition yet in our lab. A lot of pathology labs are. We aren’t because we do have really good luck with our transcriptionists. That’s one thing. When I first started, we had a room where there were eight people sitting there typing all day, and of course we had typewriters. We didn’t even have computers, so that has been a tremendous advance. About—oh, gosh! I bet it’s been six or eight years ago, the transcriptionists—it was harder to get them, and the ones we had weren’t as productive as we liked, but they were talking about typing from home. So we said, “Okay, if you can meet these certain benchmarks for your typing, we’ll let you type from home, but you’ve got to earn it.” So we sent one or two of them home, and their productivity went way up. Finally, the last one we had on site who was one of our—very nice lady, but she was very distractible, and she loved to talk. It was terrible! She couldn’t make her benchmarks for typing. We said, “Okay, you’ve got to do this.” She wanted to go home, offsite. She finally did it. We sent her home. Her productivity soared at home. They just do so much better, and they enjoy it. They don’t have to fight the traffic. And what’s done it is a fast DSL or cable connection at home, and I think we do provide their computers, so they have a good computer at home. So computer—digital technology has just—is really what has advanced us.

**1:34:05.5**

The other thing is mechanization of our instruments. We’ve really seen that help us a lot, both for consistency of product and also for speed, because we have now where we do these different staining procedures. We used to do that all by hand when I started. It was a totally manual procedure and now we have—I don’t know—a dozen instruments that handle slides. The technicians have to know how to do the procedure, because they have to program the instrument,

which has a computer, but they don't have to actually physically do it. It takes a lot of the routine out of their job and allows them to work faster. They're much more productive. We could—never handle the workload today that we have with the number of people in the way we used to do it in the past, and it's added consistency, that's just wonderful.

***Tacey Ann Rosolowski, PhD***

**1:35:09.7**

I'm wondering if there's anything coming down the line with—whether the ability to produce and recognize visual imagery is really there in digital technologies. Is there anything where that can be used?

***Janet M. Bruner, MD***

**1:35:24.3**

We are doing a lot of that. We're doing—I won't say as much as we can. We're doing some of it. These outside cases that we review—people send in the glass slides. Well, it's easy—we've talked about, "Wouldn't it be great if they could scan the image, and then we could just look at the images?" But it would require all these small pathology labs out in the community to have scanners, high-resolution scanners for slides. Those are expensive. They're \$250,000 apiece. I don't know if we're ever going to get to a day when that happens, but what we do is when we have their slides in our hands—which we have to return to them because it's a part of their permanent patient record—we have a scanner, so we scan those slides, and we attach them to our computer record on that patient. If we need to refer to that image or review that slide in the future, we've got the high-resolution image of it. That's really been helpful for us. We've used that a lot. We often refer to that image if the patient has surgery here because the question here—you know—it's MD Anderson. Does the patient have—is this a recurrence of their initial tumor, or is this a new cancer? By looking at that image and comparing, we can tell that, so it's been very useful for us. It's really helped us. I can think of several cases where somebody has said, "Can we compare that to the old slide?" and we look in the computer and—wow—it's there. We don't have to send away again, get their slides back. It saves us so much time, and the images are fine. They're very good.

***Tacey Ann Rosolowski, PhD***

**1:37:07.9**

Just out of curiosity, what kind of resolution do you scan them at?

***Janet M. Bruner, MD***

**1:37:13.6**

We scan them at 20X which is—with a 10X eyepiece, it's a 200 magnification.

***Tacey Ann Rosolowski, PhD***

**1:37:19.8**

Oh, okay.

***Janet M. Bruner, MD***

**1:37:21.6**

That seems to be sufficient. Most of the time when we look, our high power view is 40X. So it's

not quite as high as we might look on our microscope, but it usually is enough, usually is sufficient.

***Tacey Ann Rosolowski, PhD***

**1:37:38.2**

And then it's almost like a version of a tissue bank, too. You've got a huge bank—

***Janet M. Bruner, MD***

**1:37:41.6**

Right. It is. It is—

***Tacey Ann Rosolowski, PhD***

**1:37:43.8**

—images of tumors.

