

# **Thomas Burke, M.D.**

Interview #50

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## **Thomas Burke, M.D.**

Interview #50

### **Interview Profile**

**Interview description submitted:** 2014

#### **Interview Information:**

Three interview sessions: 11 March 2014, 18 March 2014, 29 April 2014  
Total approximate duration, five hours.  
Interviewer: Tacey A. Rosolowski, PhD

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

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

Dr. Thomas Burke (b., 8 May 1953, Pittsburg, Pennsylvania) joined MD Anderson in 1988 as a faculty member of the Department of Gynecologic Oncology and Reproductive Medicine. In the eighties and nineties, Dr. Burke became known for developing combination-treatment alternatives to radical surgery for uterine and vulvar cancers. His administrative career began with his role as Medical Director of the Gynecologic Oncology Center in the Department of Gynecologic Oncology and Reproductive Medicine from 1989–1998. In 1998 he also began to serve as Vice President of Medical Affairs, rising through several leadership roles until he became Executive Vice President and Physician-in-Chief, a role he served from 2005–2013, when he was appointed Vice President of the MD Anderson Cancer Care Network.

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

Personal and educational background

Military service

A portrait of a clinician with an “entrepreneurial spirit”

Research: combination therapies for gynecologic cancers

Gynecologic Oncology at MD Anderson and multi-disciplinary care

Development of multi-disciplinary care at MD Anderson

Roles as Physician-in-Chief

Developing MD Anderson support services

Developing networks to serve MD Anderson

MD Anderson culture: changes and continuities amid growth

MD Anderson's financial challenges and strategies to navigate them

**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 #50: Thomas Burke, M.D.  
Submitted by: Tacey A. Rosolowski, Ph.D.  
Date revised: 7 May 2014

This interview with Dr. Thomas Burke (b., 8 May 1953, Pittsburg, Pennsylvania) takes place over three sessions in spring of 2014 (approximate total duration, five hours). Dr. Burke joined MD Anderson in 1988 as a faculty member of the Department of Gynecologic Oncology and Reproductive Medicine. For many years Dr. Burke served as Executive Vice President and Physician-in-Chief. In 2013 he appointed the Executive VP overseeing the MD Anderson Cancer Care Network. This interview takes place in Dr. Burke's office in the Mid-Main Building of MD Anderson. Tacey A. Rosolowski, Ph.D. is the interviewer.

Dr. Burke received his Bachelors of Science in biology from Tulane University in New Orleans in 1974 and continued at that institution for his M.D., conferred in 1978. He did his Clinical Fellowship in Gynecologic Oncology at the Walter Reed Army Medical Center in Bethesda (1984-6/1986) and then went to the Tripler Army Medical Center in Honolulu Hawaii for his Clinical Residency and Clinical Internship in Obstetrics and Gynecology (7/1979-6/1982 and 7/1978-6/1979, respectively). Dr. Burke was an Instructor in Obstetrics and Gynecology, first at the University of Kansas Medical Center in Kansas City, KS from 1982 to 1984 and then at the Uniformed Services University of the Health Sciences in Bethesda, MD, 1984–1986. He then joined the faculty and served as an Assistant Professor until 1987, when he became a Clinical Assistant Professor in Obstetrics and Gynecology at The University of Texas Health Science Center at San Antonio, San Antonio, Texas. In 1988 Dr. Burke joined the faculty of MD Anderson as an Assistant Professor and Assistant Gynecologist in the Department of Gynecologic Oncology and Reproductive Medicine.

In the eighties and nineties, Dr. Burke became known for developing combination-treatment alternatives to radical surgery for uterine and vulvar cancers. His administrative career began with his role as Medical Director of the Gynecologic Oncology Center in the Department of Gynecologic Oncology and Reproductive Medicine from 1989–1998. In 1998 he also began to serve as Vice President of Medical Affairs, rising through several leadership roles until he became Executive Vice President and Physician-in-Chief, a role her served from 2005–2013, when he was appointed Vice President of the MD Anderson Cancer Care Network.

In this interview, Dr. Burke provides a portrait of a clinician with a self-described “entrepreneurial spirit” and a tendency to “remake himself.” He discusses his research and discusses the evolution of combination therapies for gynecologic cancers. He also discusses how Gynecologic Oncology at MD Anderson was practicing multi-disciplinary care before it was an institution-wide protocol and commitment. These sessions also bring out Dr. Burke's capacity to develop and leverage networks for the benefit of MD Anderson and its mission. In the process of describing his administrative roles, he provides insight into the context of financial challenge

and change that MD Anderson is now confronting, and details initiatives that the institution has in place to navigate this stressful time.

## **Thomas A. Burke, MD**

Interview #50

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*Maintaining MD Anderson Culture Despite Growth and Financial Challenges in Healthcare*  
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Chapter 00C

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## Thomas A. Burke, MD

Interview #50

### Segment Summaries

Chapter 00A  
*Interview Identifier*

Chapter 1  
A: Educational Path;  
*Taking Opportunities and Integrating Talents Drawn From Many People*

Story Codes  
A: Personal Background;  
A: Character, Values, Beliefs, Talents;  
A: Inspirations to Practice Science/Medicine;  
A: Influences from People and Life Experiences;  
C: Human Stories;  
C: Offering Care, Compassion, Help;  
C: Funny Stories;

Dr. Burke sketches his family background and early influences that left him open to taking new opportunities. He explains that he knew he wanted to be a physician when he was five years old. He notes that he still has a photo that appeared in the newspaper in which a little neighbor girl has brought him a “sick” doll and he is listening to the doll’s heart.

Dr. Burke explains his interest in the sciences, particularly the “interactive” parts of science: anatomy, dissection and comparative biology. He mentions his mother’s love of animals as an influence and notes that his mentors in surgery were enormously important.

Chapter 2  
A: Educational Path;  
*Developing A Surgical Perspective and Style, Passing it on Through Mentoring*

Story Codes  
A: The Clinician;  
A: Overview;  
A: Definitions, Explanations, Translations;  
C: Evolution of Career;  
C: Professional Practice;  
C: The Professional at Work;  
C: Leadership;  
C: Mentoring;  
A: Military Experience;  
A: Influences from People and Life Experiences;

Dr. Burke begins by describing the unique qualities of the operating room environment where, he notes, a surgeon's interactive style may be more important than his technical skills. He explains his philosophy of "de-stressing" the surgery environment to in order that a patient is not put at risk.

Dr. Burke talks about his surgery training. He observes that the environment that a surgeon created in the operating rooms influences how they were able to attract people to their specialties, a fact he has integrated into his own surgical practice and environment.

Dr. Burke tells a story of acquiring a cadaver during his clinical fellowship to redo anatomy from the perspective of surgeons. Dr. Burke explains what he learned from this and how the experience has helped him in his work at MD Anderson.

### Chapter 03

A: Educational Path;

*College at a Tumultuous Time and the Benefits of an Army-Subsidized Medical Education*

#### Story Codes

A: The Clinician;

C: Evolution of Career;

A: Personal Background;

A: Professional Path;

C: Mentoring;

D: Cultural/Social Influences;

A: Military Experience;

A: Influences from People and Life Experiences;

A: Character, Values, Beliefs, Talents;

Dr. Burke talks about his experiences at Tulane University in the 1970s (BS Biology, 1974; MD '78). He explains his concern about the draft (and his plans to avoid being drafted) and his decision to join the ROTC (1975) so the Army would pay for his medical education.

