

# **John Stroehlein, M.D.**

Interview #30

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Interview profile edited to new format

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## **John Stroehlein, M.D.**

Interview #30

### **Interview Profile**

**Interview description submitted:** 2013

**Interview Information:**

Two interview sessions: 5 December 2012, 12 December 2012  
Total approximate duration: 4 hours 30 minutes  
Interviewer: Tacey A. Rosolowski, Ph.D.

**To request the interview subject's CV and other supplementary materials, please contact:**

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**About the Interview Subject:**

John Stroehlein, MD (b.1 July 1940, Anna, Illinois) specializes in cancers of the hollow gastrointestinal tract and was recruited by Dr. R. Lee Clark in 1977 to serve as the second Chief of the Section of Gastroenterology. He held that position until 1982. His research has focused on screening for gastrointestinal cancer, the treatment of cancer with drug combinations, primary and secondary prevention of cancer. Dr. Stroehlein serves as Deputy Chair of the Department of Gastroenterology, Hepatology, and Nutrition. Since 2006, he has also served as Co-Medical Director of the Department of Patient Affairs.

**Major Topics Covered:**

Personal and educational background; military experience; retirement

Working at Methodist Hospital; MD Anderson in comparison to other institutions

Gastroenterology and oncology: history and evolution; development of team approaches

Research overview

Department of Gastroenterology: history of

Department of Patient Affairs: functions, organization

Data management initiatives

Quality assurance initiatives

MD Anderson growth; cultural change; changing relationship to Texas/Houston

**A note on 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.

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Interview Profile #30: John Stroehlein, M.D.  
Submitted by: Tacey A. Rosolowski, Ph.D.  
Date revised: 2 July 2014

This four and one-half hour interview with Dr. John Stroehlein (b.1 July 1940, Anna, Illinois) takes place in two sessions in December of 2012. Dr. Stroehlein is a specialist in cancers of the hollow gastrointestinal tract. In 1977, he was recruited by Dr. R. Lee Clark to serve as the second Chief of the Section of Gastroenterology and he held that position until 1982. He spent some years away from MD Anderson, returning to the faculty in 2003 and eventually serving as *ad interim* chair of the Department of Gastroenterology, Hepatology, and Nutrition. He is now the Department's Deputy Chair. Since 2006, Dr. Stroehlein has also served as Co-Medical Director of the Department of Patient Affairs. The interview takes place in a conference room in the Department of Gastroenterology, Hepatology, and Nutrition. Tacey A. Rosolowski is the interviewer.

Dr. Stroehlein received his B.S. from the Univ. Illinois, Urbana (1963, Chemistry) and his M.D. from the University of Louisville, Kentucky, (1967). He did three residencies at the Mayo Clinic between 1968 and 1974, with the final residency (72 – 74, Advanced Clinical Resident) securing his specialization in gastroenterology. From 1969 -1971 he served in Vietnam (864th Engineer Battalion and the 24th Evacuation Hospital) and at the Dewitt Army Hospital, Ft. Belvoir, Virginia. Since his residencies, his research has focused on screening for gastrointestinal cancer, the treatment of cancer with drug combinations, primary and secondary prevention of cancer. His administrative career evolved simultaneously at MD Anderson and, in 1982, he left the institution to become chief of the endoscopy service at the Methodist Hospital. During his time away from MD Anderson, he also joined the faculty of the University of Texas School of Medicine. In 2003 he rejoined the MD Anderson Faculty and resumed administrative service in 2007, when he became *ad interim* Chair of the Department of Gastroenterology, Hepatology and Nutrition. He became Deputy Department Chair in 2009. In 1999 Dr. Stroehlein was appointed to the Dan and Lillie Sterling Professorship in Gastroenterology and that same year received the Humanism in Medicine Award from the Healthcare Foundation of New Jersey. (He was the first UT-Houston recipient.) In 2012, the University of Texas Regents approved the John Stroehlein Professorship in Gastroenterology. Dr. Stroehlein has also been named to many Best Physician's lists.

In this interview, Dr. Stroehlein discusses the evolution of the field of gastroenterology from the 1970s, when there was very little known about the GI tract and its cancers. In addition to views on evolving research and technology, Dr. Stroehlein reveals his commitment to building teams across departments and specialties to maximize research and clinical potential for the benefit of patients. He also discusses the special role of the Department of Patient Affairs. The hiatus he took from the institution between 1983 and 2003 he compares MD Anderson to other institutions on the basis of direct experience. He is candid in his comparisons and his evaluation of MD Anderson's role in the community.

# **John Stroehlein, M.D.**

Interview #30

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## John Stroehlein, M.D.

Interview #30

### Segment Summaries

Interview Session One: 5 December 2012

Segment 00A  
*Interview Identifier*

Segment 01  
*A Supportive Background and an Early Desire to Be a Physician*  
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: The Researcher  
C: Evolution of Career

In this segment, Dr. Stroehlein briefly describes his family background and explains that he decided to be a physician when he was a boy. His family was very nurturing and his home community of Jonesboro, Illinois, offered him broadening opportunities to work as a sports editor and radio announcer. He then sketches the educational path that took him to the University of Illinois at Urbana (B.S. '63) and to the University of Louisville, Louisville, Kentucky (M.D. '67). At the end of this segment he tells an anecdote about how he came to apply for a program at the Mayo Clinic, a move that led him to specialize in gastroenterology.

Segment 02  
*Oncology: An Open Field for Innovative Work in Gastroenterology*  
A: Joining MD Anderson/Coming to Texas

Story Codes  
A: Personal Background  
A: Professional Path  
C: Evolution of Career  
A: Inspirations to Practice Science/Medicine  
A: Influences from People and Life Experiences  
A: The Researcher  
C: Professional Practice  
C: The Professional at Work



Here Dr. Stroehlein explains how he came to focus on gastroenterology and then on oncology. He went to the Mayo Clinic to study gastroenterology because the specialty included a broad spectrum of diseases that were not well understood. His interest in oncology evolved because gastroenterology –more than other specialties—intersects with oncology. He describes the knowledge lacking at the time to treat GI cancers and recalls doing the first upper GI endoscopy at the Mayo Clinic. During his advanced clinical residency at the Mayo Clinic, Dr. Stroehlein was becoming known for his work on a fecal occult blood test to screen for colorectal cancer. Dr. R. Lee Clark went to Minnesota to recruit him to become the Section Head of Gastroenterology.

### Segment 03

#### *Developing a Personal Mission*

A: Military Experience

#### Story Codes

A: Military Experience

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Professional Values, Ethics, Purpose

C: Formative Experiences

B: MD Anderson History

B: MD Anderson Culture

Here Dr. Stroehlein describes how his military experience in Vietnam underscored that the role of a physician is to provide the best care possible. He worked at the 24<sup>th</sup> Evacuation Hospital, the busiest in Vietnam. He tells about meeting Dr. Oscar (Bud) Frazier (to become a noted Houston heart-transplant specialist) and describes friendships formed during the Vietnam War.

### Segment 04

#### *Gastroenterology in the Late Seventies*

B: An Institutional Unit

#### Story Codes

A: The Administrator

B: Institutional Politics

B: MD Anderson History

C: Professional Practice

C: The Professional at Work

In this segment, Dr. Stroehlein describes the Gastroenterology Section in 1977 when he arrived at MD Anderson. There were two faculty members and the section provided diagnostic studies to other departments. Dr. Stroehlein explains that, as the new Section Head, he maintained the clinical services and the joint training program and also recruited a gastroenterologist with laboratory experience to develop the research program and establish a laboratory.

He then describes how institutional politics at the time were shaped by the rift between the Division of Medicine and the new Department of Developmental Therapeutics. Dr. Stroehlein gives an example of how he supported innovative research with animal models to “mend fences” and bridge the two bodies. He also explains that Gastroenterology integrated surgical

oncology fellows into their protocols. Fellows in Developmental Therapeutics also became involved in protocols to form cohesive teams that cross cut the two factions.

Segment 05

*Challenges to Diagnosis and Treatment in the Late Seventies*

A: Overview

Story Codes

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

C: Professional Practice

C: The Professional at Work

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

D: The History of Health Care, Patient Care

D: Cultural/Social Influences

C: Patients

C: Patients, Treatment, Survivors

C: Offering Care, Compassion, Help

Dr. Stroehlein explains that gastroenterological cancers were very challenging because it was difficult to make a diagnosis before very serious symptoms developed. (He notes that it was only in the past year that definitive research proved that removing adenomas (benign tumors that develop from epithelial tissue) from the colon reduced cancer risk by 50%.) He also describes the technological limitations that hampered diagnosis and treatment, the difficulties of staging the patient (determining the stage of the cancer), and managing complications that affect quality of life. Dr. Stroehlein lists advances: the Enterostomal Nursing Program at MD Anderson is the only approved program in the southwestern U.S.; the current rarity of ostomies; the resection of metastatic disease; and the use of chemo-radiation combination treatments that increase survival rates.

Segment 06

*Building Teams to Diagnose and to Try New Techniques*

A: The Administrator

Story Codes

A: The Administrator

A: The Researcher

C: Discovery and Success

A: Definitions, Explanations, Translations

C: Patients

C: Patients, Treatment, Survivors

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

D: Understanding Cancer, the History of Science, Cancer Research  
D: The History of Health Care, Patient Care

Dr. Stroehlein explains that, as Section Head, he stressed team-building to tap expertise in other areas and train fellows equipped to diagnose cancer early. He also describes how the Section demonstrated the value of resecting metastatic disease, even though this went against accepted wisdom. Dr. Stroehlein then talks about how this new approach helped him and others understand the differences in patterns of cancer, leading to his interest in how the “soil” (or molecular/genetic) environment of the cancer cell influences the disease. (See Interview w/ Dr. Isaiah “Josh” Fidler.)

#### Segment 07

##### *Exploring the Nature of GI Cancers*

A: The Researcher

##### Story Codes

A: The Researcher

C: Discovery and Success

A: Definitions, Explanations, Translations

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

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

D: The History of Health Care, Patient Care

In this segment, Dr. Stroehlein explains that his research path evolved alongside his competing commitments to clinical care, the operations of his department, and support of other department members. He participated in studies of the effects of chemotherapy. He also used breath hydrogen and methane as indicators of disease states. By working on the influence of GI hormones on GI cancers –and encouraging others to study the phenomena—he helped establish the relevance of gastroenterology for molecular marker studies. He also worked on establishing the diagnostic value of flow cytometry for GI cancers.

#### Segment 08

##### *Gastroenterology and Developmental Therapeutics*

B: An Institutional Unit

##### Story Codes

A: The Researcher

C: Understanding the Institution

B: Multi-disciplinary Approaches

C: Collaborations

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

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

D: The History of Health Care, Patient Care  
B: MD Anderson Culture

In this segment Dr. Stroehlein notes that he conducted joint studies with the Department of Developmental Therapeutics (DT), explaining why that department was controversial at the time and listing operational differences between Gastroenterology and DT. He describes differences of opinion in the institution over offering palliative care. He explains that he tried to identify the positive aspects of DT as he integrated many DT members into teams. He notes that many departments intersected in gastroenterology teams.

Segment 09

*A Changing View of Cancer and the Future of Gastroenterology*

A: Overview

**Story Codes**

A: The Researcher  
B: Multi-disciplinary Approaches  
C: Professional Practice  
C: The Professional at Work  
D: On Research and Researchers  
D: Understanding Cancer, the History of Science, Cancer Research  
D: The History of Health Care, Patient Care  
B: Education  
A: The Educator  
A: The Mentor  
B: MD Anderson Culture  
D: Fiscal Realities in Healthcare  
B: Institutional Processes  
B: Devices, Drugs, Procedures

At the beginning of this segment, Dr. Stroehlein touches on his philosophy of education then switches subject and considers the future of gastroenterology. In research, he says, the future lies with the development of biomarkers which can then be used in developing histories (personal, family and social) to stratify risk factors for disease. The “holy grail” of the field is the development of chemo-preventative measures for disease. Dr. Stroehlein then talks about incidences of different cancers (some rising, some decreasing in frequency) and notes that a great deal of progress has been made in diagnosis and treatment. He notes that medicine continues to be more skilled at structural intervention in the disease and that the greatest boost will come from molecular studies that demonstrate how cells communicate. Dr. Stroehlein next observes that Dr. Ronald DePinho’s Moon Shots program can possibly take advantage of advances that enable researchers to do things faster and less expensively than in the past.

Segment 10

*The MD Anderson Presidents*

B: Key MD Anderson Figures

**Story Codes**

C: Portraits  
C: Personal Reflections, Memories of MD Anderson

- C: Funny Stories
- D: On Leadership
- B: Beyond the Institution
- C: The MD Anderson Culture
- B: Critical Perspectives on MD Anderson
- C: Giving Recognition

Dr. Stroehlein notes that he has known every MD Anderson president. He characterizes Dr. R. Lee Clark as decisive, fatherly, and disciplined and tells anecdotes to demonstrate Clark's visionary understanding of cancer research and his ability to deal with the Texas legislature. Dr. Stroehlein then explains that the Mayo Clinic has a more vital sense of its own heritage as an institution than does MD Anderson. He speaks about the need to create a more awareness of the individuals who have contributed to the institution.

## Interview Session Two: 12 December 2012

Segment 00B  
*Interview Identifier*

Segment 11  
*The Evolution of Gastroenterology*  
A: Overview

Story Codes  
A: Overview  
A: Definitions, Explanations, Translations  
A: The Researcher  
A: The Clinician  
B: Building/Transforming the Institution  
C: Understanding the Institution  
D: Understanding Cancer, the History of Science, Cancer Research  
D: The History of Health Care, Patient Care

In this segment, Dr. Stroehlein reflects on the development of gastroenterology since he entered the field in the seventies. He explains that faculty in the Division of Medicine at MD Anderson did aggressive therapy and also saw cases of benign disease, while the Department of Developmental Therapeutics focused exclusively on aggressive therapies. He notes that he integrated aggressive options into the Section of Gastroenterology. He acknowledges contributions made by Interventional Radiology and Dr. Sidney Wallace ([Interview #6]) and others at MD Anderson to the development of treatments for GI cancers. He then reviews how GI medical oncology is divided into specialties today based on the locations of different cancers and explains the reasoning behind the divisions.

Segment 12  
*Research: Slow Work*  
A: Overview

Story Codes

A: The Researcher  
C: The Clinician  
C: Discovery and Success  
A: Career and Accomplishments  
A: Overview  
A: Definitions, Explanations, Translations  
C: Professional Practice  
D: On Research and Researchers  
A: The Clinician  
B: Institutional Mission and Values  
C: Hope, Healing, the Promise of Research  
C: Human Stories  
C: Offering Care, Compassion, Help  
C: Patients  
C: Patients, Treatment, Survivors  
C: Cancer and Disease  
C: This is MD Anderson  
D: Technology and R&D

In this segment, Dr. Stroehlein speaks more about his specialty in the hollow GI tract and mentions his collaborations with groups studying screening techniques. He then reflects on the fact that there is no quick fix for cancer, and that it is the nature of research to evolve slowly toward validation. Next, Dr. Stroehlein explains his belief that, no matter how serious a diagnosis, there is always hope for the patient.

He then goes on to explain that the public needs more awareness about the effectiveness of colonoscopies for preventing serious cancers. He tells an anecdote about a colleague who removed a large gastric mass and compares past treatments with today's more advanced approaches. Dr. Stroehlein explains that he always tried to bring such advances into the Department of Gastroenterology when he was in a leadership role and gives an example of the endoscopic microscope that enables pathologists and surgeons to focus on cells in real time.

Segment 13

*Teamwork: Handling Complications of Cancer*

B: An Institutional Unit

Story Codes

A: The Researcher  
A: The Clinician  
C: Patients  
C: Patients, Treatment, Survivors  
B: Multi-disciplinary Approaches  
B: Institutional Mission and Values  
B: MD Anderson Culture  
B: Institutional Politics  
B: Controversy  
B: Building/Transforming the Institution  
B: The MD Anderson Brand, Reputation  
D: On Care

A: The Leader  
C: Leadership  
A: Personal Background

Dr. Stroehlein begins this segment with some examples of patients with remarkable survivorship periods. He then explains that the Department of Gastroenterology had an impact on developing therapies because they had an appreciation for the negative effects of therapies on patients. He notes that the Department of Developmental Therapeutics was sometimes criticized for ignoring the impact of treatments on patients, and then goes on to describe how the creation of multi-specialty teams built awareness of these effects and helped improve treatments. Dr. Stroehlein says that when he reflects on what he has done in his career, he has had a very positive impact on building teams and integrating members of both the Division of Medicine and the Department of Developmental Therapeutics into the Department of Gastroenterology. This interest in teambuilding has influenced his administrative style as well. He speculates that his abilities to bring people together derive from his experiences growing up in a small town, when was required to interact with many different types of people.

#### Segment 14

*MD Anderson and Methodist Hospital: Communication and Collegiality*

B: Beyond the Institution

#### Story Codes

B: Beyond the Institution  
C: Understanding the Institution  
D: The Nature of Institutions  
A: Overview  
A: Definitions, Explanations, Translations  
A: The Researcher  
A: The Clinician  
A: The Administrator  
A: Professional Path  
B: Critical Perspectives on MD Anderson  
B: MD Anderson Culture  
B: MD Anderson History  
B: Discovery and Success  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches

Here Dr. Stroehlein talks leaving MD Anderson in 1983 (- 2003) to serve as Head of Endoscopy at Methodist Hospital [Houston, Texas]. The institution was thriving during this period, with one of the finest endoscopy units in the country. Dr. Stroehlein describes some of his work and the lessons learned.

He then shifts to compare and contrast Methodist and MD Anderson. He notes that MD Anderson placed a higher priority on a team approach to care, offered better support services, and developed a system for electronic medical records earlier. He then speaks about the bonuses an institution can reap from collegiality. He describes how good communication processes come from collegiality and he gives an example of how anesthesia services needed a clear understanding of how gastroenterologists perform necessary procedures in order to set up anesthetics properly.

Segment 15

*Awards Recognize a Dedicated Clinician*

A: View on Career and Accomplishments

Story Codes

A: Career and Accomplishments

A: The Clinician

A: Character, Values, Beliefs, Talents

A: The Leader

A: Professional Values, Ethics, Purpose

In this segment, Dr. Stroehlein first briefly mentions the other roles he served while serving as Head of Endoscopy at Methodist Hospital. He then speaks about the most important honors and awards he has received.

Segment 16

*Observations: The Department Name Change and the Fate of Nutrition*

B: Institutional Change

Story Codes

A: The Administrator

A: Professional Path

B: Building/Transforming the Institution

At the beginning of this segment, Dr. Stroehlein lists the reasons why he returned to MD Anderson in 2003. He then explains the Department name change to Gastroenterology, Hepatology, and Nutrition. Hepatology, he says, had come into its own with advances in anti-viral therapies. The addition of "Nutrition" to the name reflected the importance of intravenous nutritional support to cancer patients. He then sketches the economic reasons why support for nutrition shrank, despite the fact that the Department was pointed to study what worked nutritionally for patients. He observes that there are few nutrition programs around the country and he has difficulty seeing how MD Anderson will be able to restart its own program.

Segment 17

*The Department of Patient Affairs*

A: The Administrator

[Note: about 10 minutes into this segment Dr. Stroehlein takes a call from Taylor Wharton, the first Head of Patient Affairs. Part of that conversation is recorded.]

Story Codes

C: Understanding the Institution

B: Overview

B: Critical Perspectives on MD Anderson

B: Institutional Mission and Values

B: MD Anderson Culture

B: Building/Transforming the Institution

C: Patients

C: Patients, Treatment, Survivors



## B: Institutional Processes

At the beginning of this segment, Dr. Stroehlein explains his main goals while serving as interim chair and now as Deputy Chair of his department: provide motivation and resources for everyone in the Department to be fully involved and productive. He then shifts to a discussion of his role as Medical Co-Director of the Department of Patient Affairs whose mission is to provide assistance to Board of Visitors members who become MD Anderson patients, as well as patients referred by the President's office and the Legislature. The assistance involves helping the patients assemble their records and schedule appointments. Dr. Stroehlein explains that Robert Morton originally held the role unofficially before Taylor Wharton became the first official medical director of the Department. Patient Affairs assures these patients that the institution is concerned about them.

[Telephone call from Taylor Wharton]

Dr. Stroehlein says that he is against having anyone from the Development Department in the Department of Patient Affairs. The latter department nurtures relationships with these patients and sees approximately 65-70 new patients per month. Dr. Stroehlein describes the scope of his role and mentions the contributions of Bob Morton, Lorena Collier, Linda White, and Taylor Wharton, whom he says "walked the hall like a maître d'." He observes that patient affairs was established at a time when the institution was growing very fast and then goes into a more detailed description of his role: he reviews patients' medical needs, mentors staff, and advises staff who don't have his clinical background so they can properly refer patients to the right services.

Dr. Stroehlein notes that MD Anderson must address the challenge of offering a customer friendly face. He acknowledges that the patients served by Patient Affairs probably do get better care than the average patients. He then speaks about how to improve patients' experiences.

## Segment 18

### *Projects to Come*

A: The Researcher

### Story Codes

A: The Researcher

A: The Clinician

C: Evolution of Career

C: Professional Practice

C: The Professional at Work

B: The Business of MD Anderson

D: The Health Service Industry

Dr. Stroehlein describes the projects he will work on in the coming years. He will continue work studying the genetic profiles of different ethnic groups. He notes that there is little written on how to listen effectively and how to be a consultant and work/communicate effectively with other specialists. He would like to provide information these subjects. There are also numerous clinical observations and techniques he would like to describe. He will also continue working with individuals in the laboratory to facilitate translation of research to the bedside.

Segment 19

*Developing a Data Manager and Fostering Quality Assurance*

B: Building the Institution

Story Codes

B: Building/Transforming the Institution

B: Institutional Processes

B: Devices, Drugs, Procedures

B: Institutional Mission and Values

A: Overview

A: Definitions, Explanations, Translations

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

In this segment, Dr. Stroehlein talks about two related activities: 1) developing the Department's data manager that pulls information from all case records into one database and 2) his role as Chair of Quality Assurance. He describes the challenges of setting up the database and also what it will mean for the advancement of research. He then talks about how quality assurance activities will be increasingly important to MD Anderson as the institution requires hard evidence that procedures have a positive outcome for patients. The repository of information in the Department's evolving database will be key to demonstrating the quality of the Department's services.

Segment 20

*MD Anderson Presidents*

B: Key MD Anderson Figures

Story Codes

C: Portraits

B: Institutional Mission and Values

C: Healing, Hope, the Promise of Research

D: On Research and Researchers

In this segment, Dr. Stroehlein briefly describes his observations of MD Anderson's presidents. Dr. Stroehlein then offers his opinion of Dr. Ronald DePinho's Moon Shots Program. He says the Program is a great challenge to "do above and beyond." Even for those faculty members whose specialties are not included in the program, there is much value to be derived from the interdisciplinary teams they created to make competitive proposals for inclusion in the Program. He observes that it is very motivating to attack a common enemy.