***Janet M. Bruner, MD***

**1:37:45.8**

We talked about, “Is there ever going to be a time when the lab will produce a slide with a piece of stained tissue on it, and it will be immediately scanned, and the pathologists will only look at the image?” That day may come. I'm not quite as sure today—if you had asked me this three or four years ago I would've said we definitely are going to go there, but the technology doesn't seem to be advancing quite as fast as I thought it would, improving. It's a difference—Radiology does that. They have no more film now, but the difference is that the radiology image that is captured is a digital image. Their source image is digital because they're working from MRI scans or CT scans, which is a digital image, whereas we have no digital image. Our source image is analog. We've—we say that we're still—we're an analog specialty in a digital world, and for the time being, I don't see us being able to produce a source digital image. We have a physical piece of tissue that we have to deal with. I just don't know when it's going to—

***Tacey Ann Rosolowski, PhD***

**1:39:11.1**

When that's going to happen.

***Janet M. Bruner, MD***

**1:39:11.6**

***Tacey Ann Rosolowski, PhD***

**1:39:15.2**

Yeah. Interesting. Interesting. We have—let's see. I'm looking at the time. It's about twenty minutes of 4:00.

***Janet M. Bruner, MD***

**1:39:25.3**

Okay.

## **Chapter 10**

### **A: The Administrator**

#### ***Becoming the First Woman Chair of a Clinical Department***

##### **Story Codes**

A: The Administrator

A: Professional Path

A: Experiences re: Gender, Race, Ethnicity

A: Obstacles, Challenges

B: Gender, Race, Ethnicity, Religion

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

B: Obstacles, Challenges

B: Institutional Politics

B: Controversy

***Tacey Ann Rosolowski, PhD***

**1:39:26.6**

Would you like to start talking now about becoming chair?

***Janet M. Bruner, MD***

**1:39:32.1**

(laughing) I can.

***Tacey Ann Rosolowski, PhD***

**1:39:35.7**

Well, I just—I think I was—what was it? Dr. Batsakis suggested that you might want to think about becoming chair, and you immediately thought, “No, I don’t want to do that.”

***Janet M. Bruner, MD***

**1:39:48.0**

I know.

***Tacey Ann Rosolowski, PhD***

**1:39:48.8**

And then something changed your mind.

***Janet M. Bruner, MD***

**1:39:50.7**

Well, it was like the minute he said that and I said, “Why would I want to be a chair?” That’d never entered my mind. All of a sudden it was like, “Oh. I hadn’t thought about that before!”

***Tacey Ann Rosolowski, PhD***

**1:40:02.5**

Why do you think you’d never thought about it?

*Janet M. Bruner, MD*

**1:40:04.4**

I guess it's just that I had no thirst for power or glory, and I guess I had just never thought that that would be something I wanted to do. I just wanted to be a pathologist, make diagnoses, do some research, and just do the same thing I had been doing, but I think also that I have a certain amount of attention deficit disorder so that I do something for a few years or several years, and then it's like, "Okay, now I need something else—something more." So I think that was probably—I don't—that was probably in the early '90s and it was around the time—I was the only neuropathologist here up until 1992. In 1989 or so, I realized that I was just [phone begins ringing]—I was way too busy.

*Tacey Ann Rosolowski, PhD*

**1:41:03.9**

Oh, should I pause it while you—? Do you need to take that call?

*Janet M. Bruner, MD*

**1:41:07.5**

I guess I'd better, yeah.

*Tacey Ann Rosolowski, PhD*

**1:41:08.7**

Okay. Let me just pause it.

[The recorder is paused.]

Okay. We're recording again.

*Janet M. Bruner, MD*

**1:41:13.1**

Okay. Sometime in the late '80s, I was doing a lot of research, and the brain tumor program here was growing a lot. It was growing rapidly. We were adding neurosurgeons. We had hired a new Chairman of Neuro-Oncology, Victor Levin. So there was a lot of demand on my time, and the surgeons were doing more cases, so I had more cases to sign out, more research to do. Victor was hiring more research neuro-oncologists. I realized that I was just too busy, and finally I decided at some point that I was going to have to either get some help or get out of here, because I just couldn't survive. I interviewed a few places to try to think about moving, and I wasn't really anxious about doing that. I did ask—finally approached Dr. Batsakis, and he said, "Yeah, I think you're right. You probably do need some help." He said, "How many people do you think you need?" I said, "I think probably need two people"—which—crazy! Going from one to three? So he said—and I was shocked—and he said, "Okay. Hire a couple of people." I think what was burdening me more than the patient care work was the research, because there was so much demand for collaboration, and I had trouble getting time to do anything of my own because everybody else wanted a piece of me to collaborate in their research. I interviewed several neuropathologists, and I did find two people who joined me in 1992, both right about the same time—Dr. Lauren Langford and Dr. Greg Fuller, who are still here—and they were lifesavers.