Next Dr. Burke talks about the benefits of receiving an Army Military Scholarship for medical school, including a summer program that took him to Hawaii, as state he loves. He recalls a memorable experience of visiting the leper colony on the island of Molokai.

Dr. Burke reflects on what he learned from his time in the military: responsibility, teamwork, the ability to predict how people will behave, how to handle stressful experiences.

Dr. Burke next talks about meeting his wife, Cathy. He describes their first date and a key shared interest: the art of David Lee.

### Chapter 04

A: Professional Path;

*On the Importance of Relationships in Medicine and Medical Care*

#### Story Codes

A: The Clinician;

A: Inspirations to Practice Science/Medicine;  
A: Character, Values, Beliefs, Talents;  
A: Professional Values, Ethics, Purpose;  
B: Institutional Mission and Values;  
B: MD Anderson Culture;  
C: Evolution of Career;  
C: Professional Practice ;  
C: The Professional at Work;  
C: Leadership; D: On Leadership;

Dr. Burke explains why he specialized in Gynecologic Surgery, which he saw as bringing together his love of surgery with birth, a happy time where a physician develops and sustains a relationship with a patient over time. He goes on to explain how an oncologist and a patient are partners in risk, care and outcome, and how this is for him a very rewarding personal experience. He talks about his ability to deal with life and death situations without being weighed down by them. Since MD Anderson people can do this, they do not abandon people who will not survive their treatment

Dr. Burke next talks about the challenge of attracting cancer nurses to oncology specialties and recalls a program he established (early in his administrative career) to bring nursing students to MD Anderson. He notes that this program was successful in introducing students to careers in oncology nursing.

#### Chapter 05

A: The Clinical Provider0

*Coming to MD Anderson to For Surgical Innovation*

#### Story Codes

A: The Clinician;  
A: Joining MD Anderson;  
B: MD Anderson Culture ;  
C: Evolution of Career;  
C: Professional Practice ;  
C: The Professional at Work;  
C: Mentoring;  
C: This is MD Anderson;  
A: Personal Background;  
A: Professional Path;  
A: Influences from People and Life Experiences;

Dr. Burke explains how he came to join MD Anderson. He first explains that a surgeon's style develops as an amalgamation of those who have trained him/her, but the question is, How does a great surgeon move beyond this training? Next he explains how he came to MD Anderson from Fort Leavenworth (and sketches his positions prior to that). He explains that he had done all the routine procedures, but he wanted to become more innovative and be in a place where he could "attempt what was not possible." Dr. Burke recalls that he was the first person in Gynecologic Oncology who had not been trained at MD Anderson. He describes the atmosphere and his recruitment process.

## Chapter 06

B: MD Anderson History;

*The Late Eighties: Clinical Services in Gynecologic Oncology and Reproductive Medicine and Serving as "The Last Resort Guy"*

### Story Codes

A: The Clinician;

C: Understanding the Institution;

B: Institutional Processes;

C: This is MD Anderson;

B: MD Anderson Culture;

C: Evolution of Career;

C: Professional Practice;

C: The Professional at Work;

C: Mentoring;

C: This is MD Anderson;

A: Personal Background;

A: Professional Path;

A: Influences from People and Life Experiences;

C: Discovery, Creativity and Innovation;

C: Patients;

In this chapter, Dr. Burke describes the clinical situation when he arrived: patients came to the place, rather than to a particular surgeon, and so assigning cases was an issue.

He describes how a clinician develops a practice at MD Anderson and explains that he decided to take cases that no one else wanted, offering "a unique service to patients, families, and to the referring MDs."

Dr. Burke talks about how experiences in the military prepared him for this kind of situation. He also notes that critical situations in the military were great preparation for critical care in oncology. He gives an example of creative problem solving from an ob/gyn service in Kansas. He uses the example of two- and three-team surgeries to illustrate how MD Anderson provides innovative care to patients.

Dr. Burke notes that multi-team surgery was very limited when he arrived but increased quickly, with patient recovery improved as a result.

## Chapter 07

A: The Administrator;

*An Overview of the Gynecologic Oncology Clinic: Offering Multi-Disciplinary Care Before it Was an MD Anderson Norm*

### Story Codes

A: The Clinician;

B: MD Anderson History;

C: Discovery and Success;

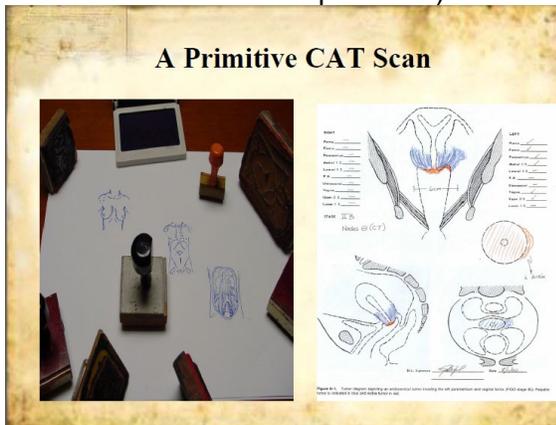
C: Understanding the Institution;

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- B: MD Anderson Culture;
- B: Building/Transforming the Institution;
- B: Multi-disciplinary Approaches;
- B: Growth and/or Change;
- C: Professional Practice;
- C: The Professional at Work;
- C: Discovery, Creativity and Innovation;
- C: Patients;

Dr. Burke explains how he came to his first administrative position as Medical Director of the Gynecologic Oncology Clinic, or Station 82, when the institution was transitioning its organization from one focused on specialization to multi-disciplinary clinics based on disease site. He notes that Gynecologic Oncology always operated that way, beginning with the founders of gynecologic practice at MD Anderson and their early recruitments.

He talks about the rudimentary situation of the clinics in the early nineties, the early record keeping practices (see example from a PowerPoint presentation, available from the Archivist, Research Medical Library). he developed on the history of the Clinic, which includes information about these practices).



## Chapter 08

- B: Building the Institution;
- Developing Multi-Disciplinary Care Within the Department and in the Institution*

### Story Codes

- A: The Administrator;
- B: MD Anderson History;
- C: Discovery and Success;
- C: Understanding the Institution;
- B: Institutional Processes;
- C: This is MD Anderson;
- B: MD Anderson Impact;
- B: MD Anderson Culture;
- B: Building/Transforming the Institution;
- B: Multi-disciplinary Approaches;
- B: Growth and/or Change;

C: Professional Practice;  
C: The Professional at Work;  
C: Patients;  
C: Patients, Treatment, Survivors;

Dr. Burke talks about his work in the early nineties on a planning group to develop multi-disciplinary care and more patient-centered care throughout the institution. (They had patients wore pedometers to see how far they had to walk for appointments.) He notes the speed at which the transition was made and the shock it could create.

Dr. Burke explains how the move to multi-disciplinary among faculty also created a situation in which all support services were also disease linked, with resulting increases in their specialization and expertise. He notes that this has been a “recipe for MD Anderson success.”

Dr. Burke notes that Gynecologic Oncology operated in a multi-disciplinary fashion from the start. He notes that MD Anderson was the first cancer center to restructure care around disease sites.