Segment 21

*A Humanist and a Team-Builder; Critical Perspectives on MD Anderson*

A: View on Career and Accomplishments

Story Codes

A: Career and Accomplishments

A: Contributions

B: Critical Perspectives on MD Anderson

B: Institutional Mission and Values  
B: MD Anderson Culture

Here Dr. Stroehlein notes his most important contributions to the institution and lists the most significant of his awards and honors, including the Stroehlein Professorship of Gastroenterology created in December 2012. He explains that he would like to become more active with the Healthcare Foundation that awarded his 1999 Humanism in Medicine Award, noting that there are few organizations that promote humanism in medicine.

Dr. Stroehlein then notes that the Mayo Clinic is the best example in the world of a humanist medical institution. In order to reach Mayo's level, he says, MD Anderson much enhance communication between the specialties and break down obstacles that patients encounter in the institution.

#### Segment 22

##### *Growth and Disconnection from the Texas Community*

B: Overview

##### Story Codes

B: Critical Perspectives on MD Anderson  
B: Building/Transforming the Institution  
B: Beyond the Institution  
B: MD Anderson Culture  
B: Growth and/or Change  
B: Obstacles, Challenges  
B: Controversy

Dr. Stroehlein next makes observations on the results of institutional growth. On one hand, the regional care centers are of great benefit to patients. However he says that MD Anderson appears to consider itself separate from the community of Houston and Texas, and until clinicians at MD Anderson reach out and establish relationships with practitioners in the community, referrals from the region will not go up. He lists some strategies faculty can use to foster these connections. Dr. Stroehlein then makes some final comments on MD Anderson, characterizing it as a "remarkable institution" capable of maintaining quality of care with a very high volume of patients.

#### Segment 23

##### *Writing and Philanthropy*

A: Post-Retirement Activities

##### Story Codes

A: Post Retirement Activities  
A: Character, Values, Beliefs, Talents  
A: Personal Background

Here Dr. Stroehlein notes that his retirement will keep him occupied with writing projects focused on subjects mentioned earlier in the interview (see Segment 18). He then explains that he will also have the time to become more involved in local organizations such as the Asia Society, Houston Young Artists, and the Pan American Society of Houston. He is fortunate to

be in a financial position to give both funds and will continue to support MD Anderson, his undergraduate institution, his medical school and the Mayo Clinic.

## John Stroehlein, MD

Interview Session 1—December 5, 2012

### **A note on transcription and the transcript:**

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## **Chapter 00A** **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**0:00:00.7**

All right. I just turned on the recorder, and we are recording. So let me read the identifier and get my watch in place where the reflection isn't on the face. There we go. All right. I'm Tacey Ann Rosolowski, and today I am interviewing Dr. John Stroehlein 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. Stroehlein came to MD Anderson in 1977 as deputy department chair—or no, excuse me—as chair of the Department of Gastroenterology. You can tell that I revised my notes here, and I didn't proofread them accurately—my apologies—and held that position until 1982. He spent some years away from MD Anderson returning in 2003 as interim chair of the Department of Gastroenterology, Hepatology, and Nutrition. He is now the department's deputy chair. He is also a professor in that department with specializations in colorectal cancer, pre-malignant lesions of the GI tract, inflammatory bowel disease, and functional disorders of the GI tract. Is that correct?

*John Stroehlein, MD*

**0:01:14.8**

I think that's reasonably accurate.

*Tacey Ann Rosolowski, PhD*

**0:01:16.0**

Okay. We'll have plenty of time to correct that.

*John Stroehlein, MD*

**0:01:19.3**

It focuses on the hollow GI tract instead of hepatology—

*Tacey Ann Rosolowski, PhD*

**0:01:22.8**

Oh, okay.

*John Stroehlein, MD*

**0:01:23.3**

—which in Gastroenterology has fundamentally become a separate specialty.

*Tacey Ann Rosolowski, PhD*

**0:01:28.4**

Okay. Interesting. All right. Well, I'll be interested to hear about that split. Since 2006, Dr. Stroehlein has also served as co-medical director of the Department of Patient Affairs. This interview is taking place in a conference room in the Department of Gastroenterology, Hepatology, and Nutrition. That's in the [Pickens Tower](#) on the main campus of MD Anderson. This is the first of two planned interview sessions, and today is December 5, 2012. The time is about 1:28. And thank you, Dr. Stroehlein, for agreeing to take part in this.

*John Stroehlein, MD*

**0:02:02.3**

Well, thank you.

## **Chapter 01**

### **A: Educational Path**

#### ***A Supportive Upbringing and an Early Desire to Be a Physician***

#### **Story Codes**

A: Personal Background

A: Professional Path

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: The Researcher

C: Evolution of Career

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

##### **0:02:03.1**

I set up this interview so it kind of goes chronologically. I just wanted to start off with some real basic background information. I wonder if you would tell me where you were born and when and where you were raised.

#### ***John Stroehlein, MD***

##### **0:02:20.6**

Well, I was born in Anna, Illinois, which is in southern Illinois, and grew up in that community, which was the Twin Cities—if you call them cities—of 5200 population for Anna and about 1400 for Jonesboro. We were just back there this past weekend. It's a wonderful place to grow up. It's a little sad to see all of the mom and pop businesses in town, which were thriving and well maintained and each one had their own personality and identity, and most are no more. It's not a ghost town, but it's entirely different. It's interesting—on NPR earlier this morning, I understand that the Indian parliament is voting on whether or not to allow some of the mega stores to come into India where ninety-eight percent of the businesses are run by small individual mom and pop businesses. But in any event, we had a community high school, and I was offered a scholarship to any state university I wanted to attend. Back in those days, the application process was very simple. I don't remember taking all the testing that is done today. I was sports editor of a county newspaper—a reasonable population—and also worked in radio on and off through medical school actually, I guess, intermittently. But my editor said, "Write to the registrar tomorrow." That was like in March of the year that I was to start to school, and University of Illinois wrote back right away. I entered a curriculum of what was called engineering physics, which was a new program they had. I always wanted to go into medicine since I was a boy—to one degree or another—and that sort of interest never left.

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

##### **0:04:32.4**

Where did that come from do you think?

***John Stroehlein, MD***

**0:04:32.6**

Well, I don't know where that came from. I wish that years and years ago—decades ago—that I had maintained an anonymous diary of interviews I've made with students and residents because I am absolutely confident that individuals who go into medicine and perhaps into nursing get the idea at a very early age, and what seeds that desire I am really not sure.

***Tacey Ann Rosolowski, PhD***

**0:04:59.4**

It's interesting that, I think, the majority of people that I have interviewed for this project—the people who are in the clinical area—they do have a very early sense—

***John Stroehlein, MD***

**0:05:09.6**

They have an early interest or desire. That may have been—one of the pictures on my wall—we could go there later if you can find your way through the paperwork—is our family physician, Don Stewart. It may have been an influence. Parents may have been an influence. My dad was a tailor—an incredibly patient man. My mother had some health issues at a fairly early age. We lived in a small community, the small community was very nurturing, and I feel fortunate to have had the experiences that I had.

***Tacey Ann Rosolowski, PhD***

**0:05:49.6**

How would you say it's nurturing? What do you recall from that time?

***John Stroehlein, MD***

**0:05:54.7**

I recall three things, I guess—maybe four. One is the relationship between other students. I think that there's a tendency today for one to compare themselves to their peers a lot more than we had. We had very little growing up. We lived in a little two-bedroom bungalow. My grandmother lived with us part of the time. That meant making the bed in the living room each evening and so forth. But we didn't know that—we tied string together to make a ball and twine, et cetera. So to make a long story short, the relationship with other students was such that people in the school across the board were very accepting no matter where you came from, and so forth. Secondly, my family structure was very positive. I really cannot remember any significant conflicts between aunts and uncles. I'm sure they may have existed. You could argue, "Well, they kept it from the kids." But something should have surfaced sooner or later, and it just was not obvious. I could show you video tapes of some family events or reunions. So the relationship with the students was very nurturing. Relationships with family were very supportive, and I was given opportunities that I think I may or may not have had in a different community. For example, I



worked as a sports editor for the county newspaper, which was a decent-sized publication. The editor/publisher was recently president of the [Illinois Press Association](#). And I worked in radio. That was my introduction to radio. So I went to the [University of Illinois](#). I worked for [WPGU Radio](#) at the University of Illinois. I worked for a commercial station in Urbana-Champaign. When I went to medical school, I said, “You know, I may never do this again.” So I auditioned for the six-to-midnight shift for WSTM-FM stereo in Louisville. They gave me the six-to-midnight program every Sunday evening, and that was my last stint in radio. I have a warm affection for the media and what it did for the community. I think there was a good relationship between the students and others in the community—warmth and support of family, although our financial resources were very limited—and the fact that opportunities were provided that may or may not have come along in a different environment.

*Tacey Ann Rosolowski, PhD*

**0:08:54.6**

So when you went to the University of Illinois at Urbana, you majored in chemistry.

*John Stroehlein, MD*

**0:09:00.9**

Right.

*Tacey Ann Rosolowski, PhD*

**0:09:05.0**

Why did you choose—you knew you were tracking in pre-med. You were going to be going to medical school.

*John Stroehlein, MD*

**0:09:06.8**

Well, I didn't start—[Sputnik](#) had gone up the year before I went to college. The only person in my family to go to college—that's aunts and uncles—was my father's brother, who was a mechanical engineer. This was a popular subject. I did pretty well in physics in high school. I didn't do that well in chemistry for whatever reason. I don't know. But when I went to Illinois, I seemed to excel more so in chemistry to the extent that I also worked for the Biochem Department at Illinois as an undergraduate. I took probably forty or fifty hours of chemistry, including the graduate biochem classes. When I went to medical school they said, “You don't need to take any more chemistry.” So I didn't. I took them up on the offer. (laughter) But these opportunities sort of come along. And the other thing that you may come to later is little events in life tend to turn us one way or the other that taken out of context would not seem to be significant. For example, I worked at [Hines VA in Chicago](#) and [Argonne National Lab](#) doing some neutron activation analysis. I worked in the isotope lab there from '60 to '65. I was house manager of a medical fraternity, which paid room and board, but I paid the cook—helped buy the groceries, et cetera—and I met somebody through the student AMA from South Carolina who

was going back to Mayo for a summer program that they had. He was hopscotching from place to place to save money. He happened to stay at our fraternity house and said, "Why don't you write to Drew Miller and apply for the program at Mayo?" Well, I did, they accepted me, and I was assigned to the Gastroenterology Division. I had a wonderful mentor there named Doug McGill, and that nurtured my interest in gastroenterology. So the experiences that we have, I think, can be pivotal in what we later end up doing. I can give you other examples.

## **Chapter 02**

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

#### ***Oncology: An Open Field for Innovative Work in Gastroenterology***

#### **Story Codes**

A: Personal Background

A: Joining MD Anderson

A: Overview

A: Professional Path

C: Evolution of Career

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: The Researcher

C: Professional Practice

C: The Professional at Work

***Tacey Ann Rosolowski, PhD***

**0:11:43.3**

Well, I just wanted to make sure I have dates correct. So in '63 you got your BS, and then in '67 you got your MD from the University of Louisville.

***John Stroehlein, MD***

**0:11:56.7**

That is correct.

***Tacey Ann Rosolowski, PhD***

**0:11:57.6**

Okay. Then you did a first medical internship from '67 to '68 in [Louisville General Hospital](#).

Was that the point where you went to Mayo? Because '68 and '69 you did a residency in Internal Medicine there.

***John Stroehlein, MD***

**0:12:13.3**

That is correct. I went there originally as a student in the summer on the information that my friend had provided. That introduced me to Mayo. I received a call from John Walsh, who was the program director. I remember during my internship he said, "We want you to apply for a residency."

*Tacey Ann Rosolowski, PhD*

**0:12:38.5**

Uh-hunh (affirmative). So prior to that, you had not had a specific interest in gastroenterology.

*John Stroehlein, MD*

**0:12:48.5**

No. No, and it's interesting. It's a fascinating phenomenon—sort of the older one gets or the less young—you encounter many scenarios. If I had not been assigned to the Gastroenterology Division, I do not know if I would have ended up in gastroenterology or another specialty. It's very, very hard to say. When I was applying for internship, I presented a case to [Dr. \[William\] Castle](#), who was a legend in medicine. He says, "Well, you need to apply to the second and fourth [Harvard Medical Service](#) at [Boston City Hospital](#)." So I went there. Another friend of mine was interviewing at the same time, but Dr. Castle was sick that day. So I ended up interviewing with somebody else completely unknown. If he had been there, would that have shifted the career otherwise? I don't know. None of us knows. But it's interesting that we have experiences, and experiences taken out of context can kind of lead one way or another.

*Tacey Ann Rosolowski, PhD*

**0:13:54.0**

What was it that drew you to a specialization in gastroenterology? I mean, once that serendipitous connection happened.

*John Stroehlein, MD*

**0:14:02.2**

Well, I think it was two things: an incredible—absolutely incredible—group of mentors, and probably the strongest—quite honestly, one of the strongest GI departments in the world at the time—and perhaps the fact that gastrointestinal diseases comprise such a broad aspect of internal medicine. You take diseases all the way from the esophagus to anal/rectal to liver, pancreas, ulcer disease, et cetera. And there was not much known about these conditions back then. I well remember the first upper GI endoscopy that I ever saw. People who were well known in medicine actually—along with myself, who was one of the students tagging along on rounds—came to take a look through the lecture scope to see what this looked like. The exam was conducted by a gentleman named Sid Phillips, who later became director of the research GI lab at Mayo. I'm not sure what the basis was, but I am confident it had to do with an interest. I am absolutely confident that the encouragement and the mentoring meant a lot. It was a broad area of medicine that covered so many different disease processes, and so little had been known at that time. Endoscopy had not been developed. Ultrasound was not available. CAT scans were not available. MRIs were not available. Laboratory tests were minimal. There was no treatment for chronic hepatitis. There was no liver transplantation—on and on. I guess those were factors.

*Tacey Ann Rosolowski, PhD*

**0:15:57.3**

So why oncology?

*John Stroehlein, MD*

**0:15:59.2**

Well, two or three things. I was offered opportunity to become the second chief of Gastroenterology at MD Anderson. [Dr. Charles Moertel](#), who was the director of Oncology at [Mayo](#), and I believe [Keith Kelly](#), who later became chairman of Surgery, and one or two others—I was driving. We had gone to Eau Claire, Wisconsin on the basis of the—in support of the [American Cancer Society](#) program there. The weather was not very good, and you're driving not too fast. You have a lot of engaging conversation, and Dr. Moertel comments that Dr. Nelson is stepping down, and maybe it's something that I should consider. And if you stop to think about it—which I did—gastroenterology more probably than most specialties involves oncology. Is the ulcer benign or malignant? Is Barrett's benign or malignant? What's the malignant risk of ulcerative colitis? If you have an abnormality on imaging back then, which did not include cross-sectional imaging, the question was is it benign or malignant. As you well know, gastrointestinal cancers are very common. So gastroenterology, maybe more than most specialties, intersects with oncology very, very closely. So I was offered an opportunity to come here. [Dr. \[R. Lee\] Clark](#) came up to Mayo. We had breakfast at the Kahler Hotel. The area where the breakfast area and café was is now a gift shop, and the café has moved down around the other side, but I could take you to the table where we sat. We talked, and in those days if you hadn't met [Dr. \[Robert\] Hickey](#), Dr. Clark suggested you meet Dr. Hickey. If you met Dr. Hickey but hadn't met Dr. Clark—it was vice versa. So we met, and I came down and met with Bob Hickey and his wife, Rose. They served a corned beef sandwich, and we sat around the house and talked. It was a pretty straightforward recruitment effort compared to the complexity of what we generally provide today.

*Tacey Ann Rosolowski, PhD*

**0:18:34.2**

Why was he interested in recruiting you in particular?

*John Stroehlein, MD*

**0:18:37.9**

Well, I'm not absolutely sure and probably it gets back to the fact that the chairman of Oncology at Mayo had made that suggestion. He may have put in a good word. I had done some work on the validation of fecal occult blood testing, which at the time was one of the modalities that you could use to screen patients for colorectal cancers. So I think it was a combination of maybe some degree of clinical expertise—the clinical studies that I had done with fecal occult blood testing—and the recommendations and support of mentors that made a difference. I wouldn't mind getting a hold of some letters to see what people said about me thirty, forty years ago—

good, bad, or indifferent. It would just be of interest, and it would not be—you know, without any agenda. It just would be sort of fun.

*Tacey Ann Rosolowski, PhD*

**0:19:39.2**

Always interesting.

*John Stroehlein, MD*

**0:19:40.1**

Fun to do. But I think those were all factors.

*Tacey Ann Rosolowski, PhD*

**0:19:42.8**

Uh-hunh (affirmative).

*John Stroehlein, MD*

**0:19:44.6**

When I was at Mayo, I did many of the—for six months—virtually all of the ERCP procedures.

*Tacey Ann Rosolowski, PhD*

**0:19:51.4**

What does that stand for?

*John Stroehlein, MD*

**0:19:51.9**

It means endoscopic retrograde cholangiopancreatography—which was just in its infancy—where you could take an endoscope and you could inject dye into the pancreatic or bowel ducts. We didn't do procedures as are done now with putting in stents and cutting the sphincter open to remove stones. That was just then being introduced. So I had the endoscopic experience. We had done the clinical studies. We must have had some clinical expertise and probably support of mentors that—for whatever reason—felt that I was a good fit for [MD Anderson](#).

*Tacey Ann Rosolowski, PhD*

**0:20:37.9**

So you came to MD Anderson in 1977.

*John Stroehlein, MD*

**0:20:53.7**

That's correct.

## **Chapter 03**

### **A: Military Experience**

#### ***Developing a Personal Mission to Deliver the Best Care***

#### **Story Codes**

A: Military Experience

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Professional Values, Ethics, Purpose

C: Formative Experiences

B: MD Anderson History

B: MD Anderson Culture

***Tacey Ann Rosolowski, PhD***

**0:20:54.3**

Okay. I just wanted to go back a tiny bit because I didn't want to neglect to ask you about the military service that you did in Vietnam between 1969 and 1971. I was wondering—I mean, you told an interesting story about—

***John Stroehlein, MD***

**0:21:11.3**

Dr. [Oscar “Bud”] Frazier.

***Tacey Ann Rosolowski, PhD***

**0:21:11.2**

Dr. Frazier, yes.

***John Stroehlein, MD***

**0:21:12.4**

Yes. We knew each other well.

***Tacey Ann Rosolowski, PhD***

**0:21:14.2**

I wanted to know in addition to some of those interesting connections if there was anything about that experience that you felt really influenced you later as a physician or as a clinician.

***John Stroehlein, MD***

**0:21:25.7**

That's a good question. It may have reinforced what I already intended to practice, and that is simply to provide the best care you can to the individual who are under—for whom you have a

responsibility. I was with an engineer battalion on a field assignment for about six months in a place called [Whiskey Mountain](#), which you can look up on the Internet, then at a large hospital rotating between the emergency room and the outpatient general medical clinic.

*Tacey Ann Rosolowski, PhD*

**0:22:15.9**

And this was the [24th Evacuation Hospital](#).

*John Stroehlein, MD*

**0:22:17.7**

That's correct, which at the time was probably the busiest hospital in Vietnam. As a battalion surgeon, you were responsible for the health of the commands. So it was not just a matter of treating injuries but also trying to be sure that the health of the command—you cannot build roads or fight a war if you're sick. So it had to do with health, sanitation, and all sorts of factors. We made friendships there that are still long lasting and are still maintained. Experiences in a situation like Vietnam can be positive or negative, obviously. It doesn't come as a surprise. But we have very close friendships and have—in the Twin Lakes area near Latrobe, Pennsylvania—a Vietnam Memorial there, where myself, and Dewey Roney and Harry Speedy and Joe Rosenberg have been so honored. I maintain good friendships. We fortunately didn't lose any medics. One was killed after I relocated from there to another site, namely the hospital. And then I was assigned to Dewitt Army Hospital in Washington.

*Tacey Ann Rosolowski, PhD*

**0:23:46.2i**

Uh-hunh (affirmative). In [Fort Belvoir](#).

*John Stroehlein, MD*

**0:23:47.9**

That's correct.

*Tacey Ann Rosolowski, PhD*

**0:23:48.0**

Virginia, yeah. How did you meet? Tell me the circumstances in which you met [Dr. Oscar Frazier](#) or “Bud” Frazier?

*John Stroehlein, MD*

**0:23:58.8**

Well, I was assigned—before moving to a place called Whiskey Mountain, which is near [Phan Thiet](#) in Vietnam, Bud was the flight surgeon for a helicopter company which was housed on the same base that the headquarters company for the engineer battalion was housed. So we both were



on the same base and got to know each other because we were physicians in two different units that were close together.

*Tacey Ann Rosolowski, PhD*

**0:24:32.2**

Uh-hunh (affirmative).

*John Stroehlein, MD*

**0:24:34.0**

And being the flight surgeon for the helicopter company, he had mobility. The first time we met, a Vietnamese had been injured on his motorcycle. Bud thought he should go to the [8th Field Hospital](#), and we flew together and took him to the 8th Field Hospital.

*Tacey Ann Rosolowski, PhD*

**0:24:56.1**

Do you find that the relationships that you established during that period have a different quality or intensity than the non-wartime friendships that are established? I'm just curious.

*John Stroehlein, MD*

**0:25:09.8**

Perhaps to a degree. One of my closet friends—it's more like a brotherhood than anything else then, too. One internist and a dentist—we became very close friends and would get together periodically, and still there's a sentiment or feeling there maybe because we were in this arena or conflict together. I would have to say that any gelling or crystallization of the friendships though were greater or more intense from those that were encountered in a more field experience than those that were encountered in a very busy evac hospital. I really don't keep up with any of my colleagues at the hospital there, but I do keep up with colleagues who were together in a field assignment. Maybe that's true. When you're in something together, you bond a little bit tighter.

*Tacey Ann Rosolowski, PhD*

**0:26:26.8**

I was wondering about that. I was wondering, too, about—I don't know if it's too much of a stretch to make the connection, but from what people have told me about the atmosphere here at MD Anderson—I'm not saying it's like war, but there seems like there was a kind of intensity and excitement. It seems that people had created very strong bonds at MD Anderson during its periods of growth.

*John Stroehlein, MD*

**0:26:53.3**

I think that there were strong bonds, and the bonds historically were stronger than they are now. That's not only true of Anderson, but it's true anywhere. When I was here originally, I am

confident I knew every clinician on the faculty—every one—and they probably knew me. Those working relationships were not interposed by a keyboard. You actually talked to people as we are talking to each other across the table. So the working relationships—it was a different era, and the working relationships were really different. Trying to nurture those working relationships today is one of the challenges, I think, of the institution, which is trying to—they're trying to do that in many ways and maybe have not been as successful as they would like, but they've made efforts.