What can I say? So that gave me a chance to feel what it would be like to work with other people and sort of supervise, if you will, although they didn't need much supervision. They knew what to do. I also had my lab people that I had supervised. About the time that Dr. Batsakis said I needed to take some steps if I wanted to become a chair, I actually did go and take some courses with the American College of Physician Executives, which has some really good leadership courses—things like conflict management, managing change, managing the difficult physician—things like that. I think that was really good for me. Then I did interview in some other places for chair, but that was more in conjunction with interviewing for the job here. Dr. Batsakis retired in 1996—or did he retire in '94? No. He retired in '96. At the time, MD Anderson was going through a lot of changes. Dr. Mendelsohn had just come on, and it was decided at some higher level of the administration that they were going to combine the Division of Laboratory Medicine—which was a division at the time—with the Division of Pathology. Both of those were higher-level entities than they are now. The administration thought this made a lot of sense because we were all pathologists, and we should be working together, and we didn't think it made any sense at all because—yeah, we were all pathologists, but we did totally different things. We said things like, “Wait a minute. Why don't you combine Diagnostic Imaging with Radiation Oncology because they're all radiologists? Shouldn't they be working together?” “Oh no, no. That's totally different!” Well, we didn't think it was totally different, but no one was listening to us, because we were very small at the time and not powerful enough, I guess.

***Tacey Ann Rosolowski, PhD***

**1:45:37.6**

I was curious about that combining.

***Janet M. Bruner, MD***

**1:45:41.1**

To me, it was a way to decrease our power, because before we were two fairly powerful divisions, and afterwards we were one.

***Tacey Ann Rosolowski, PhD***

**1:45:49.8**

What was—? Why would that have been a desirable outcome? Why would anybody want to decrease the power of those two divisions?

***Janet M. Bruner, MD***

**1:45:57.8**

Because you have less representation at the table you have to deal with—one voice instead of two, one vote instead of two if it comes to it—both in hospital issues and also I think at the practice plan level. I don't know. I was a peon at the time. It didn't make any—yeah. It didn't make any sense. So now are we working much more closely together? No. Are we perfectly happy being essentially as separate as we ever were? Yeah. I mean, it's not that we don't get along. We always got along, but we never worked together because we do totally different things, and we're okay with that. We didn't care—we're not antagonistic toward the lab people, and they're not antagonistic by the same token. Yeah. They're okay, but we're as close to them as we are to Radiology. They just do a different thing.

*Tacey Ann Rosolowski, PhD*

**1:46:58.4**

Have there been some difficulties that have arisen from that combining?

*Janet M. Bruner, MD*

**1:47:03.3**

I don't think so, really. I almost feel like we're the same as we were before.

*Tacey Ann Rosolowski, PhD*

**1:47:11.0**

Interesting.

*Janet M. Bruner, MD*

**1:47:11.5**

We're just as separate. We're just as close. I'm not sure that there have been advantages for us. I'm not sure what advantages—the hospital talks about things like economies of scale, blah-blah-blah. I don't know how they've found any of those because it's a completely different practice.

*Tacey Ann Rosolowski, PhD*

**1:47:36.0**

Yeah. Interesting.

*Janet M. Bruner, MD*

**1:47:37.3**

I feel like we're the same as we were in 1994, but we just have a different name. Now what they did save was they saved a division head position, obviously, because they only have one division head now instead of two.

*Tacey Ann Rosolowski, PhD*

**1:47:54.8**

Right.

*Janet M. Bruner, MD*

**1:47:55.3**

So they saved a division head position and the support surrounding that, which is a few support people—not a huge number.

*Tacey Ann Rosolowski, PhD*

**1:48:04.7**

So you were telling this story in conjunction with the story about you becoming chair.

*Janet M. Bruner, MD*

**1:48:08.5**

Right. Right.



*Tacey Ann Rosolowski, PhD*

**1:48:10.5**

I just wasn't—I need to get that dot connected. I'm not sure how that happened.