#### Chapter 09

A: The Researcher;  
*Bringing Experience With Surgery and National Trials to MD Anderson; Research on Endometrial Cancer*

#### Story Codes

A: The Researcher;  
A: Professional Path;  
A: Military Experience;  
A: Joining MD Anderson;  
C: Collaborations;  
D: Understanding Cancer, the History of Science, Cancer Research;  
D: The History of Health Care, Patient Care;

In this chapter, Dr. Burke sketches the evolution of his research career and the specific perspective that made him attractive to MD Anderson. He explains that he started this career while he was a Fellow at the Walter Reed Hospital in the late seventies. He notes the strange situation in which the Army was at the forefront of research in ob/gyn cancers. He then notes that, when he came to MD Anderson, there were many unanswered questions and he brought the institution his experience with national trials and his strong surgical background, and broad network of connections. He briefly explains his leadership philosophy with regards to junior faculty and research: allow them to choose different disease area interests so they don't get in each other's way.

#### Chapter 10

A: The Researcher;  
*Research on Gynecologic Cancers; the Impact of Research on How a SPORE is Administered*

#### Story Codes

A: The Researcher;  
A: Overview;

A: Definitions, Explanations, Translations;  
B: Discovery and Success;  
C: Offering Care, Compassion, Help;  
C: Patients;  
C: Cancer and Disease;  
C: This is MD Anderson;  
C: Patients, Treatment, Survivors;  
C: Funny Stories;

Dr. Burke sketches his study of endometrial cancer that involved a decade-long project of looking at techniques to reduce the radical surgery needed. His model has radically changed the management of the disease. Dr. Burke describes a uterine SPORE he worked on with Dr. George Stancel [oral history interview] and two junior faculty members, resulting in many new discoveries and new investigators attracted to the field.

He also explains an important outgrowth of this project: inclusion of patient advocates on the research team.

Interview Session 2: 18 March 2014

Chapter 00B  
*Interview Identifier*

Chapter 11  
B: Institutional Change ;  
*Maintaining MD Anderson Culture Despite Growth and Financial Challenges in Healthcare*

Story Codes  
B: Multi-disciplinary Approaches;  
B: Growth and/or Change;  
B: Controversy;  
B: The Business of MD Anderson;  
B: Institutional Mission and Values;  
B: MD Anderson Culture;  
D: Fiscal Realities in Healthcare;  
D: The Healthcare Industry;  
C: Understanding the Institution;  
C: The Institution and Finances;

Dr. Burke begins this Chapter by describing how the culture of MD Anderson has changed since 1988 when faculty easily had face-to-face relationships. He notes that many institutional values have been formalized as the institution shifted to multi-disciplinary care models and translational research.

He talks about the advantage of the MD Anderson system in which physicians are not compensated per procedure: this has been maintained a “clean way of providing care.”

He next talks about the “financial clarity” that Dr. Leon Leach [Oral History Interview] brought to the institution under Dr. John Mendelsohn.

He next talks about what makes MD Anderson unique: keeping the mission areas in balance has been part of institutional strategy.

## Chapter 12

A: The Administrator;

*Medical Director of the Gynecologic Oncology Center: Developing Processes and Faculty Talent*

### Story Codes

A: The Administrator;

A: Character, Values, Beliefs, Talents;

B: MD Anderson History;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: Institutional Processes;

C: Understanding the Institution;

C: The Institution and Finances;

C: Leadership; D: On Leadership;

C: Mentoring;

Dr. Burke begins by describing how he resolved inefficiencies in the Gynecologic Oncology Center when he took over. He describes a quality control program he set in place and sketches increases in the Clinic's patient traffic and faculty numbers.

Dr. Burke next comments on positions that can serve as training ground for mid-career physicians who will rise in the administration. He explains how his leadership skills grew and talks about his roles on the Credentials Committee and the Medical Staff Committee. Dr. Burke notes how important it is that a hospital's leadership has this broad perspective: he looks for young faculty who will be open to these opportunities and to future leadership. Dr. Burke talks about how he looks for faculty with potential and gives them chances to develop themselves.

## Chapter 13

A: The Administrator;

*Serving as MD Anderson's Chief Medical Officer and Physician in Chief*

### Story Codes

A: The Administrator;

B: Growth and/or Change;

B: MD Anderson History;

B: MD Anderson Snapshot;

C: Professional Practice; C: The Professional at Work;

C: Understanding the Institution;

C: Leadership;

Dr. Burke first explains how he came to serve 50% of his time as Chief Medical Officer in 1998. He notes the scope of this role and how it affected his clinical practice. He next notes that when John Mendelsohn became president, he was asked to come full time into administration. He explains his decision to shift into administrative work.

Next he explains the scope of his responsibilities as Physician in Chief and stresses that clinical operations should be led by a physician. He talks about the complexity of MD Anderson search processes

#### Chapter 14

B: Building the Institution;

*As Physician in Chief: Addressing Needs in Pharmacy, Nursing, and Quality and Safety*

#### Story Codes:

A: The Administrator;

B: Growth and/or Change;

B: MD Anderson History;

B: MD Anderson Snapshot;

D: The History of Health Care, Patient Care;

C: Research, Care, and Education;

C: Leadership;

C: Discovery and Success;

C: This is MD Anderson;

C: Understanding the Institution;

Dr. Burke explains the major clinical needs of MD Anderson in 2007.

He talks about pharmaceutical needs. He next explains how he built his support team by seeking out people.

He describes the Quality and Safety program focused on patient safety, explaining the related Clinical Safety and Effectiveness Program first developed for industry, but adapted for MD Anderson and other health care institutions. He talks about the influence of this Quality and Safety program.

Dr. Burke explains how changes innovated by the Clinical Safety and Effectiveness Program were first received when introduced. He notes resistance and that the Program encouraged individuals to innovate their own improvements to process and gave prizes for the best solutions to process problems. He gives examples of innovations.

#### Chapter 15

B: Building the Institution;

*Building a Highly Skilled Nursing Service*

#### Story Codes

A: The Administrator;

B: Building/Transforming the Institution;

B: MD Anderson History;

C: Leadership;

C: Discovery and Success;

C: This is MD Anderson;

C: Understanding the Institution;

D: The History of Health Care, Patient Care;

C: Education at MD Anderson;  
C: Mentoring;  
C: Leadership; D: On Leadership;  
B: MD Anderson Culture;  
B: MD Anderson Mission and Values;

Dr. Burke describes how he addressed the need for an increasingly skilled staff of oncology nurses.

He talks about partnering with Dr. Barbara Summers [Oral History Interview], Head of Nursing, to create a program to attract young nurses to the field. He explains that oncology nursing is not a “happy area” and has had difficulty attracting students. They also created programs to help nurses develop their skills and expertise with additional training and degree programs.

Dr. Burke gives an overview of changes in the field of nursing that have broadened the scope of nursing to management, administration, and advanced practice nursing. He notes that Advanced Practice Nurses have expertise and serve as preceptors to their teams and those under them, increasing the quality of care.