## **Chapter 4**

### **B: An Institutional Unit, Program**

#### *Gastroenterology in the Late Seventies*

#### **Story Codes**

A: The Administrator

B: Institutional Politics

B: MD Anderson History

C: Professional Practice

C: The Professional at Work

*Tacey Ann Rosolowski, PhD*

**0:27:54.6**

Let's focus a little bit more on how you saw MD Anderson when you came in 1977. You were recruited to be head of the department. What was sort of your mandate from R. Lee Clark? What did you want to do? What did you have here as a department when you arrived?

*John Stroehlein, MD*

**0:28:14.5**

Well, we had really probably only two other individuals in the department.

*Tacey Ann Rosolowski, PhD*

**0:28:21.4**

How many people are there now?

*John Stroehlein, MD*

**0:28:23.0**

Fourteen.

*Tacey Ann Rosolowski, PhD*

**0:28:22.7**

Yeah. Okay.

*John Stroehlein, MD*

**0:28:27.1**

I would say several things. One was we had a clinical service to provide, and Dr. Robert Nelson, who was the first chief of Gastroenterology, had done a yeoman's job of establishing a clinical service which we needed to maintain. We provided diagnostic studies—not as many therapeutic studies as we do today—but diagnostic studies for our colleagues in oncology and surgery. That was one aspect which I needed to continue to nurture and which we did. The joint subspecialty-

training program in gastroenterology had been established maybe two years at most before I came. And then there was a research component that had yet to be established in the laboratory. So I guess I basically tried to do maybe four things. One was to try to maintain the clinical service, which was fairly demanding.

*Tacey Ann Rosolowski, PhD*

**0:29:34.3**

How many patients did it serve at that time per year?

*John Stroehlein, MD*

**0:29:40.1**

I don't know exactly, but I can tell you some days we probably saw thirty or forty individuals, which is many more than today. But the therapeutic options were maybe a little bit less complex, and the people were not quite as complex and complicated as they are today. Illnesses are much more complex. Treatment modalities may address the primary problem but may create other problems. So somebody comes with a history of the disease then the complications of treatment and something else may superimpose. The complexity of the patients we see today is remarkable. What did we try to do back then? We tried to maintain a clinical service. I very strongly felt that we should support the joint training program. MD Anderson funded so many GI fellows and the medical school funded so many. We had four fellows, I think, at the time—two at each location.

*Tacey Ann Rosolowski, PhD*

**0:30:50.5**

What was it about the training program that was so important to you that you wanted to direct resources there?

*John Stroehlein, MD*

**0:30:58.1**

I guess it may have been impacted on the positive experience I had in training. And then the fact that without a training program, gastroenterology or any subspecialty department leaves a lot to be desired. Then I recruited gastroenterologists who had experience in the lab to develop some of our research activities and then later somebody else to develop those. This was at a time—and you may have heard about the Department of [Developmental Therapeutics](#) and Department of Medicine and sort of the conflicts that existed between the two. I sought to bridge those, and we did successfully. I accepted surgical oncology fellows to do procedures—not with the idea of coming down and do the procedure and leave. But if you want to do procedures, we offered that training and research activities to surgical oncology fellows who planned in their career to focus on gastrointestinal oncology. So they rotated just like the other fellows. They were a member of the team. That's how we really saw that they were accepted by the gastroenterology fellows. They were not threatening or coming down and stealing their procedures or anything. They were part of the team. They took call, and they did what others did. Byron McGregor and Katie Elwyn

were two of the fellows who did some very novel research at the time looking at the hormonal influences on colorectal cancer. Katie was a marvelous animal surgeon doing partial gastrectomies on rat animal models and doing microsurgery that I still rather marvel at today. So we maintained a clinical service. We really sought to support the subspecialty training program. We recruited individuals to work in the lab. You asked what were some of the things I did. And then I had to mend fences between these departments, which had been at loggerheads for years. And we were successful in doing that. In fact, quite frankly, very successful.

*Tacey Ann Rosolowski, PhD*

**0:33:46.2**

What were some other ways in which you addressed those fences that needed mending?

*John Stroehlein, MD*

**0:33:49.8**

Well, I think you can look at the example of the surgical oncology fellows. When they came on board, we selected those—not who are going into breast medical oncology and they might want to do a few procedures just to see what it was like. These were people who were surgeons—physicians who had a more sustained interest in gastroenterology. And furthermore, they served like the GI fellows. They became one of us, so to speak. And I must give credit to some of the developmental therapeutic folks that were helping us mend the fences there because they rotated in our department. We became involved in their protocols. And as such, in a different way, became part of the team. So the conflicts were partially neutralized by assuring that all component parts had a stake in this whole operation that was for the better good.

## **Chapter 5**

### **A: Overview**

#### ***Challenges to Diagnosing and Treating GI Cancers in the Late Seventies***

#### **Story Codes**

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

C: Professional Practice

C: The Professional at Work

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

D: The History of Health Care, Patient Care

D: Cultural/Social Influences

C: Patients

C: Patients, Treatment, Survivors

C: Offering Care, Compassion, Help

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

#### **0:35:02.7**

I wonder—would you mind if we kind of do some background here on gastroenterology and cancers of the GI tract? I would like to have a more vivid understanding of exactly what happened to a patient. As I understand—I just want to read a statistic that I got from an article that was published. Actually, Mary Jane Schier wrote it in 1979 for the [Houston Chronicle](#). It said deaths in Texas from colon and rectal cancer rose thirty-three percent between 1969 and 1977. The rates were even higher in the northeast. I believe there was another statistic that said that one out of every ten cancer patients actually died of colorectal cancer. So the rates were really, really high because—as this article said—there was so little really that could be done. So I am wondering what were the challenges that you faced—and other gastroenterologists faced—when dealing with this particular disease.

#### ***John Stroehlein, MD***

#### **0:36:07.6**

One of the challenges was making a diagnosis before symptoms developed. Ted Copeland, who was here—his uncle, Murray Copeland, was Director of the [National Large Bowel Cancer Project](#). He came from Memorial Sloan-Kettering. To make a long story short, studies indicated if you made a diagnosis before symptoms developed the outlook was much better. It had not been proven. At that point in time, there was reason to believe that adenomatous polyps—if they were removed—would secondarily prevent cancer. But it really fundamentally has only been in this past calendar year that it has been proven in no uncertain terms that removing adenomas reduces the risk of colorectal cancer by about fifty-three percent. Our success then through secondarily preventing colorectal cancer is much greater—for reasons that are not entirely

clear—in the rectum and sigmoid portions of the colon. And basically, our challenges were to render an early diagnosis. We had no cross-sectional imaging at the time and no other ways to accurately stage patients. If you want to know what has been one of the, I think, biggest influences in gastroenterology over the timeframe that I have been involved—it is being able to more effectively manage complications of cancer and cancer therapy—which impacts on the quality of life of individuals—but also enhancing the accuracy of staging so you can pick and choose who is most likely to benefit from surgery.

*Tacey Ann Rosolowski, PhD*

**0:38:17.4**

And when you say staging, you mean determining the actual—

*John Stroehlein, MD*

**0:38:23.1**

Extent.

*Tacey Ann Rosolowski, PhD*

**0:38:23.6**

—extent of the cancer.

*John Stroehlein, MD*

**0:38:24.6**

Right.

*Tacey Ann Rosolowski, PhD*

Right. Yeah.

*John Stroehlein, MD*

**0:38:25.9**

It took, in my opinion, decades for endoscopic ultrasound to come into its own. But now endoscopic ultrasound is considered to be indispensable in the staging of disease.

*Tacey Ann Rosolowski, PhD*

**0:38:42.8**

And when you say ‘coming into its own,’ you mean that physicians and diagnosticians actually read the images and understand.

*John Stroehlein, MD*

**0:38:51.4**

Well, that’s probably it, and the equipment is better and so forth. But studies have shown that the

value of the modality to cytopathologists probably is—maybe do a better job. I don't know. It seemed like you would go to meetings and people would present papers about endoscopic ultrasound, and it kind of fell on deaf ears. But now it's considered to be indispensable, and it has greatly enhanced the accurate extent of disease, which allows the surgeons to selectively operate on the people who are going to benefit most. Surgical intervention has its own morbidity and mortality, so if there are risks involved, you would like to have benefits that outweigh the risks.

*Tacey Ann Rosolowski, PhD*

**0:39:52.5**

Right. I was also reading in the article by Mary Jane Schier that there was really some cultural factors that were working against treatment of cancer because people were very reluctant or embarrassed to talk about their bowels or abnormalities or irregularities.

*John Stroehlein, MD*

**0:40:12.0**

I think that is probably generally the case. They may remember an aunt or an uncle or a parent or a grandparent who had difficulties at a time when there was little that could be done. In that article there is a jeweler who had a colostomy. He was incredibly helpful in talking to individuals. He worked in a fairly prominent jewelry store. He was dealing with the public every day. He had this ostomy. Wow! So it wasn't such an onerous condition.

*Tacey Ann Rosolowski, PhD*

**0:40:50.2**

Uh-hunh (affirmative). Has that changed culturally? Are patients now—

*John Stroehlein, MD*

**0:40:53.6**

I think it's probably changed culturally, but I think it has also changed by virtue of the fact that there are ways to manage the condition that historically did not exist. I am reminded also of the [Enterostomal Nursing Program](#) here, which we were very actively involved with.

*Tacey Ann Rosolowski, PhD*

**0:41:16.1**

I'm sorry. I missed the name of it.

*John Stroehlein, MD*

**0:41:17.0**

Enterostomal. E-N-T-E-R-O-S-T-O-M-A-L. Enterostomal Nursing Program, which when I was here initially was the only—to my knowledge—approved enterostomal nursing program in the southwestern United States. Fundamentally there may have been cultural changes, but people



also change when they're up against or they see a reality. And the reality was that their neighbor or their uncle or their cousin may have an ostomy—which we rarely have to perform today for a variety of reasons—and they could be managed very effectively. So the reality of this was greatly enhanced by the services that the enterostomal nurses provided: new equipment, Karaya seals, odorless preparations, and so forth. They could easily be managed.

*Tacey Ann Rosolowski, PhD*

**0:42:21.8**

So these were the nurses who really provided support for patients who needed a colostomy bag.

*John Stroehlein, MD*

**0:42:29.0**

And/or who had difficulty or any type of dilemmas on an ostomy, gastrostomy—any type of device. Now you see enterostomal therapy and wound healing. The wound healing has sort of come under that same umbrella, rightly or wrongly. But enterostomal nursing oftentimes in many hospitals also helps direct the programs of wound healing.

*Tacey Ann Rosolowski, PhD*

**0:42:57.4**

I had actually never heard of that before. So if you were going to remove a huge section of a person's bowel, for example or—maybe you could take me through an example to show me how you would work with a patient and then how the enterostomal nurses would work with a patient. I'm doing this for the—I think it's—

*John Stroehlein, MD*

**0:43:20.3**

The enterostomal nurses—you've got to work with the patient before the fact. As it pertains to placement of the ostomy, meeting with the patient—having them meet this jeweler. Let them see that somebody can go on with their life with that. The fortunate thing is that there have been advances in the management of cancer so that ostomies are very unusual today.

*Tacey Ann Rosolowski, PhD*

**0:43:45.4**

Really. Uh-hunh (affirmative).

*John Stroehlein, MD*

**0:43:47.6**

That's because of chemoradiation and low anterior anastomosis. There may be a temporary ostomy, but usually they are reconnected. The other thing that has evolved from a surgical standpoint is the resection of metastatic disease—which was in its infancy when I was initially chair of the department here—but which I champion. I can give you a book of a couple that was

here just last week. They spoke at the sixty-fifth anniversary celebration of Anderson and wrote a book about their experiences, *[The Dawn Will Come](#)*. I felt back then that there was a role for resection of metastatic disease, and today there is more resection of metastatic cancer at Anderson than there is resection of primary colorectal cancer. There have been other advances such that individuals who have metastatic—at least to lymph nodes—esophageal cancer can be treated with chemoradiation and have long-term survival that is measured in terms of many, many years or may in some cases be cured. Historically, that would have not been the case. So it's interesting to have gaps of time intersected by appointments elsewhere where you see something and you come back and you see it. The difference is more vivid under those circumstances.

## **Chapter 6**

### **A: The Administrator**

#### ***Building Teams to Diagnose and to Try New Techniques***

#### **Story Codes**

A: The Administrator

A: The Researcher

C: Discovery and Success

A: Definitions, Explanations, Translations

C: Patients

C: Patients, Treatment, Survivors

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

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

D: The History of Health Care, Patient Care

***Tacey Ann Rosolowski, PhD***

**0:45:22.9**

And you're referring to the fact that you left the institution in—

***John Stroehlein, MD***

**0:45:27.3**

That's correct.

***Tacey Ann Rosolowski, PhD***

**0:45:27.9**

Two thousand and—eighty—

***John Stroehlein, MD***

**0:45:29.9**

Eighty-two.

***Tacey Ann Rosolowski, PhD***

**0:45:30.7**

In '82 and then came back in 2003. I will want to ask you about the reason for that migration elsewhere and then your return, but I wanted to make sure that we cover adequately the time where you were chief of the department prior to that. So how are some ways—you've talked

about these different advances that have occurred in the practice—in the field since the '70s when you entered it. What were some ways that you feel the initiatives that you set in place here at Anderson helped make in-roads into these different areas—the research program, some of the clinical trials. What were you working on in other words?

*John Stroehlein, MD*

**0:46:19.8**

Well, I think one of the things was team building and incorporating individuals with expertise in other areas as members of the team to tackle a common enemy. And through the educational programs, training individuals who—once they finished fellowship—would be better equipped to serve in that capacity in the communities in the early diagnosis of cancer and/or removal of premalignant lesions—and perhaps just demonstrating that something could be done, such as the hepatic resection of metastatic disease.

*Tacey Ann Rosolowski, PhD*

**0:47:08.8**

Could you explain to me what that is exactly?

*John Stroehlein, MD*

**0:47:10.1**

I'm sorry?

*Tacey Ann Rosolowski, PhD*

**0:47:11.9**

Could you explain to me what that is—the hepatic resection of metastatic disease?

*John Stroehlein, MD*

**0:47:16.8**

Yeah.

*Tacey Ann Rosolowski, PhD*

**0:47:17.9**

I am asking because there will be non-specialists listening to this.

*John Stroehlein, MD*

**0:47:20.7**

Surely. Metastatic disease means something has spread to another area from, say, the colon to the liver—which historically would have been considered to not be a surgical case. It would be treated with chemotherapy or nothing. But they can be cured, and I'll share with you a very shining example of somebody who is now thirty-three years out who had metastatic disease to

the liver, was given a matter of months to live, came here and had his liver resection, and is, I think, thirty-three years out now and doing well.

*Tacey Ann Rosolowski, PhD*

**0:48:08.1**

Wow. That's amazing.

*John Stroehlein, MD*

**0:48:11.4**

So generating the mindset that some of these things could be done.

*Tacey Ann Rosolowski, PhD*

**0:48:24.2**

I'm curious why—what led to the wisdom at the time or the belief at the time that metastatic disease would not—that resecting it would not be a useful therapeutic measure?

*John Stroehlein, MD*

**0:48:39.4**

Well, I think it was the wisdom at the time—that it might not be—that it was of limited value. But then you see patients—

*Tacey Ann Rosolowski, PhD*

**0:48:47.5**

But what had reinforced it? I mean, why did people believe that?

*John Stroehlein, MD*

**0:48:51.4**

Why?

*Tacey Ann Rosolowski, PhD*

**0:48:51.5**

Uh-hunh (affirmative).

*John Stroehlein, MD*

**0:48:52.7**

I think it was assumed that once disease had spread beyond its local confines, it was not curable.

*Tacey Ann Rosolowski, PhD*

**0:49:00.1**

I see.

*John Stroehlein, MD*

**0:49:00.6**

But then there are other tumors or cancers where one consolidated disease—and there was one spot that was left over. Everything else seemed to be cured. I'm thinking of one patient who had an extrasosseous osteosarcoma—had disease in the chest, and it was later resected. The lady is alive probably thirty years later—whatever. So in other words, there were examples in cancer—that was not necessarily gastrointestinal cancer—wherein solitary metastases were resected.

*Tacey Ann Rosolowski, PhD*

**0:49:39.4**

What made you and others at MD Anderson go ahead and remove those metastases against the prevailing wisdom?

*John Stroehlein, MD*

**0:49:51.3**

I guess there were several things. One, there was no effective chemotherapy, no expectation of cure, and the pattern in metastatic disease is such that sometimes it behaves in very peculiar ways. I can remember one lady who had a colon cancer, as I recall. She had a solitary metastasis to the liver that was resected. A couple of years later had a solitary metastasis to the lung that was resected. And she went a few more years. Later had metastatic disease to the brain which was not amenable to complete resection. It was palliative resection. But this individual had complete quality of life and lived for a matter of years. So the pattern of disease is something that is not well understood. Why does one person get a solitary metastasis? Somebody else may have widespread metastatic disease, and you don't know where the primary came from. What is the molecular trigger, for example, that causes something to become malignant and held as the soil? People are now becoming very interested not just in the cancer itself but where it is growing. Is it growing in sandy soil? Is it growing in clay or whatever?

*Tacey Ann Rosolowski, PhD*

**0:51:20.3**

And I have interviewed, so the soil and the seed metaphor—yes.

*John Stroehlein, MD*

**0:51:24.3**

Yes. And there's a considerable interest in the soil. The soil is probably a lot more important than we previously recognized. And Josh has—Dr. [Isaiah Joshua] Fidler [Oral History Interview] has, I think to one degree or another, championed that concept for years at a time. If you talk about going against prevailing wisdom, prevailing wisdom was the soil probably didn't matter that much, but it probably matters. And indeed, how you treat a particular disease process

probably should be influenced by whether it is metastatic to bone or whether it is metastatic to liver or lung or what have you.

*Tacey Ann Rosolowski, PhD*

**0:52:23.7**

How effectively do you feel—in going back to your role as head of the Department of Gastroenterology—what do you feel you would achieve by the end of your time? As '82 was approaching, which was when you left the institution, what were you pleased that you had accomplished and what did you have yet to accomplish?

*John Stroehlein, MD*

**0:52:46.9**

We had maintained the clinical service. We had successfully recruited individuals to the research arm, which was not then called a department. We had solidified the GI training program—which was on very strong footing and is now in its, I guess, thirty-sixth year—and had bridged the gap between Developmental Therapeutics and Surgical Oncology.

## **Chapter 07**

### **A: The Researcher**

#### ***Researching the Nature of GI Cancers***

#### **Story Codes**

A: The Researcher

C: Discovery and Success

A: Definitions, Explanations, Translations

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

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

D: The History of Health Care, Patient Care

***Tacey Ann Rosolowski, PhD***

**0:53:44.3**

I wanted to ask you about your own research during this particular period as well before we go on—unless you would like to leave that until next time.

***John Stroehlein, MD***

**0:53:51.7**

The what please?

***Tacey Ann Rosolowski, PhD***

**0:53:51.4**

I wanted to ask you about your own research program when you arrived, too, or would you rather kind of continue—

***John Stroehlein, MD***

**0:54:01.7**

We can continue this. I could have and probably should have nurtured my research programs more than they were. I have always been a clinician. I was heavily engaged in the operations of the department with a lot of hands-on care and support of all the individuals in the department, which leaves very little time to do research. It was a full-time job to maintain the clinical service and provide the training program for the fellows, to meet with the laboratory personnel, and to try to nurture the research in that way. In that respect, I guess, I'm not really a basic researcher that many department heads have followed.



***Tacey Ann Rosolowski, PhD***

**0:55:11.8**

Would you like to tell me about some of the areas that you were involved with when you—the research areas that you were involved in when you came here?

***John Stroehlein, MD***

**0:55:21.0**

Back in those days, we did medical oncology in addition to gastroenterology, so there were joint treatment programs in medical oncology in the chemotherapeutic treatment of diseases. In conjunction with our laboratory personnel, we looked at breath hydrogen, breath methane as markers of the micro-biome, which is now under intense scrutiny because the bacterial friends that we coexist with may have an influence on disease states. The research basically involved collaboration with individuals who were more directly responsible for that, but I supported them—or certainly sought to—and saw that they had the resources and pursued the studies in which they were interested.

***Tacey Ann Rosolowski, PhD***

**0:56:38.9**

So were these clinical trials that you were working on?

***John Stroehlein, MD***

**0:56:44.4**

There were clinical trials and/or studies that looked at markers of disease—taking individuals who might have cancer—or in one trial giving them B-hemoglobin and looking at breath methane, breath hydrogen to see how the blood was metabolized differently in individuals with cancer and those who do not have cancer.

***Tacey Ann Rosolowski, PhD***

**0:57:23.8**

What were some of the findings of those studies?

***John Stroehlein, MD***

**0:57:28.3**

I would have to go back to the—basically there were differences in methane production. It was greater in individuals who had cancer.

***Tacey Ann Rosolowski, PhD***

**0:57:39.7**

Did it come to be used as a marker?

***John Stroehlein, MD***

**0:57:44.0**

Not really. Not to the extent that one might have expected.

***Tacey Ann Rosolowski, PhD***

**0:57:47.6**

Interesting.

***John Stroehlein, MD***

**0:57:48.9**

I was interested in the influence of gastrointestinal hormones on gastrointestinal cancer. It was in that context that I encouraged Dr. Elwyn, for example, to study this. She and Byron McGregor did study this. Where we probably went astray is not reporting and writing up a lot of the things that we did. We did the first studies to show that endoscopic biopsies were adequate for flow cytometry. We established the impact of gastroenterology by procuring specimens from what are in effect molecular marker studies. The studies that were in the animal models clearly demonstrated in no uncertain terms that gastrin—a gastrointestinal hormone—had trophic or stimulating effects on colorectal cancer, and this could be neutralized by the administration of gastrointestinal hormones that countered the effect of gastrin. So our research studies, which maybe—thinking back on it—were maybe a little bit more comprehensive than I superficially would think them to be. But we did validation studies of flow cytometry, worked with Bart Barlogie, who is now in Arkansas with this. We did a lot of studies with [flow cytometry](#).

***Tacey Ann Rosolowski, PhD***

**0:59:41.6**

And what was the significance of flow cytometry?

***John Stroehlein, MD***

**0:59:43.5**

Well, you could look at cell cycles to see to see whether a cell was in metaphase, anaphase, G1, G2, M—to see how the cell cycles were progressing.

***Tacey Ann Rosolowski, PhD***

**1:00:01.2**

Uh-hunh (affirmative).

***John Stroehlein, MD***

**1:00:01.5**

This is now used in a lot of studies with a number of cancers. I guess it's fair to say probably more the lymphomas, some of the myelomas, but I'm getting a little out of my area of expertise.

The bottom line is flow cytometry is available in other variants. The molecular marker studies are really an extension of that. So we established that you could do this. We did the clinical studies and participated in joint chemotherapy oncology programs.

*Tacey Ann Rosolowski, PhD*

**1:00:41.2**

So did you put some of these—did you put results to use or how did the information that was coming out of these studies contribute to what you were doing in the clinic?