*Janet M. Bruner, MD*

**1:48:14.3**

What happened was that Dr. Batsakis retired, and I'm not sure if Dr. Glassman retired around the same time. Anyway, that seemed to be the time to make this connection. They just let us float in Pathology. It may be that the other division head didn't retire at the same time. I can't remember. We had an interim chair or division head—I can't remember when it was done—for a while—and for at least a year nothing was done. We just kind of floated out there, and we lost some pathologists. A few had retired. Some people left because they just didn't—it was not comfortable being in a—sort of a temporary situation. At the same time, they were building the new hospital, so we were having to make decisions like how it was going to be laid out, how the labs were going to be—and we really had nobody—didn't have a permanent person in charge. That was—I guess it turned out okay, but it probably could've been better. Then I guess in 1997 or so, they started recruiting for a division head for Pathology and Lab Medicine. I by that time had taken—had done these leadership courses, really thought about it a lot, and I did compete for that position of division head because I'm boarded in anatomic as well as clinical pathology, so it was okay for me to do that. Even though I hadn't practiced clinical lab since I was a resident, I at least knew about them—knew what they did—which most of the pathologists here I think were not double boarded. They were mostly anatomic pathologists. I really think I made a pretty strong run at that job. They interviewed a few other people, but there were some fairly high-level people at MD Anderson who I don't think wanted an internal candidate and that is the point. I also don't think they wanted a woman. There were no women division heads, and I think they just couldn't quite envision that. It was several more years before Dr. [Eugenie] Kleinerman became a division head, and she also had a very tough time getting her job.

*Tacey Ann Rosolowski, PhD*

**1:51:15.7**

Really?

*Janet M. Bruner, MD*

**1:51:18.7**

So I think it just—it wasn't—it just wasn't the time. I think I could've done the job, and I think I was a strong candidate. It just didn't happen. It was during that period of time when I interviewed for other chair jobs outside, and I realized some very unique things about MD Anderson that made me reluctant to jump to another place. We've got some really good things here that help the chairmen and keep people working. One is our term tenure rather than lifetime tenure, and another is just the way that the funds are handled and distributed. It's the all-funds budget we have between the hospital and the practice plan, and we really are very collaborative, very integrated. We're one hospital and practice so the hospital—in a lot of other places, the hospital hires the technicians, and the doctors function separately. If you have a technician who's not doing their jobs, you can't get rid of them, because they work for the hospital, not you. Now here it's also hard to get rid of them, but at least if you document it, you can. No one's telling you, "No, you can't fire them, because they don't work for you."

**1:52:44.6**

So it was—I saw other departments of pathology where very senior pathologists had lost all their grant funding, weren't doing much clinical work, still had a lab, and had lifetime tenure and were still pulling a big salary in that the chairman had to pay for with very little resources and had no recourse because the person was tenured. I thought, "Man, I don't want to get into that situation!" Term tenure is very good here, and it keeps people working. Also, like I said before, the people here—the physicians here love what they're doing, and they work hard. They're productive for the most part—productive at either research or patient care or both. So there were a lot of advantages at MD Anderson, and I was very disinclined to actually take one of these other jobs out there. When I found out that I wasn't going to become the division head I had to decide—and my husband and I talked about this. "You have to decide. Are you going to stay there and do what you do, or are you going to stomp out of there and take a job you really don't want anyway?" So I just decided. "Okay, no problem. I can stay here, and we'll be okay." Because I had these other two neuropathologists, we had a good practice, we had good research going on. Dr. Hamilton joined. Of course, he didn't know me, and I didn't know him. I couldn't interview him since I was also a candidate for the position, but I think he realized once he got here that I was a pretty good resource. I don't know to this day if I was his choice or not, but somebody somewhere told him when he was looking for a permanent—he obviously had to get a permanent chair, because we had an acting chair. So he had to get a permanent Chair of Pathology, permanent Chair of Lab Medicine. I don't know whether it was his choice or somebody upstairs told him, "You'd better pick her," but I felt like it was okay, because I had competed for the division head position, so it wasn't like I was just selected out of nowhere. I felt like I was a good candidate, and I felt like if I thought I could do the division head job, obviously I felt like I could do this job, too.

***Tacey Ann Rosolowski, PhD***

**1:55:11.5**

Sure.