## Chapter 16

A: The Administrator;

*As Physician in Chief: Building the Survivorship Program and Pharmacy Support*

### Story Codes

A: The Administrator;  
B: Building/Transforming the Institution;  
C: Patients; C: Patient, Treatment, Survivors;  
C: Offering Care, Compassion, Help;  
C: Discovery and Success;  
C: This is MD Anderson;  
C: Understanding the Institution;  
D: The History of Health Care, Patient Care;  
B: MD Anderson Culture;  
B: MD Anderson Mission and Values;

In this chapter, Dr. Burke first explains that he hired Alma Rodriguez to head the Survivorship Program and gave her a mandate to build that program. One of the first projects undertaken was information gathering to discover what issues and needs patients had as they entered survivorship and long-term survivorship. Dr. Burke describes the feedback from patients and how the Program went about addressing those needs. He notes that today the Survivorship Clinics see thousands of patients. He explains his hope that a freestanding survivorship clinic will be built someday (the institution was close twice).

Next, Dr. Burke explains the complexity of pharmacy needs at MD Anderson, how these have been addressed, and how his office is currently building a training program in cancer related pharmacy.

Interview Session Three: 29 April 2014

Chapter 00C  
*Interview Identifier*

Chapter 17  
B: Building the Institution;  
*Comprehensive Approaches to Faculty Burnout in a Complex, Growing Institution*

Story Codes  
B: MD Anderson Snapshot;  
B: Growth and/or Change;  
B: MD Anderson Culture;  
C: Understanding the Institution;  
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;  
D: The Life and Dedication of Clinicians and Researchers;  
A: The Clinician;  
A: Personal Background;  
A: The Patient;  
C: Patients; C: Patients, Treatment, Survivors;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
C: Mentoring;

In this chapter, Dr. Burke talks about the reality and sources of faculty burnout and the support for those who experience it. He explains that faculty who are deeply connected to the institution's mission create their own mechanisms to cope with stress and burnout and those who cannot, leave MD Anderson.

Next, Dr. Burke talks about the mechanisms in place to help faculty with stress. He explains that mentoring can help young faculty find balance and also a research niche, which will help with their career stress, and gives examples from his department. He mentions MD Anderson's counseling services.

Dr. Burke talks about his personal experience with burnout.

Dr. Burke says that burnout is an ongoing issue that will not go away. He advocates that faculty work in teams and that these teams care for one another. He also mentions efforts in 2010 and after to rid the institution of dysfunctional behavior. The mentoring program and safety and quality programs arose from this effort.

Chapter 18  
B: An Institutional Unit;  
*The Institute for Cancer Care and the Challenge of Value-Based Care*

Story Codes  
B: The Business of MD Anderson;  
A: The Administrator;  
B: MD Anderson Snapshot;  
B: Institutional Mission and Values;

D: The History of Health Care, Patient Care;  
D: Fiscal Realities in Healthcare;  
B: MD Anderson Impact;  
B: MD Anderson Culture;  
B: MD Anderson Mission and Values;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
B: Industry Partnerships;  
B: Beyond the Institution;

In this chapter, Dr. Burke talks about the creation of the Institute for Cancer Care Excellence in 2008 and its role in defining value-based care. He sets this in the context of the current focus on the financial side of healthcare and the huge effort underway to map processes of care, attach cost to those processes, and determine ultimate value. He first gives context, explaining that MD Anderson wanted to be in the forefront of thinking about value based care and he and others began to make connections with the “quality movement” (e.g. Brent James). One of the first aims was to publish papers on “value propositions in health care.” Dr. Burke gives some context, explaining that quality, safety and cost lead to a notion of value.

Dr. Burke explains the viewpoint that MD Anderson took on quality --different from the prevailing viewpoint in the nation. The Institute served as the focal point to bring together all information about this ongoing conversation.

Dr. Burke explains the challenges in assembling data that support the view of quality advocated by MD Anderson.

### *Chapter 19*

B: The Finances and Business of MD Anderson;  
*Financial Realities in Healthcare: The Need for Investment in Healthy Behavior; Treatments Near the End of Life; the Affordable Care Act*

### Story Codes

B: The Business of MD Anderson;  
A: The Administrator;  
C: Patients;  
C: Human Stories;  
C: Offering Care, Compassion, Help;  
C: Cancer and Disease;  
D: Understanding Cancer, the History of Science, Cancer Research;  
D: The History of Health Care, Patient Care;  
D: Fiscal Realities in Healthcare;

In this chapter, Dr. Burke talks about the fiscal realities that MD Anderson is confronting now and in the immediate future. He first observes that there has been no effort at the national level to make an investment in healthy behaviors, though he sees some change in that recently. He mentions where the resistance has been to such investment and observes that MD Anderson has advocated for these changes, but that no single institution can influence national priorities.

Dr. Burke next talks about the difficult financial decisions tied up with establishing care protocols at the end of a patient's life. He talks about studies in progress to determine which efforts near the end of life have value (in that they improve a patient's survival). He then discusses the realities of the conversations that physicians must have with patients, the decisions that patients and families must make.

#### Chapter 20

B: The Finances and Business of MD Anderson;  
*Financial Realities in Healthcare: The Affordable Care Act*

#### Story Codes

B: The Business of MD Anderson;  
A: The Administrator;  
D: Fiscal Realities in Healthcare;  
D: The History of Health Care, Patient Care;  
B: Institutional Processes;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
B: Growth and/or Change;

In this chapter, Dr. Burke talks about the Affordable Care Act. Though creating access to care is a critical benefit, Dr. Burke explains via examples that the Act has created challenges because the payment system it relies on will not survive the Value-Based Care movement. He also gives examples of how the current system pays an institution for "doing things wrong."

#### Chapter 21

B: Building the Institution;  
*The MD Anderson Network: Origins, Mission, and Lessons of MD Anderson Orlando*

#### Story Codes

A: The Administrator;  
B: MD Anderson History;  
B: Beyond the Institution;  
B: Institutional Mission and Values;  
B: MD Anderson Snapshot;  
B: The Business of MD Anderson;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
B: Growth and/or Change;  
C: Healing, Hope, and the Promise of Research;  
C: MD Anderson Impact;  
C: Understanding the Institution;  
C: The Institution and Finances;  
C: Research, Care, and Education;  
C: Education at MD Anderson;  
C: Cancer and Disease;  
D: Fiscal Realities in Healthcare;  
D: The Healthcare Industry;

In this chapter, Dr. Burke talks about becoming Vice President of the MD Anderson Cancer Network, established early in 2014.

He gives background on how the Network began.

Next he explains why he was appointed to the position and his personal reasons for taking the position.

Dr. Burke sketches why the MD Anderson Cancer Network offers “a huge delivery” on the institution’s mission.

He comments on the dissolution of MD Anderson’s partnership with Orlando Health and the lessons.

## Chapter 22

B: Building the Institution;

*The MD Anderson Network: Building Partnerships Based on Shared Mission*

### Codes

A: The Administrator;

B: Beyond the Institution;

B: Institutional Mission and Values;

B: The Business of MD Anderson;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

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

C: MD Anderson Impact;

C: Understanding the Institution;

C: The Institution and Finances;

C: Research, Care, and Education;

C: Education at MD Anderson;

C: Cancer and Disease;

D: Fiscal Realities in Healthcare;

D: The Healthcare Industry;

In this chapter, Dr. Burke explains that his current assignment as Vice President of the MD Anderson Network is to establish partnerships with institutions whose missions link with MD Anderson’s.

He talks about a Network goals of increasing MD Anderson trained physicians and researchers. He gives examples of an innovative program to accomplish this. Dr. Burke notes the importance of this program given that the nation is confronting a shortage of oncology professionals.