*John Stroehlein, MD*

**1:00:58.0**

We put them to use, I guess, in that we validated that they could be used.

*John Stroehlein, MD*

**1:01:05.3**

We put them to use by participating actively with members of Developmental Therapeutics, which was very controversial at the time.

*Tacey Ann Rosolowski, PhD*

**1:01:16.1**

Were these on the chemo studies?

*John Stroehlein, MD*

**1:01:19.9**

Chemo studies.

*Tacey Ann Rosolowski, PhD*

**1:01:19.9**

Yeah. You had mentioned earlier that there wasn't any way to use chemo in some patients because of the way that the cancer metastasized into areas that would be very, very—the toxicity levels that would build up would be lethal.

*John Stroehlein, MD*

**1:01:38.8**

The value of chemotherapy was then much more limited because we didn't have the chemotherapeutic drugs we have today.

## **Chapter 08**

### **B: An Institutional Unit, Program**

#### *The Departments of Gastroenterology and Developmental Therapeutics*

#### **Story Codes**

A: The Researcher

C: Understanding the Institution

B: Multi-disciplinary Approaches

C: Collaborations

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

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

D: The History of Health Care, Patient Care

B: MD Anderson Culture

#### *Tacey Ann Rosolowski, PhD*

#### **1:01:45.5**

So were you involved with Developmental Therapeutics in discovering some combinations that could be used?

#### *John Stroehlein, MD*

#### **1:01:52.2**

To a degree. I must credit the Developmental Therapeutics team for their contributions in conjunction with rotations in our department. But what we did was we made—in some respects—maybe a reasonably courageous stand of pursuing developmental therapeutics in a section of internal medicine.

#### *Tacey Ann Rosolowski, PhD*

#### **1:02:28.5**

Uh-hunh (affirmative). What were some of the studies that you collaborated with them on and how did they—

#### *John Stroehlein, MD*

#### **1:02:34.2**

We collaborated for an oral form of [5-FU](#). We collaborated with the significance of [mitomycin](#)—if any—in upper versus lower gastrointestinal cancers. I believe there was a cisplatin study that I can recall. You're going back thirty-plus years, so it's a little hard to remember some of those, but those are some that I remember distinctly.

***Tacey Ann Rosolowski, PhD***

**1:03:09.7**

Now from your perspective, why was Developmental Therapeutics so controversial, and did it deserve the charge of being controversial at the time?

***John Stroehlein, MD***

**1:03:23.3**

Good question and I'm not sure exactly why it was as controversial as it was. I think it partially dealt with ownership of the patient and the therapeutic programs. From both sides of the fence, the parties involved were probably too recalcitrant to accept others as having anything to offer when they both had something to offer. In effect, seeing that they both had something to offer, I think it is fair to say that I tried to identify the positives and build on that. It wasn't all that popular with Dr. Nelson, who was the first chief of GI here. People have grown up and lived with mindsets for a long time. Now there's no problem. It's a non-issue.

***Tacey Ann Rosolowski, PhD***

**1:04:48.2**

I got the sense from stories that some people have told—and also some things that I've read—that it was almost as if the scientists in Developmental Therapeutics were seen as sort of rogue scientists—that they were experimenting excessively on patients and causing a lot of suffering in some cases that physicians who had been at MD Anderson for a longer period of time and had been there before the DT people—

***John Stroehlein, MD***

**1:05:21.0**

There was a mindset of that nature.

***Tacey Ann Rosolowski, PhD***

**1:05:23.7**

Yeah.

***John Stroehlein, MD***

**1:05:24.8**

I would have to say that the programs that we were involved with were, for all practical purposes, more frontline programs. They didn't continue to—didn't involve treating patients until their dying day.

***Tacey Ann Rosolowski, PhD***

**1:05:41.7**

Right. Well, I think that's—I know that [\[Emil J\] J Freireich](#) came back with that as a comment. You know—that they took the patients that were really severely ill.

*John Stroehlein, MD*

**1:05:52.7**

That's true. Some individuals who had appointments didn't feel that there was any role whatsoever under any circumstances for palliative care. I suspect J would agree that there are some individuals in whom palliative care is quite appropriate.

*Tacey Ann Rosolowski, PhD*

**1:06:11.9**

Uh-hunh (affirmative). Why was there that belief that there was no role for palliative care? I mean I find that—I always find that surprising to hear.

*John Stroehlein, MD*

**1:06:21.2**

Another member of the department who left and came back stopped by to say hello and so forth, said he really thought it was really awful that there could even be a palliative care service—that it should not exist. It's ironic that one has to almost have that mindset within reason to achieve improvements in the treatment of a disease process which is going to be lethal.

*Tacey Ann Rosolowski, PhD*

**1:07:02.3**

Interesting.

*John Stroehlein, MD*

**1:07:06.2**

Jay is an admired colleague. We know each other well. We have, I think, a very good friendship. You have interviewed him at some length.

*Tacey Ann Rosolowski, PhD*

**1:07:16.9**

Uh-hunh (affirmative). Yeah. It sounds like there were some differences, too—differences in views. Yeah.

*John Stroehlein, MD*

**1:07:27.1**

There were operational issues that had to be historically addressed. I think probably our department addressed them as well or better than any.

***Tacey Ann Rosolowski, PhD***

**1:07:45.7**

Can you give me an example—some examples—of some of those issues that you addressed in a really satisfying way?

***John Stroehlein, MD***

**1:07:56.0**

I think one was bringing Developmental Therapeutics—the faculty—into our department. I must give them the credit in becoming members of the team. Seeing patients in consultation—they did more than just come and tell us—there was nobody dictating what we should do as it pertained to treatments that were given, if that makes sense.

***Tacey Ann Rosolowski, PhD***

**1:08:36.8**

Uh-hunh (affirmative). Yeah, it does.

***John Stroehlein, MD***

**1:08:37.3**

I think that's the main thing—what this interview prompts me to have to think—how were things, what was different, what did we do, what did we not to do? There are a lot of things that I know I could have done—probably should have done—that were left undone. There are certain things we have done that were good. I think the things that were good are the integration of other departments in gastroenterology and the nurturing and support of the educational programs.

## **Chapter 09**

### **A: Overview**

#### ***Education, a Changing View of Cancer, and the Future of Gastroenterology***

#### **Story Codes**

A: The Researcher

B: Multi-disciplinary Approaches

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

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

D: The History of Health Care, Patient Care

B: Education

A: The Educator

A: The Mentor

B: MD Anderson Culture

D: Fiscal Realities in Healthcare

B: Institutional Processes

B: Devices, Drugs, Procedures

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

##### **1:09:17.4**

What was your philosophy of the educational program? You obviously have very strong feelings about that. What was its purpose? What kind of philosophy of education did you want it to reflect?

#### ***John Stroehlein, MD***

##### **1:09:31.2**

I guess fundamentally the patient comes first and to reflect the concept that the cancer patient is no different than other patients. They may not be any sicker than somebody with other advanced diseases.

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

##### **1:09:59.2**

Why is it important to see the cancer patient is no different from other sorts of patients?

#### ***John Stroehlein, MD***

##### **1:10:06.9**

I think that you can probably manage cancer more effectively if the patient is the focus of your activities and if you try to see what one can do. There are things that can be done for individuals who have advanced connective tissue disorders, lupus, renal failure, dialysis, kidney transplants,



and so forth—are things that could be done for cancer patients. They are just as interesting and just as challenging. Cancer sometimes tends to make things to be more earthy or mundane when they really are very involved and very sophisticated.

*Tacey Ann Rosolowski, PhD*

**1:11:09.5**

I suppose with the increasing understanding of cancer—now with the tumor heterogeneity—I mean, all this understanding of the molecular basis of the disease—that must have made it a lot easier to—

*John Stroehlein, MD*

**1:11:22.8**

It makes it easier, and it makes it more difficult.

*Tacey Ann Rosolowski, PhD*

**1:11:27.7**

It makes it easier to convince students, certainly, that the disease is very interesting.

*John Stroehlein, MD*

**1:11:36.3**

It is true that you could probably convince students that they're more interesting, but the complexity makes it very difficult for the individual clinician to get their hands around because there are so many markers. In the future, even more, the pathologists report very similar diagnostic markers.

*Tacey Ann Rosolowski, PhD*

**1:12:00.2**

Uh-hunh (affirmative)

*John Stroehlein, MD*

**1:12:01.6**

It's almost like alphabet soup. Stan Hamilton and I were talking several months ago—just very, very briefly, almost in a hallway corridor—about this. He in effect said that you haven't seen anything yet. I think he's absolutely right. Cancers are going to be categorized and sub-categorized. We already do this for breast, whether its estrogen, progesterone, [HER2](#)-positive, HER2-negative, et cetera. We have then established treatment programs for those that meet A1, C2, X3, and 24Q. You know—a bunch of numbers and letters that mean something. Keeping track of these markers is a daunting task that no one is probably prepared to embrace. How we are going to achieve this in the future, I really don't know.

***Tacey Ann Rosolowski, PhD***

**1:13:18.0**

So the task of the clinician of just understanding the disease—

***John Stroehlein, MD***

**1:13:26.0**

It's going to be very different going forward than it has been historically when we were more focused on gross morphology than molecular histology.

***Tacey Ann Rosolowski, PhD***

**1:13:43.9**

What do you see happening in your field specifically with GI cancer and colorectal cancer in particular?

***John Stroehlein, MD***

**1:13:53.1**

I think that we're going to see the development of more biomarkers and the prospects of doing nucleic acid analysis—DNA in the stool—that may indicate the prospects of the possibility of disease that does not demand invasive procedures unless you have reason to believe that something exists. So I think we're going to see more biomarkers and the laboratory tests that help to stratify risk factors. We already do risk factors based upon personal history, family history, social history. These are historical risk factors.

***Tacey Ann Rosolowski, PhD***

**1:14:56.6**

Uh-hunh (affirmative).

***John Stroehlein, MD***

**1:14:58.0**

But in gastroenterology in the future, the personal history, family history, social history will be augmented or supplemented by the utilization of various biomarkers that determine the probability of disease.

***Tacey Ann Rosolowski, PhD***

**1:15:30.7**

So this is the whole question—not just of diagnosis but of prevention as well, of course.

***John Stroehlein, MD***

**1:15:43.8**

Yes. There's no real evidence that chemo prevention works except for—if you treat hepatitis or

immunize against hepatitis B, you dramatically reduce the risk of hepatocellular carcinoma. There's no doubt about it. [Dr. \[Robert\] Palmer Beasley](#), who died earlier this year, was dean of the [School of Public Health](#) and deserved and received a lot of the credit for conducting the epidemiological studies in Asia, which proved that fact. The treatment of H. pylori may reduce the incidence of gastric cancers. There have been proven studies in Japan. The ablation of Barrett's esophagus endoscopically may prevent the development of esophageal cancer for individuals who have high-grade dysplasia. The removal of polyps that are premalignant will reduce the incidence of colorectal cancer. That was proven earlier this year. So there are a variety of things that we can do that can probably prevent cancer. The holy grail has to do with some chemo-preventative measures that have yet to be established. Individuals here and elsewhere—some of my colleagues are looking at nonsteroidal anti-inflammatory medications in individuals who have polyposis syndromes. The role of calcium, vitamin D, fiber supplementation are processes that have been used, but none have been proven in no uncertain terms to be preventative.

*Tacey Ann Rosolowski, PhD*

**1:17:46.0**

What are the incidences of these cancers like now? I mean, I mentioned a little earlier the statistics done in 1979. But what about the incidence now? Is it rising? Falling?

*John Stroehlein, MD*

**1:18:01.2**

Esophageal cancer is rising. In the past few years, it was the most rapidly rising cancer. That's adenocarcinoma of the esophagus, the basis for which is not really very clear. What switches on molecular processes that may help to forestall or prevent cancer and have those become promoters is really the sixty-four-dollar question. So in answer to your question, the incidence of esophageal cancer has gone up. The incidence of gastric cancer has decreased, except to a degree in the Hispanic population, and we are in the process of doing some studies with one of the basic science labs looking at this. They have shown some definite unpublished but to-be-released data that there are genetic abnormalities in this patient population that seem to be different from other populations—highly statistically significant. There's not much that can be done about cancer of the pancreas, but it was proven about two years ago—or reasonably so—that the natural history of cancer of the pancreas is probably much longer than we previously thought. If that is the case, it may introduce the possibility of some type of chemoprevention or chemotherapeutic intervention. Then earlier this year, of course, the removal of polyps as a definite way to prevent colon cancer was firmly established. A lot of progress has been made, but obviously more is needed. More is going to come to one degree or another from the molecular biology side of the fence. We are much better at dealing with structure than we are function—how cells talk to each other and how they get along or don't get along. In medicine, we are much more skilled at removing the stone, dilating the stricture, setting a fracture, suturing a laceration, bypassing coronary obstruction, repairing an aneurysm—the list goes on. But these are to one degree or another structural instead of functional. So how do cells talk to each other? How do they tell each

other what to do? Or what is the switch that turns something from being a suppressor to thereafter being a promoter and promoting the growth and development of cancer, which it otherwise would have suppressed?

*Tacey Ann Rosolowski, PhD*

**1:21:33.4**

It's very exciting.

*John Stroehlein, MD*

**1:21:35.4**

It is exciting.

*Tacey Ann Rosolowski, PhD*

**1:21:36.2**

Yeah. Yeah.

*John Stroehlein, MD*

**1:21:37.0**

And I think it is true, as [Dr. \[Ronald\] DePinho](#) has pointed out, you can do things today that not that many years ago were not possible or feasible for two reasons. One, they can be done in shorter periods of time and, number two, at less cost.

*Tacey Ann Rosolowski, PhD*

**1:21:57.9**

Today.

*John Stroehlein, MD*

**1:21:59.7**

Today.

*Tacey Ann Rosolowski, PhD*

**1:21:59.9**

Why is the cost less? That surprises me, actually.

*John Stroehlein, MD*

**1:22:02.6**

Methodology.

*Tacey Ann Rosolowski, PhD*

**1:22:04.8**

Can you give me example?

*John Stroehlein, MD*

**1:22:06.9**

Well, I'm not that knowledgeable about the methodology, but there are ways to—for example, we'll order a blood test in the laboratory today. I expect the results back within two hours. It doesn't have to be stat. And tests come back that previously might have taken days because the way they're analyzed is different. They're automated. It's the technology that has driven the cost down.

*Tacey Ann Rosolowski, PhD*

**1:22:46.2**

I see. Is that something that this department has been able to take advantage of in providing clinical diagnostic tests as well?

*John Stroehlein, MD*

**1:23:00.5**

I would say it's something the department is working on. There are markers that colleagues of mine are working on that may be approved by the FDA, much like various oncofetal antigens. CEA, CA-19-9, CA-125 have been approved for clinical use.

*Tacey Ann Rosolowski, PhD*

**1:23:21.8**

And what do those indicate?

*John Stroehlein, MD*

**1:23:23.0**

They may indicate the presence of colorectal cancer, for example. There are markers for hepatocellular carcinoma that do exist. There is an interest in developing markers for pancreatic cancer if indeed the cancer has a much longer natural history than was previously considered to be the case.

*Tacey Ann Rosolowski, PhD*

**1:23:48.5**

Interesting. It seems like a lot of people have—

***John Stroehlein, MD***

**1:23:56.1**

Food for thought.

***Tacey Ann Rosolowski, PhD***

**1:23:57.9**

It is. I am just remembering in conversations I have had with other individuals I have interviewed. They talk about what's coming, and it's exciting.

***John Stroehlein, MD***

**1:24:09.0**

It is.

***Tacey Ann Rosolowski, PhD***

**1:24:09.8**

It's a real unknown territory.

***John Stroehlein, MD***

**1:24:12.6**

How it's going to be assimilated and how individual clinicians can possibly embrace—and what does it all mean? You can have a lot of information about something, but it may not create knowledge or wisdom. It's information.

***Tacey Ann Rosolowski, PhD***

**1:24:37.5**

Those are two different things—very different things, yes. When I interviewed [John Mendelsohn](#), he was speaking about the personalized care institute and thinking ahead about the amount of data that's going to be generated. He talked about exactly this kind of problem. How do you move from the data to knowledge? Who are the people who are going to help give birth to that knowledge? A lot of it is individuals who just know how to use—specifically how to work with medical data in computer programs in very sophisticated ways. And then how to make it public.

## **Chapter 10**

### **B: Key MDACC Figures**

#### ***Remembering R. Lee Clark; The Need to Preserve MD Anderson Heritage***

#### **Story Codes**

C: Portraits

C: Personal Reflections, Memories of MD Anderson

C: Funny Stories

D: On Leadership

B: Beyond the Institution

C: The MD Anderson Culture

B: Critical Perspectives on MD Anderson

C: Giving Recognition

#### ***John Stroehlein, MD***

##### **1:25:21.1**

That's right. I say two or three things—one of which I am reminded of. I have served under every president, and I've known every president very well—more so with Dr. Mendelsohn and [Dr. \[Charles A.\] LeMaistre](#). I have known all of them very well. I remember when Dr. Clark—we were standing out in front of the [Alkek Hospital](#) one day. I said, “Dr. Clark, what happens if cancer is successfully cured, as it were?” It didn't take him more than a matter of seconds—maybe ten seconds—to answer. He said, “We'll study immunological diseases and rheumatology,” which I still remember. I could take you right about to where we were standing, which is near the entrance of what is now the Alkek Hospital. Because if you stop and think about it—and I don't know why he made that suggestion or recommendation—but if you stop and think about it, that's exactly the direction that cancer care has evolved. It's the immune mechanisms—these molecular conditions that we will study. Once we cure cancer, we'll study how these immune mechanisms apply to another disease such as rheumatology. That was his specific answer.

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

##### **1:26:59.7**

That's interesting, yeah. What were your impressions of him as a leader—as an individual?

#### ***John Stroehlein, MD***

##### **1:27:08.2**

Dr. Clark—he was decisive in a way. He to one degree or another kind of had a fatherly demeanor. At a memorial service for a former chairman of one of the departments here—his executive assistant for a number of years. She was his assistant for years. I mean not just a matter of months but for maybe ten, fifteen years. I can't remember how long but a long period of time.

*Tacey Ann Rosolowski, PhD*

**1:27:40.0**

Do you recall her name?

*John Stroehlein, MD*

**1:27:41.1**

I don't right off hand, and I should. Of course, we haven't seen each other in years.

*Tacey Ann Rosolowski, PhD*

**1:27:45.3**

Sure.

*John Stroehlein, MD*

**1:27:47.9**

Probably twenty years maybe. She recognizes me. We come up. We talk around at Myron Levin's memorial service at the coffee reception. And she commented spontaneously. She had never heard Dr. Clark raise his voice or say a swear word once—never once.

*Tacey Ann Rosolowski, PhD*

**1:28:05.8**

Very gentlemanly.

*John Stroehlein, MD*

**1:28:09.2**

He was very disciplined, very controlled as far as his own feelings of emotions. He had a vision. He was respected. He was decisive but in a very—not in a negative way. I don't think he had any desire under any circumstances to put somebody down just to show that he was boss. I mean you knew he was boss to begin with. He didn't have to do that. So he led, I guess, in some respects by example and was highly respected in the state legislature—highly respected.

*Tacey Ann Rosolowski, PhD*

**1:29:00.4**

Now in your dealings with him how did—did you have to be convinced to come to MD Anderson? And he was sort of the emissary. He kind of gave you a sense of what the institution was all about before you even visited. What was the impression you got from him?

*John Stroehlein, MD*

**1:29:23.8**

I started to say that he was interested in me coming here. Bob Hickey was a very influential



figure and source. He's the one that I guess I dealt with more on a direct basis. The door was always open. You could walk into his office really at any time.

*Tacey Ann Rosolowski, PhD*

**1:29:51.4**

Interesting.

*John Stroehlein, MD*

**1:29:52.5**

This institution was a much smaller institution then.

*Tacey Ann Rosolowski, PhD*

**1:29:53.9**

Yeah.

*John Stroehlein, MD*

**1:29:55.5**

Much, much smaller.

*Tacey Ann Rosolowski, PhD*

**1:29:57.3**

Everybody could gather in one room pretty much.

*John Stroehlein, MD*

**1:29:59.7**

In some respects. And a member of the same team. So if you fought one you had to fight them all, so to speak. There was a camaraderie that was very positive. The institution now has attempted to achieve a certain degree of camaraderie, but it's more challenging with a keyboard interface in between people talking to people.

*Tacey Ann Rosolowski, PhD*

**1:30:27.5**

Right. And just sheer size.

*John Stroehlein, MD*

**1:30:31.1**

There is a bureaucracy that accompanies virtually every institution.

*Tacey Ann Rosolowski, PhD*

**1:30:38.3**

Just a quick comment—we're after 3:00 actually. If you don't mind, I'd like to just ask you one more question before we close out for today.

*John Stroehlein, MD*

**1:30:45.4**

Sure.

*Tacey Ann Rosolowski, PhD*

**1:30:47.1**

Your comments on Dr. Clark's leadership style—how would you characterize him as a leader and what sort of mark did he leave as a leader on MD Anderson, besides the obvious?

*John Stroehlein, MD*

**1:31:05.8**

The words that come to my mind are "can do." We can do this. Those are the words that come to mind.

*Tacey Ann Rosolowski, PhD*

**1:31:20.9**

Was that inspirational to people, do you think?

*John Stroehlein, MD*

**1:31:24.2**

Well, I don't think there's much doubt about it.

*Tacey Ann Rosolowski, PhD*

**1:31:28.5**

Interesting.

*John Stroehlein, MD*

**1:31:31.0**

His demeanor was such that it made people feel comfortable, so to speak.

*Tacey Ann Rosolowski, PhD*

**1:31:37.7**

Interesting, yeah.

***John Stroehlein, MD***

**1:31:39.0**

He had—he was strong but very—I guess for lack of a better word—more fatherly, I guess.

***Tacey Ann Rosolowski, PhD***

**1:31:55.2**

So he kind of threw the big vision out there but made people feel like they could really reach it instead of being frightening.

***John Stroehlein, MD***

**1:32:04.2**

That we could do that. And he believed in himself because he believed it. Then he walked the walk. The legislature and other people supported him.

***Tacey Ann Rosolowski, PhD***

**1:32:21.3**

Yeah. Everyone says he was very gifted in dealing with the legislature.