***Janet M. Bruner, MD***

**1:55:13.0**

I had a lot of ideas about how we needed to go forward. That was right around the time that we were moving into this hospital, so things were happening very quickly, and I think we had a chance to really be a lot better and a lot bigger at the same time. I found Dr. Hamilton to be a very nice person to work with.

## **Chapter 11**

### **A: The Administrator**

#### *Administrative Philosophy*

#### **Story Codes**

A: The Administrator

C: Mentoring

C: Leadership

A: The Mentor

D: On Leadership

*Tacey Ann Rosolowski, PhD*

**1:55:37.8**

I want to talk about those ideas that you have, but I wanted to go back just for a moment because you had said that Dr. Batsakis had suggested to you several things that you could do to prepare for administrative—to move into administration and that you were taking the leadership courses. I was wondering, what were some of his suggestions?

*Janet M. Bruner, MD*

**1:55:58.8**

Well, some of his suggestions were that I needed to get much more involved in national associations and national committees and I really didn't—I didn't do that much, but I think he also suggested that I needed to kind of change my attitude and think more about the global picture and not so much about my own career or neuropathology but think more globally.

*Tacey Ann Rosolowski, PhD*

**1:56:39.0**

Globally in the sense of—?

*Janet M. Bruner, MD*

**1:56:41.2**

Of about the entire department and how things affected it and how it functioned and even the institution.

*Tacey Ann Rosolowski, PhD*

**1:56:52.8**

So what—? When you began to do that, what did you discover when you started asking those questions of yourself?

*Janet M. Bruner, MD*

**1:57:03.2**

I discovered that I really enjoyed solving problems and fixing things and making things operate in the best way that they could and making opportunities for other people. That's one thing too that I—discovered in—I think in thinking about the process of becoming a chair, you realize that if you're going to be good at it, it's not all about you. It's about thinking about how you're going to bring every person around you to their highest capability, and that was something I hadn't

even realized it before, but I remember conversations that I had with my neuropathology mentor back in Ohio, because he had a lot of problems with the chair there who didn't allow him to grow as much, and he chafed under that. He said, "I think if you really are a good mentor and a good leader, you have to be willing to have the people that you're leading or the people behind you grow to be bigger than you are, and if you can't do that, you're never going to be as good as you could be. You can't be afraid that they're going to be greater than you are." I think that's sort of the issue. It's the same issue with the chair. You can't be afraid. You can't see yourself as the most powerful one. You have to be the person who gives everybody a leg up, and if they grow to be greater than you are—more famous, better known, bigger in national institutions, in national organizations, more publications, better research—then you have to want that. You can't resent that because you can't think, "I have to be the biggest one here." They—the more—the larger they grow, the better that is for everybody. So I think that's—that I think has been my whole philosophy, trying to set the example and trying to not only not hold people back but how can I make it easier for them to do even better than they are?

*Tacey Ann Rosolowski, PhD*

**1:59:57.0**

It's a great philosophy.

*Janet M. Bruner, MD*

**1:59:57.9**

Yeah. Yeah, and I really believe that. I still—even though I'm not the chair anymore that's just—I'll never not think that way.

*Tacey Ann Rosolowski, PhD*

**2:00:08.4**

I'm aware that it's 4:00, and I want to make sure that I don't abuse your time today.

*Janet M. Bruner, MD*

**2:00:12.2**

So I became the chair in 1998.

*Tacey Ann Rosolowski, PhD*

**2:00:15.5**

All right.

*Janet M. Bruner, MD*

**2:00:16.9**

And I was shocked to realize that I was the first woman chair of a clinical department at MD Anderson.

*Tacey Ann Rosolowski, PhD*

**2:00:23.3**

Yeah.

*Janet M. Bruner, MD*

**2:00:23.9**

In 1998. I was just—that really amazed me.

*Tacey Ann Rosolowski, PhD*

**2:00:29.1**

And I'll be looking forward to hearing about that next time because that's—that's a cliffhanger!

*Janet M. Bruner, MD*

**2:00:36.1**

Yeah, that's amazing.

*Tacey Ann Rosolowski, PhD*

**2:00:39.4**

All right. It's two minutes after 4:00, and I'm concluding the interview for today. Thank you very much, Dr. Bruner.

**2:00:44.6**