Next he mentions the Network’s role in expanding access to MD Anderson’s clinical trials, lists the features of a good partner institution, and talks about how he is going about bringing MD

Anderson's outside connections under one umbrella. He notes that these partnerships represent revenue streams for MD Anderson.

## Chapter 23

B: Building the Institution;

*Building the MD Anderson Cancer Network*

### Story Codes

A: The Administrator;

B: The Business of MD Anderson;

B: MD Anderson Culture;

B: Education; D: On Education;

B: Research;

B: Care; D: On Care;

B: Beyond the Institution;

B: Institutional Mission and Values;

Dr. Burke begins this chapter on his strategies for building the MD Anderson Cancer Network with a discussion of the major challenges that this initiative must face.

He talks about the importance of "profiling" the patient populations at each partner institution in order to select the right clinical trials for their involvement and gives an example.

He discusses the financial projections for the Network's operation (in the 60 – 80 million range) and how that revenue will be used.

Dr. Burke explains his philosophy and goals. By bringing all partner institutions under a single umbrella, the Network can touch as large a percentage of the United States population as possible.

## Chapter 24

A: The Researcher;

*Significant Research Initiatives*

### Story Codes

A: The Researcher;

C: Discovery, Creativity and Innovation;

D: On Research and Researchers;

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

A: Career and Accomplishments;

In this chapter, Dr. Burke talks about the significant research he conducted prior to devoting most of his time to administration. He was involved in early projects defining the respective roles of radiation and chemotherapy. He talks about the challenges of large-scale clinical trials, particularly with rare cancers. He sketches his work defining the surgical staging for uterine cancer in the eighties and nineties and his work training individuals in robotic and laproscopic techniques.

Dr. Burke next explains why vulvar cancers were “a great niche” for him to take on in the sixties and seventies and describes an additional study.

At the end of this chapter –and the interview—Dr. Burke talks about how satisfied he has been to work at an institution that enabled him to reinvent himself. He is content to know that he has trained many people and put together many teams that have launched all kinds of services.

## Thomas Burke, MD

### **About transcription and the transcript**

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

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

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

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

### **Chapter 0:A**

#### **Interview Identifier**

**[00:00:00]**

*Tacey Ann Rosolowski, PhD*

[00:00:00]

We're good, and we are now recording. So for the purposes of the archive, I will say I'm Tacey Ann Rosolowski. Today it is March 11, 2014, and today I am in the Mid-Main Building in the office of Dr. Thomas W. Burke, who is—just so I get your title correct—Executive Vice President overseeing the MD Anderson Cancer Network.

[00:00:32]

*Thomas Burke, MD*

[00:00:32]

Correct.

[00:00:33]

*Tacey Ann Rosolowski, PhD*

[00:00:33]

And I am conducting this interview for the Making Cancer History Voices Oral History Project, run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. And just for overview purposes, you came to MD Anderson in 1988?

[00:00:49]

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***Thomas Burke, MD***

[00:00:50]

1988.

[00:00:50]

***Tacey Ann Rosolowski, PhD***

[00:00:51]

1988, okay. Correct. And you were a faculty member in the Department of Gynecologic Oncology and Reproductive Medicine.

[00:00:57]

***Thomas Burke, MD***

[00:00:57]

Correct. I still am.

[00:00:59]

***Tacey Ann Rosolowski, PhD***

[00:01:00]

And you still are.

[00:01:01]

***Thomas Burke, MD***

[00:01:01]

I still am.

[00:01:02]

***Tacey Ann Rosolowski, PhD***

[00:01:02]

Well, of course you are. Of course you would be. Yes. (laughs)

[00:01:04]

This interview is, I think I mentioned, taking place in Dr. Burke's office in the Mid-Main Building, and this is the first of two planned interview sessions, and the time right now as we're starting is 1:11 p.m. So thank you very much for allowing me to take your time this way.

(laughs)

[00:01:24]

***Thomas Burke, MD***

[00:01:25]

I'm looking forward to it. I think this'll be fun.

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[00:01:26]

***Tacey Ann Rosolowski, PhD***

[00:01:26]

Well, I'm glad. I'm glad. I hope it is for you.

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## **Chapter 1**

### **A: Educational Path**

#### ***Taking Opportunities, Integrating Talents Drawn From Many People***

Story Codes

A: Personal Background

A: Character, Values, Beliefs, Talents

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

C: Human Stories

C: Offering Care, Compassion, Help

C: Funny Stories

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

[00:01:26]+

Well, I wanted to start with just personal background, where were you born and if you could give me your date of birth and tell me a little bit about where you grew up.

[00:01:37]

#### ***Thomas Burke, MD***

[00:01:37]

Sure. I was actually born in Pittsburgh, Pennsylvania, in 1953, and my father worked for a very large private chemical company, and he was the head of their marketing division, and they moved their offices to Chicago in the early 1960s.

So I recall vividly I was six at the time we moved, and I remember being on a turbo-prop airplane. It was the first time I'd flown in my life, was the move from Pittsburgh to Chicago, and went ahead and we moved into the suburbs about fifteen miles west of downtown Chicago, which is where I grew up all the way through high school.

I've since learned that this was a really stressful time for my family because my parents had three young children. I was the oldest, so I had a brother who was four at the time and a sister who was one. My father had not planned on his promotion, and so he owned a home in Pittsburgh that we lived in. He was building a second home. He was making more money and doing well and was moving a family to a bigger place. He also paid for a home for his parents, who did not have the resources to own their own home, and then he was buying a home in Chicago to support the move.

[00:03:18]

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***Tacey Ann Rosolowski, PhD***

[00:03:19]

That sounds like a nightmare. (laughs)

[00:03:20]

***Thomas Burke, MD***

[00:03:20]

So as a six-year-old, obviously, I never was impacted by that story, but later in life, my wife and I were in the military. We had met in Hawaii where I was doing my residency training. My wife came to Hawaii never expecting to meet someone and be married, and so she immediately bought a condominium in Hawaii. I immediately, after we were married, got transferred to Leavenworth, Kansas, where we bought a house, and then I did my cancer training at Walter Reed in the mid-eighties, and so we were in a position of owning a condominium in Hawaii, a house in Leavenworth, Kansas, and renting a third place in Silver Spring, Maryland. And I kind of remembered back, and my father said, “Well, let me tell you about the time—.” (Rosolowski laughs.) So that goes back to the move from Pittsburgh and owning multiple places—

[00:04:18]

***Tacey Ann Rosolowski, PhD***

[00:04:19]

It’s sort of like the moral of the story, never own property. (laughs)

[00:04:20]

***Thomas Burke, MD***

[00:04:20]

—at the same time.

So I grew up and went to high school and so on in Chicago. Then my father had a rule in our house you needed to go a thousand miles away from home for college, and the rationale was that you had to deal with being homesick relatively quickly, you couldn’t bring dirty laundry home to your mother. I think the real reason, also stated by him, was that it’s always good to live with people different than you and different than what you’re used to when you grow up, and that the United States was a melting pot and that you should be comfortable anywhere, and that you should make decisions in your life about where to live and what to do based on opportunity and not on the geographic location or your attachment to it. So that was the way we grew up. I went to New Orleans for school. It was a long way from Chicago, you know.

[00:05:30]

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***Tacey Ann Rosolowski, PhD***

[00:05:30]

Yeah, very different culturally too.