***John Stroehlein, MD***

**1:32:26.6**

You may have interviewed Dr. Meinerte. He made a comment—he was vice-chancellor at [A&M](#), and I think I'm quoting accurately. He was scheduled at the appropriations committee or whatever—in sequence of the UT's different components—to go after Dr. Clark. Dr. Clark's turn was next so he—as he gets up to sit down at the desk there, I guess, with the legislatures and their committee on the dais, they applaud. He tells them what he thinks he needs and wants and starts to go back to his seat, and the chairman says, “Dr. Clark, just a minute.” He says, “Is there anything else you would like?” (laughter) You can corroborate this story yay or nay with Dr. Meinerte, but I think he will corroborate it word for word. And he believed in this. I think that one of the things I would encourage the institution to do—I trained at Mayo. Their heritage is deep—the waters run deep in the heritage at Mayo. I'm not sure that Anderson has captured the heritage to the degree that it should be captured. There is a Chinese proverb—Richard Johnson was a good friend and former editor of *The Chronicle*, and John Murray wrote a book about Richard. And in that, he uses a Chinese proverb that those who drink the water should remember those who dug the well. I mean it cut to the chase. Here's the person who really got it started. The institution has changed over time because times have changed. We're talking about the molecular pathology. It did not exist back then. So things are done today in part because they can be done and in part because they may make a difference. There still is an element of the history that it behooves us to hold on to. There is an institution out east that is thinking about selling some ancient hymnal that goes back three hundred years to make money for a university program. It has become very controversial.

*Tacey Ann Rosolowski, PhD*

**1:35:14.1**

I can imagine.

*John Stroehlein, MD*

**1:35:15.8**

Maybe you should raise money otherwise than selling off your most valued historical asset. I propose that much like Mayo has Heritage Hall, maybe we should have a heritage park or something to convey the contributions that people historically have made that helped to get us where we are today.

*Tacey Ann Rosolowski, PhD*

**1:35:49.3**

Those things, I think, are particularly important when the institution becomes so large—to get people to have a sense of a shared history. It's sort of a stepping stone to developing more community or at least—

*John Stroehlein, MD*

**1:36:03.6**

I think it is and Mayo has successfully done that. I'm not sure that we have successfully done that.

*Tacey Ann Rosolowski, PhD*

**1:36:14.1**

Well, we're a little bit over time. I know we have another session scheduled next week, I believe.

*John Stroehlein, MD*

**1:36:21.6**

Okay.

*Tacey Ann Rosolowski, PhD*

**1:36:21.9**

So can we close off for today? Is there anything you would like to add at the end of the session?

*John Stroehlein, MD*

**1:36:28.8**

No, I guess not. I was thinking that I think that we need to acknowledge some of the leaders of the past better than we have—J [Freireich], perhaps, being one of them, quite frankly.

***Tacey Ann Rosolowski, PhD***

**1:36:45.6**

[Emil] J Freireich [Oral History Interview].

***John Stroehlein, MD***

**1:36:48.7**

This display they have for Dr. Mendelsohn, in fact, is absolutely superb. I compliment it and commend it. They did the right thing. They did the right thing by bringing the plaques down from the eleventh floor. I know other people who say that they go by and read those. I think that's good—very good. Ben Love, whom I knew fairly well, is in bronze, which was given to the institution. They didn't pay for it to my knowledge. It's crowded in a little space. There's no way of displaying it. Dr. Trahilio is over in a corner somewhere. Fred Conrad's plaque—I think we could do a better job of acknowledging the people who gave their lives or their careers to develop programs which—the fruits of which we now enjoy.

***Tacey Ann Rosolowski, PhD***

**1:37:58.5**

It's also the case that people—not all of the staff and employees and faculty here know even the names. Someone was mentioning that you turn on [Bertner Avenue](#). How many people know who that's named for?

***John Stroehlein, MD***

**1:38:15.6**

Who Ernst Bertner was—he was a pediatrician.

***Tacey Ann Rosolowski, PhD***

**1:38:18.6**

Exactly. Just to have that basic understanding—the sense of continuity with the past as part of a *lingua franca* of what this community shares. I think it is very important.

***John Stroehlein, MD***

**1:38:33.3**

Okay. (phone buzzes) Let me take this call

***Tacey Ann Rosolowski, PhD***

**1:38:35.0**

Oh, absolutely. And I will turn off the recorder at five minutes after three.

*John Stroehlein, MD*

**1:38:41.3**

And I will go to the office and we'll show you around.

*Tacey Ann Rosolowski, PhD*

**1:38:41.8**

Okay. Great. I'm turning off the recorder at five minutes after three.

**1:38:45.6** (End of Audio 1)

## **John Stroehlein, MD**

Interview Session 2—December 12, 2012

### **Chapter 00B** **Interview Identifier**

*Tacey Ann Rosolowski, PhD*

**0:00:00.5**

Let me quickly put an identifier on. Today is December 12, 2012, and the time is about 1:34, and I am sitting in a conference room in the Department of Gastroenterology, Hepatology and Nutrition in the Pickens Tower on the main campus of MD Anderson. Today I am beginning my second session with Dr. Stroehlein, who is deputy chief of that department. Before the recorder was formally turned on, I had mentioned that I was looking at a book that you gave me last time which is called *The Dawn Will Come* by James H. Wiley, a former patient of yours, and I mentioned that I learned by reading that that you treat a much wider range of cancers than I suspected. You're beginning to talk to me about historically—give some historical context with that.

## **Chapter 11**

### **A: Overview**

#### ***The Evolution of Gastroenterology***

#### **Story Codes**

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

B: Building/Transforming the Institution

C: Understanding the Institution

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

D: The History of Health Care, Patient Care

#### ***John Stroehlein, MD***

#### **0:00:57.4**

That is true, and when I first came to Anderson as chief of GI back in 1977, the Gastroenterology Department was not called a department then or a section, I guess. They had oncological therapy where you treated folks for chemotherapy. This was really a dividing point between the internal-medicine-based oncologists and Developmental Therapeutics, with the latter more aggressively pursuing the treatment of cancers and doing only cancer therapy as opposed to seeing benign disease and complications of treatment, et cetera. What I think we accomplished was the incorporation of developmental therapeutics in our department with joint protocols. Back then the therapeutic options were limited. There was no ultrasound, no CT scans, no MRIs. Endoscopy was reasonably well developed. We did a lot of procedures, and various types of [chemoembolization](#) were being developed by the Interventional Radiology Department here, which leads me to suggest that Dr. Sidney Wallace [Oral History Interview] would be someone ideal to talk to—or Gerald Dodd, if you haven't—because the history of interventional radiology was birthed, so to speak, at MD Anderson with a person who was in private practice at [Carle Clinic](#) in Urbana, Illinois who would come here on sabbatical, [Dr. \[Cesare\] Gianturco](#). And together in the lab, he and Dr. Wallace really developed a lot of the techniques that are still used for embolization and interventional radiology procedures.

#### **0:03:12.8**

Getting back to gastroenterology, in those days the treatment options were limited. They were not as complex as they are today nor are they as complex as they will be in the future. Look at GI medical oncology today. Some individuals treat esophagus and stomach. Some treat liver and liver only. Some treat liver but not necessarily bile duct cancers. There's colorectal and anorectal cancers. Within an area of specialization as well defined as GI medical oncology where you're talking about oncological treatment with chemotherapy—i.e. medical oncology for gastrointestinal disorders—there is subspecialization. I started to say that I heard a buzzword at a program directors workshop many years ago, but I still—sometimes buzzwords stick with you—



some from political debates and others scenarios. But it was omniscient, and the concept of the presenter was that—and that was a number of years ago. No longer could one be omniscient. There's a song about Mr. Football USA could pass and kick and throw. Give him the ball and watch him go. Well, you don't see people who are place kickers, punters, passers, and running backs and do it all. We're in the area of specialization, like it or not, and it's going to become more specialized as we go forward.

*Tacey Ann Rosolowski, PhD*

**0:05:01.7**

I had a couple of questions, and one was as you were talking about how GI medical oncology is broken up today into these different subspecialties. Why were the subspecialties defined the way they were? You know, that certain organs are connected with certain portions of the GI tract. Maybe that's an obvious question to someone who is in medicine.

*John Stroehlein, MD*

**0:05:27.4**

That's probably a good question. They say that every question is a good question. The thought occurs to me that it reflects the interest of the people, and the interests of the oncologist had to deal with—or dealt with a particular area or a specialization. The other fact involves probably risk factors for cancer. Esophageal cancer, [Barrett's esophagus](#), what turns it on, what turns it off, different distributions of gastric cancer that may be partly ethnically driven. In the case of [hepatocellular cancer](#) where viral infections are oftentimes a precursor, an individual oncologist may have an interest in viral infections of the liver, and they kind of incorporate the treatment of oncology. Others have an interest in benign conditions like Barrett's that may evolve into cancer. I don't know the answer to it, but I think it's driven in large measure by the fact that the treatment options have become more specialized, and the interest of the individual practitioners helps to drive where they sit in the vehicle. Are they in the driver's seat or in the passenger's seat or what have you?

*Tacey Ann Rosolowski, PhD*

**0:07:07.3**

Am I understanding correctly that each individual practitioner defines the scope of his or her specialty in a unique way?

*John Stroehlein, MD*

**0:07:16.0**

To a degree. Many people in private practice are much more broadly based, but in an institution as large as Anderson, by and large, individuals have expertise, and why they gravitate to one area or another is maybe a little hard to understand. For example, in our department we have—our chair is primarily interested in liver disease and liver-related cancers. Another colleague does a lot of endoscopic ultrasound and has an interest in the diagnosis of pancreatic cancer. Someone

else does a lot of therapeutic endoscopic work and may be interested in biliary cancer. One of my colleagues is an expert at removing unusually large polyps from the colon, thus obviating the need for surgery, and has a focus in colorectal cancer. We have a colleague who is in the laboratory who deals more with liver cancer. These are driven in large measure in part at least by the interest of the individuals involved, and the individuals realize that they can't do everything. No longer can one do everything. You don't see the professor who works in the lab who teaches and has the clinical expertise and is a triple threat. You just don't see that very much. Well, historically we did do oncology. We made decisions about oncological treatment, and that is reflected in Mr. Wiley's comments and so forth. Much of gastroenterology involves oncology because in many of the conditions we see the question comes up. Are they benign or malignant or are they premalignant?

## **Chapter 12**

### **A: Overview**

#### ***Research: Slow Work***

#### **Story Codes**

A: The Researcher

C: The Clinician

C: Discovery and Success

A: Career and Accomplishments

A: Overview

A: Definitions, Explanations, Translations

C: Professional Practice

D: On Research and Researchers

A: The Clinician

B: Institutional Mission and Values

C: Hope, Healing, the Promise of Research

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients

C: Patients, Treatment, Survivors

C: Cancer and Disease

C: This is MD Anderson

D: Technology and R&D

***Tacey Ann Rosolowski, PhD***

**0:09:22.5**

What about your own specialty? Tell me about your particular cluster of interests.

***John Stroehlein, MD***

**0:09:29.8**

I guess my cluster of interest focuses more on the hollow GI tract than it does the liver. It always has. Why, I don't know. When I was in training there were no treatments for hepatitis, no liver transplantation. Interventional biliary work was in its infancy. There were a lot of therapeutic limitations, but gastroenterologists did hepatology. My interest has been more in the hollow GI tract. We did the first validation studies of fecal occult blood testing, described some of the first cases of [C. difficile-related colitis](#). I have had some interest in inflammatory bowel disease and its relationship to cancer but more interest in [sprue and celiac disease](#), which is seen not infrequently in the cancer patient population, but it's the hollow GI tract as opposed to the liver, the bowel ducts, or the pancreas.

*Tacey Ann Rosolowski, PhD*

**0:10:40.8**

Now, you mentioned that when you were at the Mayo Clinic you were developing screening tests using fecal material for colorectal cancer. Is that correct?

*John Stroehlein, MD*

**0:10:52.6**

That is correct. We did the validation studies, which had not been done before, to demonstrate the sensitivity of false positive/false negative ratios for fecal occult blood testing.

*Tacey Ann Rosolowski, PhD*

**0:11:11.4**

And what was the effect of your findings on the possibilities for diagnosis?

*John Stroehlein, MD*

**0:11:18.6**

I think it, to a degree, nurtured or contributed to the idea of screening. We were involved back then with a group—an international work group on colon cancer, and I'm sure that I was invited to join that in part because of the work in the fecal occult blood testing. But the outgrowth of this involved the adaptation of colonoscopy and the publication earlier this year that [colonoscopic polypectomy](#) could successfully reduce the incidence of colorectal cancer.

*Tacey Ann Rosolowski, PhD*

**0:11:58.1**

You mentioned that last time. Were you involved in those studies?

*John Stroehlein, MD*

**0:12:01.3**

I was not involved in the national polyp study, but we were active collaborators with individuals who were involved. We were involved with some mediators around the country to promote the idea of the concept of screening for colorectal cancer, so the mere fact that you could do it, the mere fact that the effect of the screening modality had been defined and getting this out to the public was something that I think we probably contributed to.

*Tacey Ann Rosolowski, PhD*

**0:12:44.0**

Now that's an awfully long time. I mean we're talking from—

***John Stroehlein, MD***

**0:12:47.9**

Oh, it is a long time.

***Tacey Ann Rosolowski, PhD***

**0:12:48.9**

The early '70s—

***John Stroehlein, MD***

**0:12:51.1**

Late '70s or mid '70s.

***Tacey Ann Rosolowski, PhD***

**00:12:52**

Yeah, 'til now.

***John Stroehlein, MD***

**00:12:53**

That's right. That's correct. It takes a long time for definitive work to be established. It's the nature of clinical research to a degree and the nature of basic science research, the nature of investments. I met somebody this past weekend who has invested a lot of land, purchasing it acre by acre to assemble this large tract of land which now can be developed as a big business park. It's taken twenty years. There was an article in the *Chronicle* about a researcher at Rice who has taken twenty years to develop a particular research program to fruition, so I think no matter what one does, there's no quick fix, and there's no quick fix for cancer. And even though you cannot do everything, at least you can do something, and I think that's the mindset that we should have going forward. It's the mindset that I try to provide patients because there's always hope there, and you have to have hope that if you didn't have a disease—or maybe it's surgically removed. If it's not, then maybe it's manageable or the symptoms can be controlled. Somebody cares about you or whatever. There's a whole spectrum of factors of hope. A prominent rabbi in Houston has written a book called *You Cannot Live With Hope Alone, But You Cannot Live Without It*, fifth in a series of books that he has written. I have a copy of that, too.

***Tacey Ann Rosolowski, PhD***

**0:14:51.4**

What is the name of that rabbi?

***John Stroehlein, MD***

**0:14:53.1**

Joseph Segal. I don't know if you know him or know of him.

***Tacey Ann Rosolowski, PhD***

**0:14:55.8**

I don't, but it's nice to have the name to append to the title. It's a very nice saying. I'm wondering with that length of time, you mentioned that there was a media initiative to bring this information to the public because it seems to me that the need for colonoscopies had been pretty well established in the public. Or is that not the case? Does it have—

***John Stroehlein, MD***

**0:15:22.9**

I think it's of recent vintage, so to speak. I think it's a relatively recent vintage. Consider the fact that certainly when I was in training colonoscopy was really starting to be established. The whole idea of removing large polyps and closing them with an endoscopic clip—the defect—and obviate suturing together, having surgery—that is even more recent. And I think we've learned a bit about the natural history of disease. And with the endoscopic staging techniques, the accuracy of determining if something is intramucosal or just in the lining or how deep it goes helps you decide whether you can do something with curative intent or not. A colleague of mine removed a reasonably large gastric mass in a patient who was at increased operative risk. He showed me the pictures. I guess it was the day before yesterday. I asked if they had done an ultrasound and the answer was yes. Well, the ultrasound at graphic staging showed rather precisely—the best you could tell with no test being perfect—that the lesion was indeed intramucosal, although it was large. And so it was removed by endoscopy, and the defect that the endoscopic removal created was closed by some metal clips that approximated the edges of the wound. This is a good example, and I've had a chance to see this play out in real time, as to how one modality affects another.

**00:17:23**

For example, you wouldn't want to—this was a patient who if their surgical risk would have been halfway reasonable would have gone straight to surgery in years past. And it's an example of how endoscopic ultrasound influenced the decision-making process for another type of procedure, namely endoscopic removal of the lesion. What is now becoming of interest is endoscopic submucosal resection wherein through the endoscope one can cut down to the submucosa just above the muscle layer and remove a tumor or cancer. So there have been a lot of advances along the way, and I fortunately have lived through the period of time when most of those advances occurred and have sought to bring those advances to the department when I had any type of leadership role related there to. We have an endoscopic real-time microscopic examination technique that can be used because the way things look or they feel determines oftentimes where a surgeon takes a specimen or a biopsy. This takes it one step further, not only how they look or they feel to the naked eye or through the scope but what it should look like in effect under the microscope because you can see individual cells with this modality.

*Tacey Ann Rosolowski, PhD*

**0:19:17.3**

This is an endoscopic electron microscope.

*John Stroehlein, MD*

**0:19:19.4**

Or not an electron microscope but a microscope.

*Tacey Ann Rosolowski, PhD*

**0:19:25.2**

And maybe it's difficult to explain, but how would you recognize—what sort of changes do you visualize in the cells when you see them microscopically like that?

*John Stroehlein, MD*

**0:19:38.7**

I guess inhomogeneity—a large nucleus, morphological differences. You look at the same things that a pathologist looks at under the microscope except your microscope is three feet long.

*Tacey Ann Rosolowski, PhD*

**0:19:54.6**

And it's like living pathology.

*John Stroehlein, MD*

**0:19:56.1**

It's real time. All these things have come along during the time of my career, and every one of them has impacted in one way or another on the accuracy of staging, diagnosis, or treatment of malignancies.

## **Chapter 13**

### **B: An Institutional Unit, Program**

#### ***Teamwork: Handling Complications of Cancer***

#### **Story Codes**

A: The Researcher

A: The Clinician

C: Patients

C: Patients, Treatment, Survivors

B: Multi-disciplinary Approaches

B: Institutional Mission and Values

B: MD Anderson Culture

B: Institutional Politics

B: Controversy

B: Building/Transforming the Institution

B: The MD Anderson Brand, Reputation

D: On Care

A: The Leader

C: Leadership

A: Personal Background

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

#### **0:20:21.0**

Can you take me through what may be one of your more memorable experiences clinically with diagnosis or with treatment?

#### ***John Stroehlein, MD***

#### **0:20:35.1**

Well, resection of liver metastasis is one that's chronicled in Mr. Wiley's book. I have a patient who had an adverse reaction to sedation and was very hesitant to have to repeat endoscopy. But we were able to convince her to have this, found a cancer, and she is now twenty-six years out. Another lady I can think of had iron deficiency anemia and had a colonoscopy elsewhere. They said it was normal, but a good friend of hers who was on the staff here said, "You know, there must be some reason for the iron deficiency. Why don't you go to see Dr. Stroehlein?" And so we took a look and found colon cancer, and she's cured of this thirty years later or so. A fellow who—we see esophageal obstructions—which one of my colleagues is really an expert on here nationally—following radiation or treatment or surgery where an individual cannot swallow. I remember one individual who could not talk because he'd had a laryngectomy, and he could not swallow because he was obstructed. We provided him with the artificial voice vibrator that is opposed to the outside of the throat and dilated the esophagus where he could eat what he wanted to. Talk about somebody who is happy, who could then communicate, and who could eat what he wanted to. Those are sort of basically really memorable occasions, and there are obviously



others. There are some that are not memorable and that are discouraging, so to speak, more so when you see cancer in young people, teenagers, kids, et cetera.

***Tacey Ann Rosolowski, PhD***

**0:22:48.3**

I have two comments. One is that as with head and neck cancers, there's a huge functional element to the GI cancers that affect quality of life.

***John Stroehlein, MD***

**0:23:02.7**

That's true, and that's one of the things I mentioned earlier that the Gastroenterology Department did historically. We handled the complications of cancer and cancer therapy as opposed to just treating cancer with chemotherapy. I think as clinicians, we had a very good appreciation as to what treatment was capable of doing and how it could in fact do harm.

***Tacey Ann Rosolowski, PhD***

**0:23:40.7**

How did you address that? Can you give me some examples of how you dealt with a treatment and turned it around so it wouldn't have a harmful effect?

***John Stroehlein, MD***

**0:23:52.0**

I guess the main thing is communicating these findings to individuals who provide the treatment who may innocently not realize or be blind to the complications that are occurring because they are not the ones who followed the patient. If they're not the ones who follow the patient, then the person who does follow the patient needs to let the other individual know that we've encountered this problem or that problem. Are you aware of it? And a lot of times individuals who provide the treatment and then never see the patient in followup or see them very infrequently do not have a good understanding as to what the treatment actually does.

***Tacey Ann Rosolowski, PhD***

**0:24:38.6**

Were these circumstances in which someone was a researcher and was providing a certain kind of therapy which then, when put into practice in the clinic, was having these effects, and it was sort of a disconnect between laboratory and patient?

***John Stroehlein, MD***

**0:24:54.7**

I think through some sort of a disconnect. This was a criticism with many people in the Medicine Department historically with [the Department of ] Developmental Therapeutics, although they

have much to offer. And by bringing things under the same roof, those lines of communication were strengthened, and I think that we ended up with a better product, quite frankly.

*Tacey Ann Rosolowski, PhD*

**0:25:24.7**

I'm starting to see another of the big outcomes and motives of mending those fences, as you referred to it last time when you were talking about the rift between the Division of Medicine and Developmental Therapeutics—that there was actually not only mending fences in a political sense for the institution but also having an impact on patient care as a result by creating these teams.

*John Stroehlein, MD*

**0:25:50.2**

I think there's a lot of truth in that, and there was a lot of conflict historically, as you probably know from your other interviews.

*Tacey Ann Rosolowski, PhD*

**0:26:00.0**

Well, people have mentioned that the treatments were just incredibly aggressive, and so in some cases the aggressiveness of the therapy had these negative impacts, and people were kind of plunging ahead and ignoring the negative impacts on the functionality of the patient.

*John Stroehlein, MD*

**0:26:16.4**

I understand.

*Tacey Ann Rosolowski, PhD*

**0:26:18.7**

Interesting. I kind of lost my train of thought for a second. (laughs)

*John Stroehlein, MD*

**0:26:29.0**

We'll regroup.

*Tacey Ann Rosolowski, PhD*

**0:26:29.5**

We will regroup. But I'm kind of putting together what you've been saying today with what we talked about last time and your focus on building teams and getting people to understand how they can navigate those fields.

***John Stroehlein, MD***

**0:26:43.7**

Yeah, I thought about that after the interview last time. What have I done? There's a lot of things that I haven't done, to cut to the chase—a lot of things—opportunities that I've had that I didn't capitalize on. But there have been some things we have been successful in doing. And as I thought about what we talked about before, maybe one of the things that I've been most successful in doing is building teams that can work together, as exemplified by the rift between Developmental Therapeutics and Medicine by the incorporation of surgical oncology fellows into our department. And then when I relocated to Baylor and was chief of endoscopy at Methodist, there was the challenge of getting the full-time academic faculty and the people in private practice who use exactly the same unit to pull together for the common good. Establishing good relationships and trying to see that everyone is a part of the team was really many of the challenges; and when I later was interim chair of the department here, it was probably the biggest challenge to try to bring the entire group together. Even historically in our department, the research team officed on a different floor than the clinical team. When we amalgamated into one common office area, so to speak, I had everybody get together in, for lack of a better word, a mini retreat so that they got to know each other. Dr. LeMaistre was very kind to come and speak. Walter Baile, who is from Psychiatry, Bill Vaughn, who directs the fitness program here, and I believe we may have had one other speaker as well—but the idea was if we're all part of the same team and we're living in the same apartment building, we ought to get to know each other. I think I've been reasonably successful in that. There are other things that I should have done that I haven't done. I hope that in the time I have left I can pull together manuscripts and publications and communicate some of the observations I've made that should help others.