[00:05:32]

***Thomas Burke, MD***

[00:05:32]

I was eighteen. I saw Bourbon Street. I said, “This is for me,” and I signed up. I went to Tulane.

My brother and sister obviously went to other locations but also went a long ways from home. My children grew up in the same environment, listening to their grandfather, and so all of our children went—our son went to William & Mary in Virginia from Houston, our middle daughter went to St. Louis, and my youngest went the furthest to University of Vermont. So they all sort of took that advice. And I think it actually over the course of my life played out very well, because I always chose where to live and what to do based on opportunities and not on I need to live where I grew up or I need to be at a place where I have some kind of a family connection. So I think ultimately that served our family well.

[00:06:33]

***Tacey Ann Rosolowski, PhD***

[00:06:33]

Sort of gave you a kind of freedom that other people maybe don't have.

[00:06:36]

***Thomas Burke, MD***

[00:06:37]

Yeah, and I've met friends, mostly foreign friends, who live, grow up, and work in the same place where they were born, and they would never think of being in another part of their country or a different place because they're so attached to those roots. So I think that it limits you in terms of what you're able to do. So I think that was totally unrelated to the practice of medicine or subsequently what I've done, but just was great life advice about what to do.

[00:07:12]

***Tacey Ann Rosolowski, PhD***

[00:07:13]

Let me ask you just a couple specific questions about that earlier period. What was your actual birth date?

[00:07:20]

***Thomas Burke, MD***

[00:07:20]

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May 8<sup>th</sup>.

[00:07:22]

***Tacey Ann Rosolowski, PhD***

[00:07:22]

May 8, 1953. And tell me about when you first knew that you were going to be in the sciences or be in medicine.

[00:07:33]

***Thomas Burke, MD***

[00:07:33]

You know, I knew I wanted to be a doctor when I was five.

[00:07:37]

***Tacey Ann Rosolowski, PhD***

[00:07:38]

Oh, really? Tell me about that. (laughs)

[00:07:39]

***Thomas Burke, MD***

[00:07:39]

I focused in on it. I don't know what attracted to me. There was no role model. There was no one in my family who was a physician, nobody even in healthcare or medicine, and I just kind of latched onto that. My mother has saved a great photograph of the local newspaper of me and a little girl who was our neighbor, and I have a stethoscope on and we're listening to her doll's heartbeat. So this was at age five, and it sort of was predictive of where I ended up in my career.

But, you know, I never wavered from that. I had some surgery, minor surgery, a little cyst on my ear when I was six or seven—six, I think—and all I remember about the experience was I had to be in the hospital for the day to have this removed surgically. And there was a nurse there who I thought was just absolutely beautiful, you know, and I'm sure, looking back, I'm six and she's probably thirty-five, you know.

[00:08:59]

***Tacey Ann Rosolowski, PhD***

[00:09:00]

Oh, wow.

[00:09:00]

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***Thomas Burke, MD***

[00:09:00]

And so I'm there with my mother and the nurse is there. They're supposed to give you a little kiddie cocktail to sedate you, and it didn't work. I was wide awake, I was just wired, and so they gave me a second one, and I was completely wiped out. So my only recollection of the event was this woman who I perceived as being this absolutely gorgeous nurse, and I made my mother send flowers to her in my name after I went home.

[00:09:29]

***Tacey Ann Rosolowski, PhD***

[00:09:29]

Oh, my goodness. And she did it? (laughs)

[00:09:31]

***Thomas Burke, MD***

[00:09:32]

And she did it. And she did it. And I subsequently married a nurse who is a beautiful woman and all of that, so maybe there was sort of that kernel of connection that was very far back. But I always was interested in sciences, and I did lots of science class, obviously, in high school. In college I was a biology major.

[00:09:56]

***Tacey Ann Rosolowski, PhD***

[00:09:57]

Where did you feel your gifts emerging?

[00:09:59]

***Thomas Burke, MD***

[00:10:00]

You know, I always liked to—I liked the parts of science that were sort of interactive, so I think that's how I ultimately ended up in surgery. So I liked anatomy, I liked dissection, so the kinds of things that you see in some of the comparative biology courses and other things were places where I think I had the most fun. You know, I enjoyed chemistry and physics and other sort of harder, more mathematical sciences, but the places I really had the best time were in those kinds of biology areas.

My mother was always very connected to outdoors activities. We always had pets, we always did something in the summer that was outside, and so I always interacted with sort of animals, plants, other things that were more interactive than sort of interior, internal. So I think that's what ultimately sort of directed me toward a surgical side of things as opposed to—

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[00:11:21]

***Tacey Ann Rosolowski, PhD***

[00:11:24]

What about your hand skills as a surgeon? I mean, did you make models as a kid, or where did—

[00:11:31]

***Thomas Burke, MD***

[00:11:31]

You know, I think that's just something that I trained over time. I didn't ever make a conscious effort to do anything, you know. I think about most of what you learn in surgery is who your mentors are, and you sort of gravitate to people whose skills you admire, and as you learn more and more, you get good at picking out, you know, this is a really great person who has terrific technical skills, and this one is somebody maybe not. And there's pretty much a wide range of skills. So what I always tried to do as I learned surgery was to take bits and pieces from all kinds of different people and incorporate them into the way I was in the operating room, and so a lot of that is the technical part, you know, I really liked the way this person did this step of this procedure. And so your own technique becomes an amalgamation of fifty other people's style.

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## **Chapter 2**

### **A: Educational Path**

#### ***Developing a Surgical Perspective and Style, Passing it on through Mentoring***

##### **Story Codes**

A: The Clinician

A: Overview

A: Definitions, Explanations, Translations

C: Evolution of Career

C: Professional Practice

C: The Professional at Work

C: Leadership

C: Mentoring

A: Military Experience

A: Influences from People and Life Experiences

##### ***Thomas Burke, MD***

[00:11:31]

And I think the other thing that I really learned as I moved into surgery was an operating room environment is a very unique one. It's very intense, it's very team-focused, and the potential for risk and mistakes are very real. And so I always tried to—and as a trainee, I was subjected to all kinds of surgical environments, you know. They're dominated by whoever the lead surgeon on the case is, and so a lot of the sort of interactions in the environment are driven by the personalities and the sort of interactive style of the surgeon, maybe more than their technical skills and ability.

And so when I came to a position where I was actually teaching people surgery and I was sort of in charge of the environment, I really made a conscious effort to sort of defuse the room. And I think that people who are learning surgery, people who work in a high-stress environment, do much better if there isn't additional stresses and pressures put on them to perform. So I always tried to work in a room that had a low-key atmosphere, had great exchange between people on the team, and it was sort of, if you would, a fun experience, it was something that people enjoyed doing. Because there isn't a lot of things you can do where every distraction has to be removed. You know, if you're in an operating room, you have to be completely focused on what's happening, and you need everybody else connected to that thing.

So a big piece is learning the technical capabilities and teaching yourself to do that. Another important piece is managing the environment in a way that you really get the best out of the people who are part of what you do, and I don't think a lot of people think about that.

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[00:15:18]

***Tacey Ann Rosolowski, PhD***

[00:15:18]

Yeah, because I'm interested in—you've been the first person I've spoken with who's really focused on that in quite that way. Now, how did you develop your own strategies, you know, to create that special environment? How do you go about doing that?