***Tacey Ann Rosolowski, PhD***

**0:29:30.2**

Going back to that idea of team building, where do you think you developed the skills to do that kind of institutional work?

***John Stroehlein, MD***

**0:29:42.8**

The first thought that comes to my mind—they say when you have a test you go with the first answer—is probably coming from a small town and interacting with a diverse population and perhaps the respect that my parents and family had for people of different socioeconomic backgrounds and different job sets and so forth. That may be it. If the first answer is the best answer, that's what comes to mind because that's what you do in a smaller community. You interact with each other in ways that—I'm not sure I like the keyboard because the keyboard has been thrown up like the Berlin Wall. It's a barrier between individuals. If they're on the other side of the sheetrock, they'll send you a text message instead of coming around to talk to you.

***Tacey Ann Rosolowski, PhD***

**0:30:57.2**

Face-to-face, yeah. Well, in your comments about team building, you brought us up to the point where we stopped in the last interview, which was when you decided to leave your position as section head of gastroenterology and move to another institution. Maybe you could talk about how that happened.

## **Chapter 14**

### **B: Beyond the Institution**

#### ***MD Anderson and Methodist Hospital: Communication and Collegiality***

##### **Story Codes**

B: Beyond the Institution

C: Understanding the Institution

D: The Nature of Institutions

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

A: The Administrator

A: Professional Path

B: Critical Perspectives on MD Anderson

B: MD Anderson Culture

B: MD Anderson History

B: Discovery and Success

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

##### ***John Stroehlein, MD***

**0:31:19.9**

I was given the opportunity to be the director of the endoscopy unit and be based full-time at Methodist, and for kind of personal family reasons and with those opportunities I made the switch. This was at the pinnacle of the operations there. They were really at the peak.

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

**0:31:53.7**

What do you mean by that?

##### ***John Stroehlein, MD***

**0:31:55.0**

Well, I mean that the institution was really thriving. We designed what was probably one of the finest endoscopy units in the country. [Dr. \[Michael E.\] DeBakey](#)'s consultative practice was robust, along with his team. I saw many of his consults and was a good friend of his, and I think what I learned from those experiences probably makes me a little bit more effective in what I do now that I'm back at Anderson.

*Tacey Ann Rosolowski, PhD*

**0:32:40.5**

What were some of the lessons that you learned from that?

*John Stroehlein, MD*

**0:32:43.7**

I think lessons of time management. It's something that he was not publicly known for, and that was the amount of time that he spent with the hospital district with committees and working behind the scenes, so to speak, to see that things were accomplished.

*Tacey Ann Rosolowski, PhD*

**0:33:06.1**

So basically his administrative style.

*John Stroehlein, MD*

**0:33:08.6**

Yes, that is true, the administrative style, because there were a lot of requests, demands, and expectations coming left and right, and to see how one could calmly handle all these inquiries was, I think, beneficial.

*Tacey Ann Rosolowski, PhD*

**0:33:27.6**

Tell me a little bit more about the endoscopy unit. You said that it was the premier endoscopy unit in the country. What catapulted it to that kind of position?

*John Stroehlein, MD*

**0:33:41.5**

I think that the unit which was featured in one of the endoscopic publications or magazines was catapulted in large measure because of the physical design and the structure, the patient waiting room, the way the vital signs were taken. We had prep rooms for colonoscopy in the receiving area. We had radiology equipment in most of the rooms, we had a full spectrum of studies to look at gastrointestinal motility, and it was adjacent to a medical treatment unit for further observation, IV fluids, transfusions, paracentesis, et cetera. The setup was designed in such a way that it really contributed greatly to the good of the patient and to the good of all concerned. That was in the days before all the private endoscopy units which have developed in surgical centers in the meantime.

But this provided a great asset to individuals in the practice who could see a patient, talk to the family, maybe do a procedure, go back to the dictation or endoscopy room. It was really user friendly, attached to the hospital, and located on a floor which was also in close proximity to radiology and the other modalities. The design of units is very important. The design of patient

rooms is dreadful for the most part, and most individuals who are in the architectural business do not have any concept as to what patient rooms should look like. [Henry Plummer](#) at the Mayo Clinic did. The clinic rooms are still designed the same way that Henry designed them in probably the late 1920s. But there are concepts that are absolutely simplistic that are simply not practiced.

***Tacey Ann Rosolowski, PhD***

**0:36:22.6**

What are some of those concepts?

***John Stroehlein, MD***

**0:36:24.8**

For example, an individual exam room would be designed where the desk and a seating area would be longitudinal to each other so you could sit at the desk and across the edge of the desk talk to the patient. Exam tables were facing opposite the doors so the patient wasn't facing the door. There was a little dressing area to the left inside. The sink was on the far corner instead of between the doctor and the patient. These are very simple concepts. In the Smith Tower, we designed most of the examining rooms there on that same concept, but most examining rooms and the ones here do not embrace that concept. They're awkward. The clinicians don't like them, but they have no say in how they are designed.

***Tacey Ann Rosolowski, PhD***

**0:37:30.9**

Since you spent—let's see. You went to Methodist in 1982 and then returned to MD Anderson in 2003, if I'm remembering dates correctly. You had a significant period of time to really look at another institution. What are some comparisons/contrasts that you saw between the two institutions in however you want to scale that?

***John Stroehlein, MD***

**0:38:00.9**

At Anderson, I think there is probably a greater focus maybe on a team approach to caring for the patient, and there is considerable expertise in some departments in Anderson that are superior in that way—Pathology and Radiology for imaging, for example—that all clinicians have to use. These departments are absolutely outstanding. The development of the sort of electronic medical record system, although that's going to change, was I think a step ahead here. Now other places are developing a system, and we're going to get a new system which hopefully will be better than the old one. The idea of seeing the patient, having a multidisciplinary team approach, having support services that are of the quality that they happen to be, and having a way to record what you do are things that I think at that time helped to set Anderson apart and still does to one degree or another.

*Tacey Ann Rosolowski, PhD*

**0:39:43.7**

Were there some areas in which you felt Methodist had something more to offer?

*John Stroehlein, MD*

**0:39:51.8**

This was a different era. What Methodist has to offer today or not I don't know. It's really different, and the era of medicine has obviously changed, and the thing that has changed most is the camaraderie which we had at Anderson before, too, and the collegiality between the clinicians.

*Tacey Ann Rosolowski, PhD*

**0:40:17.2**

You're inferring that that was more present in the past than today.

*John Stroehlein, MD*

**0:40:20.4**

In the past no matter where you were—there, here, anywhere. It may be true nationally as well.

*Tacey Ann Rosolowski, PhD*

**0:40:29.5**

You've mentioned it a number of times, and obviously that's a quality of the institution that you really miss. What did that bring with it? When you had that kind of connection with colleagues, what were some of the bonuses that came out of that?

*John Stroehlein, MD*

**0:40:45.4**

The bonuses I think were looking at processes and not trying to blame any one person for one thing or the other but seeing how a process could be improved. And if one personally knows someone, you better understand where they are coming from when they recommend a certain course of action. And communication was, I think, taken more seriously, for lack of a better word.

*Tacey Ann Rosolowski, PhD*

**0:41:33.6**

Could you give me an example of something that—an example of how that worked better in the past than it does now? A situation in which a process could be improved because you had better communication.



***John Stroehlein, MD***

**0:41:56.1**

It's a little difficult to identify specific areas. When you're dealing with a patient with a particular problem, if the individuals caring for the patient do not understand the nature of the findings or recommendations, it's very difficult for the other party to accept what one has to say. One today may receive a consult. Well, just scope them. Just stick a scope in or up or down or whatever. Well, there are a lot of nuances to this: how you go about it, how you set up to get the information. What are the relative risks? Is there any benefit? It's become a little bit more mechanistic with the expectation that one will do whatever a referring service suggests that they do.

***Tacey Ann Rosolowski, PhD***

**0:43:10.4**

People are kind of operating blind, in a sense.

***John Stroehlein, MD***

**0:43:13.1**

Or without understanding the nature of the situation or the implications of a particular procedure or maybe having an idea of what the procedure involves. We have very good support from Anesthesia now, but until the team understood what our procedures involved and about how long did they last and so forth, it was very difficult for somebody providing another service in the form of sedation or anesthesia to know how to set up or plan or administer something that is safe on the one hand and will last the required period of time knowing that you probably are not going to need much more time than that.

***Tacey Ann Rosolowski, PhD***

**0:44:17.1**

Is there anything else that you want to speak about from your time at Methodist and these other institutions—things that had a significant impact on your thinking before you came back to MD Anderson in 2003?

## **Chapter 15**

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

#### *Awards Recognize a Dedicated Clinician*

#### **Story Codes**

A: Career and Accomplishments

A: The Clinician

A: Character, Values, Beliefs, Talents

A: The Leader

A: Professional Values, Ethics, Purpose

#### *John Stroehlein, MD*

**0:44:38.8**

That's a very good question but I'm not sure that individually—it's very hard to identify one particular component part. When I was at UT Houston, I also attended at the LBJ Hospital where resources and equipment were limited. But that was, I think, a good experience and further crystallized my approach to medicine and the encouragement of fellows and so forth to address and treat everybody the same, which was one of the basic compliments, I guess, in letters of recommendation that I received for what was the first [Humanism in Medicine Award](#) given at UT. It was partially, I think, cited on the basis of treating individuals the same regardless of which area they came from. Maybe this impacts on the team building. If you don't respect individuals for what they have and where they're coming from, it's very difficult for them to feel part of the team.

#### *Tacey Ann Rosolowski, PhD*

**0:46:15.9**

And just for the record, that Humanism in Medicine Award—you received that in 1999.

#### *John Stroehlein, MD*

**0:46:22.8**

I think that's right.

#### *Tacey Ann Rosolowski, PhD*

**0:46:24.1**

Was it a surprise that you were awarded that?

#### *John Stroehlein, MD*

**0:46:30.0**

In a way. Our department chair then was very supportive of that, and that was very meaningful to me because this is an individual who came more from a laboratory background but was very

supportive of the concept. I don't know if you'd call that a surprise or not, but it was a very pleasant encounter.

*Tacey Ann Rosolowski, PhD*

**0:47:08.7**

Well, it really goes to a pretty core value that you've spoken about when it comes to not only patient care but also leadership, setting up an institution, and education. It's a continuing theme.

*John Stroehlein, MD*

**0:47:24.1**

I think there's probably a common thread that runs through all this.

*Tacey Ann Rosolowski, PhD*

**0:47:29.9**

That's wonderful. Are there any other roles that you had during that period that you'd like to mention before we talk about your return to MD Anderson?

*John Stroehlein, MD*

**0:47:45.3**

I worked closely with some of the trauma surgeons in particular, I guess, and with radiology and pathology colleagues. I don't know if there's anything that really otherwise stands out. Through one of my patient encounters I was awarded a professorship, which still goes on, and we were able to establish a fund for the fellows for their recognition and/or travel.

*Tacey Ann Rosolowski, PhD*

**0:48:30.1**

And what is the name of this professorship?

*John Stroehlein, MD*

**0:48:32.2**

It was the Dan and Lillie Sterling Professorship.

*Tacey Ann Rosolowski, PhD*

**0:48:41.5**

And does the fellowship award have a specific title, too?

*John Stroehlein, MD*

**0:48:46.4**

That's the Dan and Lillie Sterling—

*Tacey Ann Rosolowski, PhD*

**0:48:48.9**

Oh, it's attached to that.

*John Stroehlein, MD*

**0:48:50.3**

—Professor of Gastroenterology. The chairman of the department at UT Houston currently holds that title. And after that was established, the family—both now deceased—established additional funds that were in memory of their son who was deceased. There has been perpetuity there. It still goes on. It has genesis in the care that these individuals—that I sought to provide.

## **Chapter 16**

### **B: MD Anderson in Transition**

#### ***Observations: The Department Name Change and Changes in Departmental Focus***

#### **Story Codes**

A: The Administrator

A: Professional Path

B: Building/Transforming the Institution

***Tacey Ann Rosolowski, PhD***

**0:49:47.2**

Tell me how it happened that you came back to MD Anderson in 2003.

***John Stroehlein, MD***

**0:49:52.6**

I guess two or three things happened, one of which was that they were looking at recruiting patients who did not have cancer for a particular study. That was the dominant issue, and in 2000 my wife and I divorced, and so you have life-changing events, and you think about what do I want to do, where do I want to go, what are the opportunities, et cetera, and I was offered the opportunity to return. And then one thing after another has happened in respect to the various appointments, recognition, and becoming, I think, an important part of the operations and nurturing of younger colleagues and providing a leadership role in the department prior to the recruitment of a permanent department chair.

***Tacey Ann Rosolowski, PhD***

**0:51:18.7**

You came in as the ad interim.

***John Stroehlein, MD***

**0:51:20.8**

I was appointed to that not too long after I came back. I came here as a member of the faculty and was given the opportunity to do some writing, develop friendships with other colleagues who have like interests, and this was at a phase when we had recruited successfully and from the department of three or four individuals up to now fourteen, many of which have come since our permanent chair, but several of them who were key recruitments occurred when I was interim chair.

***Tacey Ann Rosolowski, PhD***

**0:52:08.1**

And during this period, too, the name of the department shifted from being a section to being a department and was renamed the Department of Gastroenterology, Hepatology, and Nutrition.

***John Stroehlein, MD***

**0:52:22.3**

Well, hepatology, you see, had come into its own, and the department was named Gastrointestinal Medicine and Nutrition historically. Hepatology was not part of the name. It should have been, so we changed the name to Gastroenterology, Hepatology, and Nutrition to more globally reflect what we were doing because antiviral therapy had subsequently been developed in hepatology. Chemotherapy had the potential for unmasking occult hepatitis, which could become florid then when the immune surveillance was compromised, and there were other treatments, including liver transplantation, for small tumors or cancers and/or [radiofrequency ablation](#) of tumors in the liver, chemoembolization, liver resection for metastatic cancer. It was really a natural that hepatology should be part of our identifying trademark. But as far as nutrition was concerned, in 2008 or 2009 we established a consultative service in nutrition which had to be discontinued at the economic downturn when we were mandated to cut expenses by a certain amount. This is the area that would have been cut if it had not been for a decision by two individuals in Nutrition to do something else elsewhere, so the nutrition program could not be sustained. And even today, there is an effort to get this back on track, but it's very difficult because of the intensity of work that everyone in the department does to take on anything more. There are very few people in the country who have experience and expertise in the nutritional care of patients.

***Tacey Ann Rosolowski, PhD***

**0:54:59.2**

Tell me a little bit more about what the intents are in nutritional care. What are some of the issues?

***John Stroehlein, MD***

**0:55:06.5**

Some of the issues involved—as we established the program, we established it with the idea of doing an inpatient and later an outpatient service so individuals receive intravenous nutritional support. But what's the composition of that support? How many calories should they receive? What other nutrients are needed? What are their deficiencies? Our department or someone in the department saw every patient outside of Pediatrics who was going on intravenous nutritional support and worked with dieticians and Pharm Ds to provide the product. We're about ready to look at an outpatient nutritional program because nutrition has a lot of application to gastrointestinal cancer, particularly perhaps as it relates to obesity. It was about that time that the Be Well Anderson project was developed where healthy eating habits were encouraged. A

change in the display of food products was embraced, and the exercise fitness center was opened. There are some institutional sort of derived approaches to encourage the personnel to be well. That's what it was called was Be Well MD Anderson. Our department was not the one that was the driving force for this, but we were actively involved in committee meetings, et cetera, to establish that program.

*Tacey Ann Rosolowski, PhD*

**0:57:05.5**

And what was the time period that the Be Well program was established?

*John Stroehlein, MD*

**0:57:08.7**

I would say the time period was roughly 2010.

*Tacey Ann Rosolowski, PhD*

**0:57:19.7**

So that's relatively recent.

*John Stroehlein, MD*

**0:57:21.3**

It's relatively recent.

*Tacey Ann Rosolowski, PhD*

**0:57:23.0**

Wow. I'm surprised. I remember in that article that I mentioned when we met last time—it was an article that was published in 1979 in the newspaper—they were already mentioning diet as being significant at that time.

*John Stroehlein, MD*

**0:57:49.5**

The question is what works and what doesn't work. And that's what we were poised to study, and this had to be broken on the rock of reality. And the reality was the economic downturn and uncertainty as to how long the institution could continue to pay its bills with the resources that were coming in day in and day out. In the state of Texas, unlike some university systems elsewhere, you're not allowed to delve into the endowment fund to help pay operating expenses. Operating expenses are paid for otherwise, so when the economic downturn came there was only one choice, and that was to cut expenses by a certain amount, which meant in effect in our department there were four individuals whose jobs were eliminated. Those positions have been reactivated and refilled.

***Tacey Ann Rosolowski, PhD***

**0:59:03.9**

Now were those positions specifically in Nutrition?

***John Stroehlein, MD***

**0:59:07.0**

Two were specifically in Nutrition, and one was indirectly in support of the nutrition research activities.

***Tacey Ann Rosolowski, PhD***

**0:59:20.4**

What do you think the prognosis is for reestablishing that dimension? I mean, I'm asking because it's part of the department title.

***John Stroehlein, MD***

**0:59:28.0**

It's part of the title, and there have been questions whether we should keep it in the title, but it's been in the title for ages—well before we added hepatology, which is really very relevant. We have two junior faculty who see patients in the liver clinic and one very advanced clinician who is coming in the next month or so to contribute to the liver program. The liver program should be well under way. I'm not particularly optimistic in view of the intensity that everyone has with the endoscopy unit and the clinical activities. It's hard to see how the nutrition program per se could be reestablished. We have plans to have a training program leading to board eligibility in nutrition, but all this had to fall to the wayside. There's been an interest in the department of General Medicine to establish a program under their umbrella, but I don't see it really happening. There are very few programs around the country where they have nutrition programs. It's not part of the [ABIM](#) that provides the board certification in nutrition. But at Mayo, to my understanding, it's the endocrinologists that provide the intravenous hyperalimentation nutritional consults.



## **Chapter 17**

### **A: The Administrator**

#### ***Serving as Department Chair and as Co-Medical Director of The Department of Patient Affairs***

#### **Story Codes**

C: Understanding the Institution

B: Overview

B: Critical Perspectives on MD Anderson

B: Institutional Mission and Values

B: MD Anderson Culture

B: Building/Transforming the Institution

C: Patients

C: Patients, Treatment, Survivors

B: Institutional Processes

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

#### **1:01:08.9**

When you took on the role as interim chair and then now as deputy chair, what were some of the projects that you wanted to commit yourself to?

#### ***John Stroehlein, MD***

#### **1:01:22.1**

I wanted to encourage everyone in the faculty to be doing something while recognizing that everyone could not do everything, but everyone could do something. I felt that the department should provide the basic resources that contributed to how easy it was for someone to do a particular job. For example, a lot of individuals who are primarily clinicians do not have the research background of getting things packaged to be presented to the review boards, et cetera, and the financial aspect of things as it pertains to auditing and monitoring and looking at the percentage of effort of time and things like that. It was my desire that everyone in the department would see that they had the value and that everyone would be expected to do something in their own individual area and that we in turn as a department would provide the basic foundation or the very basic resources that would allow that to succeed.

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

#### **1:03:00.3**

And what effect has that move had?

#### ***John Stroehlein, MD***

#### **1:03:04.7**

I think that everybody in the department is actively involved for a variety of reasons, not the ones

that I can necessarily claim, but everybody in the department is very inwardly motivated. They don't have to be cajoled to work. They are very industrious and very committed as a group and interestingly very much so. You just have to encourage individuals to have the mindset that they can do something or that they should do something, and even today I will ask individuals how they are doing and has this been completed or has that been completed. How are things going? Without that level of encouragement, oftentimes things can sit dormant.

***Tacey Ann Rosolowski, PhD***

**1:04:02.4**

Now I'm also aware that during the time you have been operating in this role, you've also been the co-director of Patient Affairs. That's since 2006, and you still hold that role. I'm wondering if you could, first of all, tell me about that particular department and then explain your involvement.

***John Stroehlein, MD***

**1:04:29.4**

Well, the department of Patient Affairs is here to serve members of the Board of Visitors, certain governmental agencies, the president's office, who wish to come to MD Anderson and maybe don't quite know how to go about it, or a board member will encourage somebody to be seen here. They wish to be seen, but which clinic do they go to? How does it happen? Personnel in the department—there are two different groups. One is an administrative role and the other a patient care role. Most in the administrative role help to register and obtain slides, CDs, and so forth. We try and make the process smooth so when one comes here they are not encumbered by bits and pieces of data that are lacking. Then individuals are met by one of the representatives who will help them from point A to point B to see that their activities—their completion of the studies—is efficient without getting involved with the patient care or other aspects of advocacy, et cetera.

***Tacey Ann Rosolowski, PhD***

**1:06:14.5**

How did you come to have that role? Who recruited you for that, and why were you interested?

***John Stroehlein, MD***

**1:06:22.5**

Well, the role I guess historically was in many respects a very non-official role. Somebody named Robert Morton, who was a radiologist by profession, had had a role of being a facilitator of patient care. He was not necessarily an advocate for the patient or an advocate for the doctor but tried to see what could be done to bring them together, and he was very effective at this. Dr. Taylor Wharton, who was a former professor of gynecology and I guess department chair, if I recall, became the medical director of the department. And then since the time of his retirement, a decision needed to be made as to who would assume that role. I had an interest in the role, and I may have made it known that I had an interest. But I was identified, and because of the division

of the campus on both sides of the street, it was decided that there would be a co-medical director for the Mays Clinic side of the street and one for the Clark Clinic side of the street.

In this capacity, we really served as a reviewer of referrals, trying to see that they get to where they need to be, answering any questions that the administrative or support staff had, and from time to time meeting or greeting individuals to let them know that we're concerned about their care, the institution is concerned about their well-being. You have to recognize that many individuals who have prominent positions also have constraints of time. They're not retired. They have to have an efficiency of operation. (phone rings)

*Tacey Ann Rosolowski, PhD*

**1:08:53.8**

Shall I pause?

*John Stroehlein, MD*

**1:08:54.5**

Hello. (Dr. Wharton on the phone)

*Tacey Ann Rosolowski, PhD*

**1:08:58.4**

Hi, it's very nice to meet you via the phone.

*Taylor Wharton, MD*

**1:09:00.9**

Thank you, Tacey. Nice to meet you.

*Tacey Ann Rosolowski, PhD*

**1:09:03.4**

And yes, Dr. Stroehlein and I were talking about how the department of Patient Affairs came to be established and its role. What can you tell me about what you feel the mission of the department is?

*Taylor Wharton, MD*

**1:09:16.8**

To assist the patients to make the process a little easier.