[00:15:34]

***Thomas Burke, MD***

[00:15:35]

Well, I think part of it is how you personally react to stress, you know. Obviously, you're sort of translating your own dysfunctions, if you will, on to the rest of your team. So if you're doing it well and you're kind of going with the day, then everybody else absorbs that. If you're really out of sync or inappropriate or rude or loud or whatever, the rest of your team will inherit that stress and actually put your patient at risk. You know, we talk about this a lot today in terms of patient safety and all kinds of surgical strategies for how to do that. That's a very recent thing, you know, and it came out of the airline industry and other sort of high-stress environments. But I'm talking about twenty-five or thirty years ago, where I think a lot of surgeons were notorious for being domineering and not particularly interactive.

[00:16:40]

***Tacey Ann Rosolowski, PhD***

[00:16:41]

And even romanticized for it.

[00:16:42]

***Thomas Burke, MD***

[00:16:42]

Yes. It was an expectation.

[00:16:45]

***Tacey Ann Rosolowski, PhD***

[00:16:45]

Yeah, absolutely.

[00:16:46]

***Thomas Burke, MD***

[00:16:46]

So I've been in those environments. Obviously, when you're a trainee you don't get to pick which environment you're in. But especially when I started my cancer training, I worked with

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people who are just technically expert, but calm and thoughtful mentors, and I learned a lot from them and the environments that they created. And the byproduct of that was they attracted all kinds of people to their specialty areas. You know, you would see people, you know, “Man, this is a terrific experience. I want to be like them.”

So at the time I did fellowship training, I was in the military, so I was at Walter Reed and at Bethesda. I had some absolutely fabulous mentors who went on to become the biggest people in my field in the country, and I sort of learned surgery from them when they were at their peak clinically. In that era, they probably attracted a third to a half of the trainees into cancer subspecialty training because of the kinds of people they were. So I saw that as a kind of a thoughtful strategy for how I would want to kind of build my own career going forward.

So the kinds of practical things I did was, you know, I would always have the people that were going to operate with me as trainees read about the operation the night before. You should not come in cold. You should come in—I don’t expect you to know how to do it. You should know the steps of what we’re going to do, you should know why we’re doing that on this particular patient. And then at the scrub sink, we kind of just go back through that, you know. You’re sitting there washing your hands for five minutes and we’d say, “Okay, so here’s the steps. We’re going to start out doing this.” So they kind of have a mental plan of what’s going to unfold in the operating room.

[00:18:59]

***Tacey Ann Rosolowski, PhD***

[00:18:59]

It creates a community too. We’re all here for the same purpose.

[00:19:03]

***Thomas Burke, MD***

[00:19:03]

Yeah. And it sort of sets the expectations of what your role’s going to be and how we’re going to kind of move through the operation. And then as you get in, you sort of just, say, get down to the technique pieces and that’s where you kind of teach the specific techniques of surgery. So I think that just became a really nice way to defuse people’s uncertainty and then you would have to adjust how much you let them do based on what their skill was and what you knew the complicated parts of an operation were. That’s part of the art of understanding how it works.

The best scenario is when something goes horribly wrong and how you react to that. So there are always bad events in an operating room, and we deal with cancers, so there’s some areas that are incredibly difficult. So, can you keep that same persona and that same kind of team focus when it’s very stressful that you can when it’s a little more usual kind of environment.

[00:20:17]

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***Tacey Ann Rosolowski, PhD***

[00:20:17]

Is that something that you had to teach yourself to do?

[00:20:19]

***Thomas Burke, MD***

[00:20:19]

Yeah, I did.

[00:20:20]

***Tacey Ann Rosolowski, PhD***

[00:20:20]

Oh, you did?

[00:20:20]

***Thomas Burke, MD***

[00:20:21]

I saw some of it from mentors, but most of it I developed as I went through.

The other thing I did that I really value having done now is I had, obviously, taken anatomy as a first-year medical student, and everybody kind of works through the cadaver lab as their first semester, and so you learn anatomy just as a sort of an academic pursuit. So when I was doing my cancer training, I arranged for a cadaver to be available to my surgical team every Friday afternoon. The military has a Uniformed Services University in Bethesda that has a medical school, and so I arranged for one of the cadavers at the anatomy lab to be available to our surgical team. So I went back and I took my residents and my fellows with me, and we redid dissection from the perspective of surgeons. So all of the things that you probably didn't appreciate as a first-year medical student that you now understood anatomically from operating on live patients, you could explore again in the anatomy lab.

[00:21:45]

***Tacey Ann Rosolowski, PhD***

[00:21:46]

Now, tell me about what that shift in perspective was. What did you see anew as a surgeon?

[00:21:52]

***Thomas Burke, MD***

[00:21:53]

So the big difference is, aside from the patient being alive or a cadaver, obviously, is that in the anatomy lab you're really just trying to go through all of the sections of the human body and

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learn relationships. From the surgical perspective, you're trying to know where you should not be, where you'll get in trouble.

[00:22:20]

***Tacey Ann Rosolowski, PhD***

[00:22:20]

Interesting.

[00:22:21]

***Thomas Burke, MD***

[00:22:21]

So where do these vessels lie, what's the relationship of these particular nerves that you know you have to preserve, that you know you can't get near. And redoing the dissection with a couple of years of experience of trying to avoid structures provides a completely different experience. By that time, you're probably eight or ten years removed from when you took a basic anatomy class, and so to kind of come back and refresh yourself was a really nice way to develop more surgical skills but also to kind of re-appreciate. A lot of the things that we've done at MD Anderson were to change techniques and to develop more conservative approaches to radical operations, and so knowing that anatomy in detail would give you insights as to where you could change procedures or try something a little bit different.

[00:23:23]

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## **Chapter 3**

### **A: Educational Path**

#### ***College During a Tumultuous Time and the Benefits of an Army-Subsidized Medical Education***

##### **Story Codes**

A: The Clinician

C: Evolution of Career

A: Personal Background

A: Professional Path

C: Mentoring

D: Cultural/Social Influences

A: Military Experience

A: Influences from People and Life Experiences

A: Character, Values, Beliefs, Talents

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

[00:23:26]

I have a question I want to ask you about style, but I think I'd like to ask you that as we're going through a little bit more closely your educational path.

So you went to Tulane. 1974 was your bachelor of science. What did you major in?

[00:23:47]

##### ***Thomas Burke, MD***

[00:23:47]

Biology.

[00:23:48]

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

[00:23:48]

In biology, okay. Anything else? What was your minor, anything really striking during that period?

[00:23:54]

##### ***Thomas Burke, MD***

[00:23:54]

You know, I graduated in three years.

[00:23:56]

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***Tacey Ann Rosolowski, PhD***

[00:23:56]

Wow.

[00:23:57]

***Thomas Burke, MD***

[00:23:57]

And I did it because I was trying to save money. I went to Tulane in the early seventies, which in our country was a very tumultuous time. I was seventeen and eighteen in, what, 1968 and '69, and so huge changes in our country. I lived outside Chicago, and if you remember the Democratic Convention in 1968, there were huge riots in Chicago and the police department was tear-gassing demonstrators. So that was kind of the background environment of when I was going to college. And of course, I was young and part of the group that kind of was at the time probably pretty radical in terms of their national view.