*Tacey Ann Rosolowski, PhD*

**1:09:28.5**

It's a pretty complicated process, I gather.

*Taylor Wharton, MD*

**1:09:31.0**

Uh-hunh (affirmative).

*Tacey Ann Rosolowski, PhD*

**1:09:33.5**

And the individuals that you serve are pretty special to the institution, as I understand it.

*Taylor Wharton, MD*

**1:09:41.1**

They are, but we'll take care of anybody who needs help.

*Tacey Ann Rosolowski, PhD*

**1:09:48.1**

So it's a broader demographic than simply Board of Visitor members or individuals who contact the president's office? Or are those kind of the gates?

*Taylor Wharton, MD*

**1:09:58.2**

Those are the most important ones.

*Tacey Ann Rosolowski, PhD*

**1:10:02.2**

And who are some of the other individuals that you serve?

*Taylor Wharton, MD*

**1:10:09.4**

Patients are about it.

*John Stroehlein, MD*

**1:10:12.8**

Taylor, you were the first—after Bob Morton, before this was really designed as a department—you were the first sort of full-time medical director, if I recall.

*Taylor Wharton, MD*

**1:10:24.4**

That's right.

***John Stroehlein, MD***

**1:10:25.9**

So basically the lineage is Bob Morton, yourself, and then—

***Taylor Wharton, MD***

**1:10:32.8**

Lorena Collier.

***John Stroehlein, MD***

**1:10:34.9**

Lorena Collier. And then more recently, the team that's currently assembled.

***Taylor Wharton, MD***

**1:10:45.5**

Uh-hunh (affirmative). Linda White was very important in there.

***John Stroehlein, MD***

**1:10:49.1**

Yeah, that's right. I forgot about Linda. These were individuals who had a nursing background, but I was telling Tacey that these were not patient advocates or doctor advocates but were advocates of getting things done, seeing that patients and doctors and their care was as efficient as possible, and I mentioned to her that these were individuals who in their own life's activities have busy schedules, and there are practical as well as personal reasons to try to see that things go smoothly.

***Taylor Wharton, MD***

**1:11:29.2**

That's right.

***Tacey Ann Rosolowski, PhD***

**1:11:31.2**

Now when you took over as a formal chair of this new department, did you find that things were pretty well set up, or were you setting up a lot of the operations?

***Taylor Wharton, MD***

**1:11:44.5**

I was setting up a lot of the operations.

***Tacey Ann Rosolowski, PhD***

**1:11:46.4**

Wow. So how long did it take before things were up and running pretty smoothly?

***Taylor Wharton, MD***

**1:11:53.3**

About two years.

***Tacey Ann Rosolowski, PhD***

**1:11:54.3**

Two years. Wow.

***John Stroehlein, MD***

**1:11:57.8**

And Linda was here at that time, right?

***Taylor Wharton, MD***

**1:12:01.0**

Yeah. Linda was very important.

***Tacey Ann Rosolowski, PhD***

**1:12:04.8**

Well, it sounds like I'm gathering some other names of people to talk to, and I don't want to interrupt your business.

***John Stroehlein, MD***

**1:12:09.9**

Taylor, I called earlier. I was going to kind of reiterate what I understood the history was because I knew I was meeting with Tacey this afternoon. I thought I would call you because I really respect you a lot, and it's an honor really to follow in your footsteps as best we can.

***Taylor Wharton, MD***

**1:12:31.3**

Well, you're doing a wonderful job.

***John Stroehlein, MD***

**1:12:32.3**

I thought I would bend your ear, and it's ironic that literally within a sentence ago she said, "Let's talk about Patient Affairs," and that's when you returned my call. Listen, you take care. I

do appreciate hearing from you. You and Mary have a wonderful Christmas, and we'll be in touch.

*Taylor Wharton, MD*

**1:12:54.3**

Thank you, John.

[Phone conversation ends.]

*Tacey Ann Rosolowski, PhD*

**1:13:04.3**

That is funny luck. So when you came in, things were pretty well set up then.

*John Stroehlein, MD*

**1:13:10.5**

They were pretty well set up. There had been some changes, but it's a matter of keeping going. I have not been in favor of, nor do I think Dr. Weber is in favor of, combining our efforts with or having anybody from Development in our department. I have felt that we contribute a lot to—if somebody has a good experience, they're more likely to contribute to the institution, to cut to the chase. We don't have to have somebody from Development in our department in an office to meet with people and try to encourage them to donate. If they have a good experience, they are more likely to have an inclination to contribute.

*Tacey Ann Rosolowski, PhD*

**1:14:10.7**

Yeah, because the members of the Board of Visitors are already financially supporting the institution, so they're kind of VIPs in that way.

*John Stroehlein, MD*

**1:14:20.9**

And many people from the Board of Visitors feel very strongly about the institution. If they know somebody—a friend with cancer—they will call to refer them to the institution. Sometimes they'll call me personally. Sometimes they call the department. Sometimes with a patient who is prominent with a major corporation, there's some question as to whether that individual should go to department A or department B, so to speak, because as I told you earlier, things are very subspecialized today. One of the roles we can play is to review the medical records and try to direct individuals where they need to go.

*Tacey Ann Rosolowski, PhD*

**1:15:11.8**

Now where do—the Patient Affairs department is available to any patient who wants to call.

***John Stroehlein, MD***

**1:15:21.2**

Not necessarily.

***Tacey Ann Rosolowski, PhD***

**1:15:23.6**

My question was where do patients go in general if they need this kind of information about how to find their way through this complicated institution?

***John Stroehlein, MD***

**1:15:35.1**

Well, each center has a business center and a referral service, and each center has a patient advocate who is in effect advocating for the patient, which is a little bit different than enhancing the efficiency of operations, so that things get done. We have no desire to find fault in one thing or another unless there is something that has happened that is inappropriate or egregious in one way or another. We have an interest in supporting the common good.

***Tacey Ann Rosolowski, PhD***

**1:16:26.0**

Well, and the idea is, too, that these individuals have almost a prior relationship with the institution if they're Board of Visitor members.

***John Stroehlein, MD***

**1:16:38.8**

They are. Or alternatively, if they are referred by a member of the Board of Visitors, they have a relationship through another context—a mutual friend, somebody who knows the institution. The other individual may not know the institution as one who is new, but they know somebody who is new.

***Tacey Ann Rosolowski, PhD***

**1:17:04.1**

Patient Affairs is about continuing to nurture those special relationships.

***John Stroehlein, MD***

**1:17:10.4**

Patient Affairs in effect nurtures relationships: relationships that we have with patients, Board of Visitors, members of the government, members of the president's office, et cetera.



***Tacey Ann Rosolowski, PhD***

**1:17:27.5**

And I can understand why. I mean, is it Development that floated the idea of perhaps having a member of that department in the Patient Affairs office?

***John Stroehlein, MD***

**1:17:37.0**

Sure, you could see it from their standpoint, but is it a good idea? I think not, I have expressed that opinion, and I think in the final analysis actually we'd probably do more from a developmental standpoint if we don't do it too directly.

***Tacey Ann Rosolowski, PhD***

**1:18:00.0**

I mean of course you would like to ensure that individuals who are in a position to give to the institution have—basically are shown the best face and have their needs attended to, but on the other hand, having too heavy a hand in that request—

***John Stroehlein, MD***

**1:18:17.5**

It's a balance, and how you balance it is hard to say.

***Tacey Ann Rosolowski, PhD***

**1:18:20.0**

That is a very tough one.

***John Stroehlein, MD***

**1:18:20.7**

It works. It works very well.

***Tacey Ann Rosolowski, PhD***

**1:18:29.2**

How do you get feedback on how well Patient Affairs is working?

***John Stroehlein, MD***

**1:18:34.0**

Historically they've done surveys and a report to have a director and have a person who is sort of co-director for the personal assistance to the patient. There are surveys and feedback.

*Tacey Ann Rosolowski, PhD*

**1:18:59.8**

And how many patients do you handle per month, per year?

*John Stroehlein, MD*

**1:19:08.2**

I could find out in a few moments the per month, and the volume is not that great because the care is very individualized. But new patients per month I would guess probably eighty or thereabouts.

*Tacey Ann Rosolowski, PhD*

**1:19:31.2**

As many as that.

*John Stroehlein, MD*

**1:19:34.1**

I could find out. That may be a little bit high.

*Tacey Ann Rosolowski, PhD*

**1:19:35.7**

Yeah, I'm surprised.

*John Stroehlein, MD*

**1:19:42.3**

We'll find out.

*Tacey Ann Rosolowski, PhD*

**1:19:42.9**

Okay. I'll pause the recorder.

*John Stroehlein, MD*

**1:19:48.7**

(on the phone) —a month that may be new to the institution. Take all of you together, you and Lisa and Linda and the whole kit and caboodle, how many? How many patients a month? I know you have the spreadsheet, but can you guess? Twenty, forty, sixty, eighty, a hundred? What?

*Female Speaker*

**1:20:16.7**

(on the phone) I would say at least about—probably between twenty and thirty.

***John Stroehlein, MD***

**1:20:23.3**

Okay, that's brand-new.

***Female Speaker***

**1:20:31.4**

Yeah, that's new. I could give you the (inaudible). Some months are slower than others.

***John Stroehlein, MD***

**1:20:42.3**

Yeah, talking about everybody—Carmen, everybody.

***Female Speaker***

**1:20:56.1**

For last month (inaudible).

***John Stroehlein, MD***

**1:20:57.7**

That's for you?

***Female Speaker***

**1:20:58.7**

That's for me. For Carmen (inaudible).

***John Stroehlein, MD***

**1:21:15.9**

What about Linda?

***Female Speaker***

**1:21:23.4**

She had—let's see—twenty-six.

***John Stroehlein, MD***

**1:21:40.2**

So that's fifty. And then Lisa.

***Female Speaker***

**1:21:47.5**

Lisa has twelve.

***John Stroehlein, MD***

**1:21:56.0**

So that's sixty-two. So sixty-five to seventy easily.

***Female Speaker***

**1:22:09.8**

Those are brand-new patients.

***John Stroehlein, MD***

**1:22:11.2**

Brand new. Okay, very good. Thank you. That wasn't too far off. It's very hard because some of these people are coming back, and some months I'm sure it's eighty. But when you talk about getting the referrals, contacting the business center, being sure the x-rays are here, getting the slides there, walking them down or whatever else is needed, whatever is needed to see that the job gets done and gets done right. You almost never, ever have any incomplete operations. They dot the i's. They cross the t's. Everything is fine.

***Tacey Ann Rosolowski, PhD***

**1:22:50.8**

So it goes very smoothly. Now, what about studies that a patient might be eligible for?

***John Stroehlein, MD***

**1:22:56.6**

We don't get involved in any aspect of patient care. Absolutely zero.

***Tacey Ann Rosolowski, PhD***

**1:23:01.2**

Okay, so it's all arranging the logistics.

***John Stroehlein, MD***

**1:23:05.2**

Logistics and arranging and, for the most part, staying out of the scheduling issues. Sometimes there will be a scheduling concern. You can communicate that concern to somebody in a department that's responsible for scheduling a particular test, and they go, "Oh, sure. We can accommodate them at the ROC," where they do outpatient CT scans, "tonight at eight o'clock." You can ask the patient. "Okay, sure, Robert can come at eight o'clock tonight." In other words, something may be available that the individual didn't know about because nobody told him. It's a matter of serving as a resource. Bob Morton and Lorena Collier, Linda White, served in that role, and Morton was incredibly effective.

***Tacey Ann Rosolowski, PhD***

**1:24:16.7**

What made him so effective do you think?

***John Stroehlein, MD***

**1:24:20.3**

He was like a maître d' who walked the floor. He was there walking the hallways checking on things. Not intrusive, not by pointing fingers or reporting somebody to some agency or through a keyboard or something like that but a matter of just seeing where the problems existed and taking care of them. The same if you go to a good restaurant. There's probably a maître d'. Somebody needs water. Somebody else is ready for their bill. Somebody else spilled their cup of coffee. It's the availability and the presence and then an approach or an attitude which was not threatening to anybody because there was no agenda to create a process or a punishment or anything. Just get the job done and do it right.

***Tacey Ann Rosolowski, PhD***

**1:25:28.4**

Now you've been in that role since 2006, so six years. What do you find gratifying about it?

***John Stroehlein, MD***

**1:25:40.2**

I guess the more gratifying thing is being able to help the personnel, the staff, who are highly motivated to help the patient but may not have the expertise to know which direction to take a particular referral.

***Tacey Ann Rosolowski, PhD***

**1:26:11.5**

And does the Development office work with Patient Affairs to track in any way?

***John Stroehlein, MD***

**1:26:19.2**

They're really independent.

***Tacey Ann Rosolowski, PhD***

**1:26:20.3**

They're independent.

***John Stroehlein, MD***

**1:26:21.4**

We get patients also from Development as well as the president's office, the Board of Visitors or

from the government. They may be a source of referrals and they probably know the individuals that they see, but the two are operationally independent.

***Tacey Ann Rosolowski, PhD***

**1:26:44.8**

Yeah, I was just curious if there was any statistics on whether individual's giving increased after or is established after individuals are helped by Patient Affairs. You know, tracking how effective the—

***John Stroehlein, MD***

**1:27:02.0**

I don't know if the data exists or not. I really don't know.

***Tacey Ann Rosolowski, PhD***

**1:27:06.1**

I was just curious. I know from speaking with Nancy Loeffler, who was obviously a patient. She spoke very candidly about how her experience as a patient really deepened her appreciation for what the institution can do, and I imagine you've heard her speak about that.

***John Stroehlein, MD***

**1:27:31.1**

And I think that's true, and that's public record. She's spoken about it publicly and if somebody has a good experience—and most of the time they do—individuals here have the position of trying to help people for the most part. We had some individuals from another institution who came to look at our department a few years ago, and coming from the garage they were stopped three times. "Can I help you? Are you lost?" The idea of helping other individuals find their way in a complex environment where you're not thinking about where you're going. You're thinking about the new diagnosis that has just been rendered.

***Tacey Ann Rosolowski, PhD***

**1:28:27.2**

It's interesting, too—well, I should ask the question. Why was the department formally established in 2004? If it had been in existence—

***John Stroehlein, MD***

**1:28:39.9**

Maybe a little bit longer than that. I don't know the answer, and that was one of the things I was going to ask Dr. Wharton before we met today. I called earlier. He wasn't home. He came back home, got the recording, and then he called. But I think this may have been a realization of two things: a need on the one hand, and the effectiveness of Bob Morton and Lorena Collier on the other. Individuals who were doing this in a non-structured way were effective, and they

contributed significantly to the institution. On the one hand, you saw that it was good, and then on the other hand, there was a recognition that there was a need to formalize things.

*Tacey Ann Rosolowski, PhD*

**1:29:38.0**

I'm thinking that was really in the midst of the time that MD Anderson was expanding at an incredible rate.

*John Stroehlein, MD*

**1:29:47.2**

Absolutely, and that was at a time when Dr. LeMaistre established an organizational structure that historically did not exist.

*Tacey Ann Rosolowski, PhD*

**1:29:56.3**

Do you mean Dr. LeMaistre or Dr. Mendelsohn?

*John Stroehlein, MD*

**1:29:58.7**

Probably Dr. LeMaistre. He established a lot of the organizational structure, and I think he called upon his role as chancellor in doing that. But it came at a time when there was considerable growth to the institution. It continued under Dr. Mendelsohn. The institution was sufficiently large that they had to establish a structure. Not everybody could go ask Dr. Hickey if it was okay to do A, B, or C.

*Tacey Ann Rosolowski, PhD*

**1:30:36.2**

What plans does Patient Affairs have to refine their services or add additional services? What's the future look like?

*John Stroehlein, MD*

**1:30:51.3**

From a practical standpoint, their space will be remodeled in part because part of the Patient Affairs office is going to be given to the emergency center. But in doing that, they will have smaller rooms, smaller than this room where individuals could meet as opposed to a big lounge area where one family is there, and another one tends not to go in. I think we're going to have better utilization of the space, even though it will be smaller, and I don't know of any major changes. I mean it works. It serves a real purpose, and it is without a doubt an asset to the institution.

***Tacey Ann Rosolowski, PhD***

**1:31:43.2**

How would you describe why it's an asset?

***John Stroehlein, MD***

**1:31:51.4**

By making the entry process easier and by individually letting patients know that the institution cares about their welfare.

***Tacey Ann Rosolowski, PhD***

**1:32:18.9**

How long do you plan on staying involved?

***John Stroehlein, MD***

**1:32:24.8**

Probably as long as I'm employed here, as long as they want me to stay involved. And based upon comments which you heard Dr. Wharton say, and others at our holiday dinner and so forth, what I do they are very happy with. I don't think the department has any desire whatsoever to change. If they do, they do. It's their choice. Not mine.

***Tacey Ann Rosolowski, PhD***

**1:32:55.2**

What exactly is your role?

***John Stroehlein, MD***

**1:32:58.5**

My role is to review, to sometimes mentor, and perhaps more precisely, to advise individuals who may not have the clinical background that I have so the individual gets to the right clinic or the right consultant to deal with a particular problem.

***Tacey Ann Rosolowski, PhD***

**1:33:28.7**

That's the medical piece.

***John Stroehlein, MD***

**1:33:30.1**

That's the medical piece. Some of the personnel come from a background of social work, some from a background of nursing. But as the level of sophistication of medical expertise has changed a lot, we've already talked about how things are more specialized, and so you get this packet of information. Should an individual go to clinic A or clinic B? Where could they best be



served? And if you make the right decision up front, then you do not encumber the time and effort to go back and start over again.

*Tacey Ann Rosolowski, PhD*

**1:34:18.8**

I'm almost hesitant to ask this question, but I feel I have to ask it. To what extent do you think Patient Affairs ensures that these individuals have a better experience at MD Anderson than a person who may just call up to make an appointment at a department and doesn't have those kinds of advocacy or referral resources?

*John Stroehlein, MD*

**1:34:43.7**

I can't quantitate that, but I'm sure it's better. One of the challenges of Anderson—and to a degree, one of its deficiencies—is more customer-friendly receipt of inquiries to various centers. Clinicians across the board—and it varies from one center to another, but they will receive inquiries or complaints that the patient may have called many times and never been able to talk to anybody. I think our intake process needs improvement, but that's not for me to decide.

*Tacey Ann Rosolowski, PhD*

**1:35:42.8**

I'm curious. If Patient Affairs gets about seventy to eighty new patients per month, I'm wondering what the average is for the other department—for the clinical departments at MD Anderson. I'm sure it's infinitely larger than that.

*John Stroehlein, MD*

**1:36:03.1**

Oh, much larger.

*Tacey Ann Rosolowski, PhD*

**1:36:04.8**

Yes, so there's a logistical reality there, too, which is not to say that—

*John Stroehlein, MD*

**1:36:09.8**

But there are operational things that can be introduced that make the process easier for the patient. There are simple things. For example, some centers will require all of the information to be provided. The patient gets all the information. Then they're told by their insurance that they don't qualify. Before you go through all the time and effort to have the patient get their records, make the CD, FedEx it here and do all this and wait for a week or two and then be told they don't qualify—but then there's two different departments that the people that deal with the registration, and they deal with the insurance, and they're kind of separate satellites or orbits. It

would seem to make sense to see if you qualify. If you don't qualify, why not tell the patient first before somebody takes all this time and effort to get the material? There are some simple things that probably could be introduced that would be of help.

***Tacey Ann Rosolowski, PhD***

**1:37:43.8**

Is there anything else you'd like to say about Patient Affairs before we move on to another topic?

***John Stroehlein, MD***

**1:37:50.6**

It's an effective, well-run department that serves the institution well and attempts to do so in a very unobtrusive way.

## **Chapter 18**

### **A: The Researcher**

#### ***Future Projects***

Story Codes

A: The Researcher

A: The Clinician

C: Evolution of Career

C: Professional Practice

C: The Professional at Work

***Tacey Ann Rosolowski, PhD***

**1:38:12.9**

And I wanted to go back at this point and pick up a few additional questions about your role as deputy chair of the department. You had mentioned that there were some projects that you hoped to see through, and you mentioned a few of them. But I wanted to make sure that you had an opportunity to look ahead and tell me about all of the different things that you hoped to bring to conclusion.

***John Stroehlein, MD***

**1:38:40.6**

I've been involved in some clinical studies which I think are going to come to fruition.

***Tacey Ann Rosolowski, PhD***

**1:38:47.1**

And what are those?

***John Stroehlein, MD***

**1:38:48.1**

Well, one is looking at some of the genetic characteristics of gastric cancer in different ethnic groups. Another one involves the palliation of malignant ascites. I give a lecture to the general medical—the [GME](#) for the individuals who are in graduate programs that are Anderson based and not affiliated with the university—on being a consultant, on which there is very little, almost nothing written. How do you be a consultant?

***Tacey Ann Rosolowski, PhD***

**1:39:23.9**

And why is that significant?

***John Stroehlein, MD***

**1:39:26.4**

Because one has to interact no matter which area of medicine you're in. You have to interact with other individuals and specialists. Everything is specialized today, and you're calling consultants. You don't want to speak for the consultants and tell the patient or family, "Well, Dr. Jones will do your endoscopy tomorrow morning at nine o'clock" before you even know if Dr. Jones is even going to be here tomorrow, let alone whether the schedule is free at nine o'clock. The relationship of the primary referring service is important, and how the consultant accepts the referral is important. It's a two-way street, and very little is written about it and very little talked about it. There are many clinical experiences that I have that I think I should put down and convey. There's an article on listening—the value of listening—which people generally don't do today. I need to revise that and send it back to the journal to which it was sent.

***Tacey Ann Rosolowski, PhD***

**1:40:43.0**

What's the journal?

***John Stroehlein, MD***

**1:40:44.8**

I sent it to the [Pharos of AOA](#), which is an honorary medical society. But there's some conceptual positions which may be a little bit more philosophical from one person than another. But they I think hold truth and substance that needs to be communicated, and I would hope that maybe I can pull some of these loose ends together, some coming indirectly from the lab and some coming from the clinical and some coming from my role as a clinician over many years.

***Tacey Ann Rosolowski, PhD***

**1:41:28.8**

Now you're speaking beyond the article on listening at this point. Am I correct?

***John Stroehlein, MD***

**1:41:34.6**

Yeah.

***Tacey Ann Rosolowski, PhD***

**1:41:36.0**

And so what are some of the other areas? What are some of those other loose ends?

***John Stroehlein, MD***

**1:41:41.0**

There are loose ends related to clinical observations that need to be communicated, techniques

that need to be described and that have been reported in abstract form, and I simply need to carve out the time to see that these things are accomplished and to work more effectively with some of our individuals in the lab to, in a translational way, bring some of the basic science observations to the bedside.

*Tacey Ann Rosolowski, PhD*

**1:42:19.0**

What specific studies do you think are closest to making that shift?

*John Stroehlein, MD*

**1:42:30.3**

Maybe studies related to processes that will shift a premalignant but benign disease to become malignant, as in the case of [adenocarcinoma of the esophagus](#) complicating Barrett's esophagus or in the case of genetic disparities between cancers seen in different ethnic groups. Or in the case of the malignant ascites, proving that a catheter can be inserted for palliation of the abnormality to save the patient the time, effort, and cost of coming back and forth to the clinic and having a procedure done every two or three weeks or once a week even. There are things we can do that I think contribute to the cost savings and to the comfort of the patient in a palliative way, things that we can do that impact on better communication between consultants and referring services, things that we can do to encourage basic scientists to further understand what turns on or turns off the development of cancer.

## **Chapter 19**

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

#### *Developing a Data Manager and Fostering Quality Assurance*

##### **Story Codes**

B: Building/Transforming the Institution

B: Institutional Processes

B: Devices, Drugs, Procedures

B: Institutional Mission and Values

A: Overview

A: Definitions, Explanations, Translations

C: Professional Practice

C: The Professional at Work

D: On Research and Researchers

D: Fiscal Realities in Healthcare

*Tacey Ann Rosolowski, PhD*

**1:44:10.9**

Is there anything additional within the department in an administrative sense that you're interested in accomplishing?

*John Stroehlein, MD*

**1:44:22.0**

We have a data manager that is in a position to pull together huge pieces of data that can be included in one database, and I think that this is very important. From the startup funds of somebody that I recruited, they are using those resources to pay an individual. We're very much data driven. We are procedure focused, and we need to pull together this information to see what insights there are to make correlations between various diseases. And in a new role which I have, which is chairman of the Quality Assurance Committee for the department, quality assurance is going to become very important in the future where if you cannot prove that you have a quality product it may not be compensated. I need to work with my colleagues to come up with individual items or projects that impact on quality and can be used to support the consensus that we have a quality product, which we're confident we do. But of course, the data—without data anymore it's going to be difficult to prove that you did something. With the data you can improve that.

*Tacey Ann Rosolowski, PhD*

**1:46:35.0**

And I can see how this most likely intersects with that last project, which is the creation of the database.

***John Stroehlein, MD***

**1:46:43.1**

Oh, without a doubt. Without the database—we have different recording systems. We've had the Pentax reporting system for many years, then an Olympus reporting system. We may get another reporting system. All these are proprietary. They're designed not to talk to each other, but you can—with the appropriate information technology people—drag data from one database to another, giving us a repository of tens of thousands of cases of disease X or disease Y that very few places in the country have access to.

***Tacey Ann Rosolowski, PhD***

**1:47:24.2**

How is that working? Is the metadata attached to those cases already entered into the original repository, or do you have to create an entirely new system for that platform? I'm just curious.

***John Stroehlein, MD***

**1:47:40.9**

I'd have to ask the IT because one of the dilemmas has been getting the pathology reports incorporated. But that's, I think, feasible. It's going to be when they go to the new data system here, whichever one they pick—whether it's Siemens, whether it's Epic, or whatever—there's years and years of data in ClinicStation. How do we transition that over? Are we going to have two parallel systems for a while? Or alternatively, will all the ClinicStation material be dumped into the new system? Since ClinicStation was developed in house, the prospects of transferring that—because it's not a proprietary product, it's restricted in its use. It's our product. We designed it and we made it. It should be easy to—from that standpoint—take information in ClinicStation and put it into the new reporting system, whichever one that proves to be.

***Tacey Ann Rosolowski, PhD***

**1:48:52.2**

Yeah, I'm just reflecting on part of the conversation we had last time where you were making that distinction between information and knowledge and how here are all these bits of information but they need to be put in a—

***John Stroehlein, MD***

**1:49:05.2**

You need to put them together, and you need to ask the right questions. In our department we now have a process where it's going to be not for retrospective reviews but for prospective clinical studies where—and this is an institutional requirement, as far as I know—where prospective protocols have to be reviewed in the department before they can go to the clinical study or institutional review boards. The institutional review boards want this vetted in the department and with the department giving its blessings that we will go forward with project A and have reviewed the contents.

***Tacey Ann Rosolowski, PhD***

**1:49:56.9**

That's kind of the first step in quality control, I guess.

***John Stroehlein, MD***

**1:50:00.1**

That's one of the steps, but there are other aspects of quality control. How do you monitor that patients have been notified about tests or procedures? Do you record that in the medical record? Where do you record it? But it's going to be increasingly important, and it will financially impact around compensation and contractual relationships between insurance companies in the not-too-distant future.

***Tacey Ann Rosolowski, PhD***

**1:50:42.0**

Well, and that's going to be increasingly important now with changes in healthcare.

***John Stroehlein, MD***

**1:50:48.1**

That's right.

***Tacey Ann Rosolowski, PhD***

**1:50:50.9**

Any other projects that you see coming?

***John Stroehlein, MD***

**1:50:54.8**

I think that's enough. The quality assurance, if done correctly, is going to require a lot of time and effort.

***Tacey Ann Rosolowski, PhD***

**1:51:06.5**

And why do you feel a particular commitment to that?

***John Stroehlein, MD***

**1:51:15.8**

My first thought here, again, is that I may be the best qualified to lead that committee.



***Tacey Ann Rosolowski, PhD***

**1:51:24.8**

Why do you say that?

***John Stroehlein, MD***

**1:51:26.7**

Because of my experience, and I don't have really an ax to grind in one area or another. I can look at things more globally. I think as far as who is available in the department—the time and effort that they need—it's unrealistic for research intensity of individuals to do this. Some are spending so much time doing procedures that they cannot realistically do it. There are not too many in the department who are in a position to do this or who have the experience. It's my responsibility to step up to the plate and see that the program is successful. And if it is, our department will be in effect the star of the show.

***Tacey Ann Rosolowski, PhD***

**1:52:24.0**

The star of the show—meaning sort of a guiding light for the rest of the institution?

***John Stroehlein, MD***

**1:52:27.9**

For the rest of the institution for sure.

***Tacey Ann Rosolowski, PhD***

**1:52:32.7**

And what would that mean?

***John Stroehlein, MD***

**1:52:36.6**

I think it would mean that we would be looked very favorably upon when we are seeking needs, funds, and recognition—what have you.

***Tacey Ann Rosolowski, PhD***

**1:52:50.9**

Yeah, as you said, it's going to be an increasingly important kind of objective.

***John Stroehlein, MD***

**1:52:56.5**

Without a doubt.

## **Chapter 20**

### **B: Key MD Anderson Figures**

#### ***MD Anderson Presidents***

#### **Story Codes**

C: Portraits

B: Institutional Mission and Values

C: Healing, Hope, the Promise of Research

D: On Research and Researchers

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

##### **1:53:00.5**

Can you tell me what your view of the different presidents has been and is? We talked a little bit about this last time, but we didn't talk about everyone. You had an opportunity to meet R. Lee Clark. Oh, I should also say we're over time. Is it okay if we go a bit over time?

#### ***John Stroehlein, MD***

##### **1:53:20.6**

It's okay if we go a few more minutes over time. But the presidents all had a different personality. I've known them all. I've worked under every president, but the focus, I think, is that Dr. DePinho is going to be more focused in certain aspects of research and development, as perhaps he should be.

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

##### **1:53:41.2**

How would you compare his leadership persona and style with previous presidents? It's been said by a number of people, actually, that MD Anderson has had the president it needed at the time, which I thought was an interesting observation for a number of people to repeat. I'm wondering if you agree with that and what you think the need is that each of the individuals served.

#### ***John Stroehlein, MD***

##### **1:54:11.9**

I think there's some validity to this. Obviously the search committee felt that way. Dr. LeMaistre was very much a hands-on person, knowing the personnel, walking among the troops. Dr. Mendelsohn provided tremendous leadership and growth of the institution and I think did a fabulous job. Clark really had a concept. He was very visionary, and I think his role has kind of been lost in a way, unfortunately.

***Tacey Ann Rosolowski, PhD***

**1:54:47.8**

How so?

***John Stroehlein, MD***

**1:54:49.6**

Well, it's not recognized.

***Tacey Ann Rosolowski, PhD***

**1:54:51.2**

Really? Well, everybody I talked to just speaks glowingly of him, but you think in general in the institution he's kind of forgotten?

***John Stroehlein, MD***

**1:55:00.6**

I think to a degree, unlike the Mayo brothers.

***Tacey Ann Rosolowski, PhD***

**1:55:06.5**

Yeah, that's true.

***John Stroehlein, MD***

**1:55:11.0**

Of course, the Mayo Clinic is not nearly the same as it used to be. The technology and the sophistication of the research is in a whole different magnitude than it was, and I think Dr. DePinho is correct in that things can be done today that five or ten years ago were not possible, either because of time or money or both.

***Tacey Ann Rosolowski, PhD***

**1:55:37.9**

What's your view of the [Moon Shot Program](#) and that particular approach and even the aim?

***John Stroehlein, MD***

**1:55:44.8**

I think it's great in that it has two main advantages. It challenges individuals to do something above and beyond, which is very positive. And for the individuals who are not part of the Moon Shot it has in effect—I started to stay forced, but it has positioned them to assemble a team to put together a proposal that would compete against the other proposals. But as he pointed out before, there is a lot of value to be derived from the teams that have been established. I would be prepared to argue that in effect breaking down silos and building the team to attack disease

processes that were not accepted as part of the Moon Shot may be the more unadvertised benefit of the whole program, and he himself said this in so many words.

I don't know if that makes sense or not, but fundamentally the various departments have put together a diverse population of researchers, clinicians, and epidemiologists for virtually every disease. Having done that, they hopefully now can see how they can work together for the common good, because as a minimum they work together to come up with a PowerPoint presentation that was used as their competitive approach to being included. How will the Moon Shot be funded? I don't know, and I think there are some reality issues there that need to be addressed.

*Tacey Ann Rosolowski, PhD*

**1:58:14.1**

I'm thinking, too, of capitalizing on the value of establishing those teams for the cancers that are not included in the Moon Shots. Are there institutional incentives or are there kind of resources—

*John Stroehlein, MD*

**1:58:32.1**

I'm not sure if there is an institutional incentive or resource, and the funding is going to be a real issue. But what you would hope would happen and what might happen is people will see that they can work together on a particular project, and just the realization that it is possible to join forces to attack a common enemy may be motivating in and of itself. And ironically, that may be the greater good.

*Tacey Ann Rosolowski, PhD*

**1:59:15.0**

People speak about the extreme compartmentalizations and specialization augmented by, as you said, the keyboard.

*John Stroehlein, MD*

**1:59:25.0**

And we have an extreme specialization, which is necessary today, because the complexity of what the researchers and the clinicians do is such that you can't be the researcher, educator, and clinician that one could in years past.

*Tacey Ann Rosolowski, PhD*

**1:59:46.6**

The omnicompetent person.

***John Stroehlein, MD***

**1:59:48.7**

I love that word. It's a wonderful word.

***Tacey Ann Rosolowski, PhD***

**1:59:50.2**

It is, even though we have to look at it nostalgically.

***John Stroehlein, MD***

**1:59:56.3**

They say I'm a little nostalgic, and that's okay.

***Tacey Ann Rosolowski, PhD***

**2:00:11.5**

Is there anything else that you'd like to observe about the big institutional mission at this point—where you hope it will go? I mean under Dr. DePinho.

***John Stroehlein, MD***

**2:00:25.3**

Well, I would hope it would be successful, number one, and it's going to have to be an early success of some sort or another to jettison it to the next level. And while that's going on, you cannot forget about the patients who have the disease at this point in time. Until the automatic sprinkler system is installed and the high technology sensors are in place, if there's a brush fire in the backyard that's threatening the house, maybe it's good to get out the garden hose. While we're trying to do these magnanimous high-tech research things, it behooves us not to forget about day in and day out going about the business at hand so that we can, in parallel with looking toward the moon, take care of the problems on the Earth.

## **Chapter 21**

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

#### ***A Humanist and a Team-Builder: Critical Perspectives on MD Anderson***

##### **Story Codes**

A: Career and Accomplishments

A: Contributions

B: Critical Perspectives on MD Anderson

B: Institutional Mission and Values

B: MD Anderson Culture

***Tacey Ann Rosolowski, PhD***

**2:01:39.3**

As you look back at the work that you've done in the institution—I know I asked you this question on your role as section head last time, but looking globally at what you've done at this institution, what would you pick out as being the most significant of your projects that you've been able to bring to completion?

***John Stroehlein, MD***

**2:02:05.4**

I think probably—and I thought about this after your first interview—it's probably establishing teamwork that has led to other advances and developments that might not have been possible or not have been possible in that same timeframe. Establishing an importance of the role of clinical service—those two probably are paramount.

***Tacey Ann Rosolowski, PhD***

**2:02:51.8**

I wanted to mention again your awards. I have a few of them written here—the 1999 Humanism in Medicine Award from the Healthcare Foundation of New Jersey. Is that correct?

***John Stroehlein, MD***

**2:03:05.4**

That's correct.

***Tacey Ann Rosolowski, PhD***

**2:03:07.8**

And that was in 1999, as I mentioned. We spoke briefly about that. And then there are a few other awards. There's the 2005 Eagle Award from [Cancer Fighters](#) and the Best Physician from [Health and Fitness Sports Magazine](#). How did that happen?

***John Stroehlein, MD***

**2:03:25.5**

I've been listed on virtually most of the best doctor lists, whether it's *Health and Fitness* or [Castle Connolly](#) or Best Doctors *U.S. News & World Report*. That's one of the groups. And the professorship that's been established and approved by the Board of Regents. I guess it was December. It was established this past year.

***Tacey Ann Rosolowski, PhD***

**2:03:56.4**

And remind me of the name of that?

***John Stroehlein, MD***

**2:04:00.7**

Well, it will go by the name of my last name, Stroehlein, Professor of Gastroenterology, and who will be named to the post is to be determined. It was funded in a very short period of time.

***Tacey Ann Rosolowski, PhD***

**2:04:21.5**

And which have the most significance to you and why?

***John Stroehlein, MD***

**2:04:30.0**

Probably the professorship because there's a perpetuity in this, and it goes on and on. A close second I think would be the Humanism in Medicine Award—not necessarily because of the award, but I was the first recipient.

***Tacey Ann Rosolowski, PhD***

**2:04:51.7**

Why is that so significant to you?

***John Stroehlein, MD***

**2:04:54.6**

I think it probably reflects on the way that I sought to treat people and the way that they should be treated.

***Tacey Ann Rosolowski, PhD***

**2:05:08.2**

I think it really shows a broadness, I think, which is really interesting. I've also done some interviewing for the [Foundation for the History of Women in Medicine](#), and you may know they give a Renaissance Woman in Medicine Award, so the recipient has to not only be very

accomplished in her medical field but has to have another field of interest as well, and often these individuals are activists, so there's a kind of breadth in their perspective that's really interesting. That Humanism award reminds me of that.

***John Stroehlein, MD***

**2:05:45.4**

And I would like to somehow also become a little bit more actively involved with the foundation that supports this because without their support—and they now are responsible for the White Coat Ceremony that's now conducted in almost all medical schools. I gave the White Coat lectureship a number of years ago, but to make a long story short, without that foundation there's almost no organization that promotes or encourages the concept of humanism in medicine, although medicine of all professions is probably more in effect humanistic at a very basic level.

***Tacey Ann Rosolowski, PhD***

**2:06:41.0**

And how would you describe that? I know what I'm imagining, but how would you define the idea of humanism in medicine?

***John Stroehlein, MD***

**2:06:52.4**

Giving priority to the patient and the patient's needs as opposed to one's own agenda, income, or other factors. That's probably the success of the Mayo Clinic, putting the patient first. If you do that, a lot of these other things come along automatically.

***Tacey Ann Rosolowski, PhD***

**2:07:37.6**

You've mentioned the Mayo Clinic a couple of times. Do you feel that MD Anderson manifests that kind of humanistic spirit as well? Or is there a certain work that needs to be done yet? Do you feel the Mayo Clinic is a better example of that as an institution?

***John Stroehlein, MD***

**2:07:58.2**

The Mayo may be the best example in the world, and that's just the way it is. That's just reality. Is Anderson up there with the best? Yes, it's definitely up there with the best. Mayo simply may be the best of the best.

***Tacey Ann Rosolowski, PhD***

**2:08:26.8**

What does MD Anderson need to do or change about the culture, do you think, to make strides in that area?



***John Stroehlein, MD***

**2:08:41.9**

Somehow enhance the communication between different specialties and specialists and to break down some of the encumbrances that patients encounter when they're trying to be entered into the system.

## Chapter 22

### B: Institutional Change

#### *With Growth Comes Disconnection from the Texas Community*

#### Story Codes

B: Critical Perspectives on MD Anderson

B: Building/Transforming the Institution

B: Beyond the Institution

B: MD Anderson Culture

B: Growth and/or Change

B: Obstacles, Challenges

B: Controversy

*Tacey Ann Rosolowski, PhD*

**2:09:15.5**

Do you think that MD Anderson grew too fast? What's your perspective on that growth piece, which obviously had a huge impact?

*John Stroehlein, MD*

**2:09:25.8**

It's had a huge growth, and it has grown very fast. Other institutions—even Mayo has grown fast but not quite at the accelerated pace. But if you take in the other campuses in Florida and Arizona, the new medical school, there are many components of growth there that collectively are about the same. If Anderson had not grown the way it was when it did, it might not have the opportunity to have grown that way in the future. The [Regional Care Centers](#) are of tremendous benefit to patients, as evidenced by their relative growth in activity. The global health initiatives as well. The relationships that one has as an institution with these other entities globally becomes somewhat problematic, and I'm not an expert to know exactly how those relationships should be structured. But I am confident, as exemplified by every major medical center, that you have to work outside of your immediate confines to be successful in the future.

Mayo has at least forty private practices in the Wisconsin/Iowa/Minnesota area that they manage or own or collaborate with very closely. Anderson's Regional Care Centers have become very successful. Their global initiatives have become successful. What Anderson has tended to do to a degree is to consider themselves to be separate from the community and have no relationship with the community. I think that [Dr. \[Lewis E.\] Foxhall](#) deserves a lot of credit in the institution as well in covering the cost of membership of the [Harris County Medical Society](#), which is the largest county medical society in the United States. Until clinicians at Anderson get out of their silo and get out into the community, the referrals from the community will not go up. People are asking why are they as low as they are. There are many reasons for this, but one of the reasons is that the individual clinicians do not have a relationship with other members of the practicing community. And until you establish that relationship, it's very difficult to expect those

individuals to automatically refer patients to the institution. And then when they do, they may hit a roadblock. I'm called not that infrequently because somebody has tried to get in and they simply couldn't—and in very straightforward situations, not having to bend the rules or anything like that to bring somebody into the system.

*Tacey Ann Rosolowski, PhD*

**2:13:20.2**

I hadn't heard anyone approach the issue from that perspective before. What do you think would make that situation better? What kinds of connections? What could clinicians here do?

*John Stroehlein, MD*

**2:13:40.7**

One of the things is to be sure that members of the faculty at Anderson are members of the medical society, for which you don't have to pay. The institution pays, and I think that's a big plus, and we need to let people know. We need to advertise that we are part of the team. We're members of the community. We need to be more active participants in everything from health fairs to other activities that may involve volunteer work or what have you. Staying in the silos puts a barrier between the community and the institution.

*Tacey Ann Rosolowski, PhD*

**2:14:35.5**

I know it would seem to have an effect not only on the ability of the institution to deliver care to residents in this area but also to the bottom line.

*John Stroehlein, MD*

**2:14:49.3**

Because you want to get referrals from your local community. I think that it's—I may be wrong about the numbers. You may know what percentage of patients from Harris County come to Anderson who have cancer. It's a decided minority, maybe twenty-six percent or so. It's a small percent.

*Tacey Ann Rosolowski, PhD*

**2:15:14.2**

Is there anything else that you'd like to add about MD Anderson or your time working here?

*John Stroehlein, MD*

**2:15:21.1**

It's a remarkable institution that I think has done a very good job of, for the most part, individualizing care and still maintaining the quantity of throughput, and I mentioned before to Dr. Mendelsohn—and I think this is perhaps the biggest challenge of the institution is to look upon every patient as an individual who has their own individual needs and expectations and at

the same time maintain the volume that we do. That is the challenge. How do you process more people through the system and at the same time give each individual the time, interest, and effort that makes them feel special? That is I think a real challenge, and I'm not sure what all the answers are.

**Chapter 23**  
**A: Post-Retirement Activities**  
*Writing and Philanthropy*

*Tacey Ann Rosolowski, PhD*

**2:16:30.5**

Do you have a target date in mind for your retirement?

*John Stroehlein, MD*

**2:16:34.5**

The answer is no.

*Tacey Ann Rosolowski, PhD*

**2:16:37.0**

Well, given that that is in the future, do you have some plans that you're thinking about, things that you would like to be doing when you finally leave the institution?

*John Stroehlein, MD*

**2:16:49.4**

I would like to put together—pen to paper—some of the things that we've talked about. It really takes time and effort to do that, but that would be very desirable.

*Tacey Ann Rosolowski, PhD*

**2:17:07.5**

Any other plans for more—or you're going to be writing?

*John Stroehlein, MD*

**2:17:13.7**

Yes, and probably—we're very actively involved, my wife and I, in Houston Young Artists concerts, with Cancer Fighters, with the church, with the Pan-American Society of Houston, the symphony, the Asia Society. I'm at a time in life also where I can give back to the community with service and also with funds or resources because I've been fortunate enough to have had generally good health and to have enough resources that I can—within limits—share these with what I think are deserving institutions, including not only the ones I mentioned but also MD Anderson and my undergraduate university, my medical school, and Mayo. So I would hope that I'd be able to support institutions that are important to me and to support organizations that are going to be helpful for generations to come.

***Tacey Ann Rosolowski, PhD***

**2:18:40.6**

Is there anything else that you would like to add before I finish the interview?

***John Stroehlein, MD***

**2:18:44.9**

No, but I would like to thank you because you have done a marvelous job of thinking ahead and preparing and having some questions in mind. And what it does for the individual who is being interviewed is it prompts them to think about the questions that are asked later and see where I am coming from and what am I doing. It's in that context that perhaps the thing that maybe I've done best of all is to individually care for patients and collectively build teams.

***Tacey Ann Rosolowski, PhD***

**2:19:25.6**

That's certainly been a theme that's come out over the course of the interview which I've found very, very interesting. From reading your background materials that was not a surprise, but I hadn't expected that. But it emerged and really makes a lot of sense given when you came.

***John Stroehlein, MD***

**2:19:45.8**

I think it makes sense, too.

***Tacey Ann Rosolowski, PhD***

**2:19:46.1**

Yeah, it does. Well, I want to thank you very much for your time.

***John Stroehlein, MD***

**2:19:49.7**

Thank you.

***Tacey Ann Rosolowski, PhD***

**2:19:50.7**

I'm turning off the recorder at—did you have something you wanted to add?

***John Stroehlein, MD***

**2:19:53.9**

No, thank you.

***Tacey Ann Rosolowski, PhD***

**2:19:55.7**

I'm turning off the recorder at five minutes of 4:00.

**2:19:59.8** (End of Audio 2)