So when I went to Tulane, I knew that I would be eligible for the draft, and so since I was five I wanted to be a doctor, I was trying to find the most direct route to get through college and medical school, and then whatever happened after that, I could manage. So when I went to Tulane, I actually was trying to get out early to save money because I knew my family couldn't support my education all the way through. I had a brother and a sister behind me. So I was trying to sort of compress the time, and so I took extra courses every semester.

Then I realized that my second year in college I had taken ten science courses. I took five or six biology courses, laboratories, a couple of chemistry courses, and nothing else. So I had pretty much bracketed all of it, and those were the requirements for medical school applications, so I had grades in the courses that I would need. And it left me with a third year where I could do all kinds of fun things, and so I took theater arts, I took political science, I did some plant biology courses, and so I had a really interesting third year.

But the third year was the year I was eligible for the draft, and so at the time, there was a national lottery that determined who would be drafted and who would not, and it was based on your birth date. So I said, you know, the worst thing was that I would be in the middle of my education and I would get drafted and have to disrupt it. I wasn't so much worried about serving the country as it would prevent me from kind of reaching my goal in a direct way.

[00:26:50]

***Tacey Ann Rosolowski, PhD***

[00:26:51]

Just for the sake of the record, we'll say what you were worried about here was going to Vietnam.

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[00:26:55]

***Thomas Burke, MD***

[00:26:55]

Right. So Vietnam was actually very big in '71 and '72.

[00:26:58]

***Tacey Ann Rosolowski, PhD***

[00:26:59]

Yes, yes.

[00:26:59]

***Thomas Burke, MD***

[00:27:00]

And I had friends who had been drafted and other things, and so I said, well, you know, the best strategy would be to join ROTC, and at the time you had six weeks to actually sign the paperwork. The lottery was the first week of February, so I said I could sign up for ROTC the second semester of college. If I were accepted into ROTC, then I would be deferred all the way through my education before I would serve, which would achieve my goal of completing my education intact. Then I said if I got a lottery number where I knew I would not be drafted, I could drop out of ROTC and just go about my way and I would have played both sides of that equation. So that's exactly what I did. I signed up for ROTC. I had long hair, I had all of the things that people at that time did, and they didn't like it much. And I said, well, I've got six weeks before I have to sign, and I'll cut my hair and do everything I need to at the point I sign the papers.

So I have a very vivid memory of being in a physics lecture, a big lecture hall, two-hundred-and-some students, and it was draft lottery day, and we all had transistor radios. We didn't have iPods and all the stuff you have today, so we all had transistor radios turned down low, and it was like a Bingo game, you know. They would call out a birth date and then a number, and I would hear people in the room just awful and other people who were celebrating based on what would happen. So this was very real if you were nineteen or twenty at the time.

[00:28:43]

***Tacey Ann Rosolowski, PhD***

[00:28:43]

Sure.

[00:28:43]

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***Thomas Burke, MD***

[00:28:44]

So I got a number that I knew would not result in being drafted, so after class, I went over to the Dean's Office and I dropped ROTC, and there was a huge line of people lining up to sign up for ROTC. The irony of all of this is that two years later in medical school, I joined the United States Army as a way to fund my medical school education and to get my dad off the hook for doing it. That was in actually 1974, '75, so it was right as the war was winding down and the army needed medical officers. There were a lot of wounded people from Vietnam who needed care. So I said I could do this, and I signed up. So it was a really ironic set of circumstances to go from one side to the other.

[00:29:42]

***Tacey Ann Rosolowski, PhD***

[00:29:43]

But also a very real story about how politics was played.

[00:29:45]

***Thomas Burke, MD***

[00:29:45]

Sure.

[00:29:46]

***Tacey Ann Rosolowski, PhD***

[00:29:46]

I mean, the Vietnam War was just huge, the kind of upheaval in the country around that. I mean, I remember as a girl seeing that and realizing, oh, my gosh, you know, half the population around me is going to be asked to die. (laughs) And I wouldn't because I was female, you know, but people suddenly were aware of this at a very young age in a totally different way.

[00:30:08]

***Thomas Burke, MD***

[00:30:08]

You know, and I think at the time, it was on every TV, it was on every venue—

[00:30:14]

***Tacey Ann Rosolowski, PhD***

[00:30:14]

Oh, constant.

[00:30:15]

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***Thomas Burke, MD***

[00:30:15]

—every day, and you didn't have the diversity of the media that we have today. So there's three TV stations, and every one was playing every night what was happening.

[00:30:26]

***Tacey Ann Rosolowski, PhD***

[00:30:26]

And there were not the controls of what was shown in the media, too, I mean the body bags, the body bags, the body bags. I mean, it was unrelenting.

[00:30:33]

***Thomas Burke, MD***

[00:30:34]

Yeah, it was a pretty vivid time.

[00:30:35]

***Tacey Ann Rosolowski, PhD***

[00:30:35]

It was very vivid.

[00:30:36]

***Thomas Burke, MD***

[00:30:36]

I think people that grew up at that have different experiences of it.

So the other great thing about taking an army scholarship was that every summer in medical school, one of the requirements was that you had to do six weeks of active duty. There were eight or ten of my medical school classmates that were on military scholarships, and the year we joined, the army decided to open up this six weeks in the summer to Hawaii. They had a huge training base and medical center in Hawaii.

[00:31:20]

***Tacey Ann Rosolowski, PhD***

[00:31:20]

And just for the record, let me say you did your MD at Tulane subsidized by the [unclear].

[00:31:27]

***Thomas Burke, MD***

[00:31:28]

Right. Right. So I had gone from undergraduate to medical school at Tulane. So Tripler Army

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Medical Center was the big military medical center on Oahu, and they hadn't been able to recruit any students to their training programs because the army wouldn't let you go for that six weeks in the summer. So what the medical students would do is, you know, I did my six weeks at the place in Denver or Walter Reed or somewhere in San Francisco, and because you knew people there and got used to it, that's where you would try to do your residency training. So all of the programs in Hawaii said, "We're not attracting any students to our programs because you won't let them come for the summer."

So we got a letter saying these are the programs you can go to, so all of us in New Orleans said we would love to spend six weeks in Hawaii in the summer, so we all signed up. We all went. We lived in the bachelor officers' quarters above the hospital for six weeks. And I did that every summer that I was in medical school. So I would complete the spring semester, I'd sort of clean things up in New Orleans for a couple of weeks, and then I'd fly to Hawaii on the army. I'd work there for six weeks. I'd be doing a rotation in the hospital, and the rest of the time I was at the beach and doing the things that you do in Hawaii.

So I ended up, obviously, doing my residency training out there, so overall, I lived full-time in Hawaii for four years, but then for three summers I had spent all summer, so over a course of seven years I lived in Hawaii. As a military person over there, you had easy access to other islands, to other military facilities, so I probably have hiked almost every trail in the Hawaiian Islands, I've driven every road, I went to lots of places and had great experiences as part of my training.

You know, a really unique one is that I went to Kalaupapa, which was the leper colony on Molokai that was established in the probably late 1800s, and was a physically completely isolated place. It was a peninsula on the back of the island with about a 2,000-foot cliff face above it. So at the time, if you got leprosy, there was no way for treatment, and these people were ostracized and taken away from their families. And in Hawaii, you were literally taken by boat and thrown over the side off of Kalaupapa, and if you made it to shore, you became part of the colony. And that's where Father Damien established his ministry and all of the stories that kind of come with that.

Well, when I was there in the late seventies, early eighties, there were eight living people left in the colony, and they had no families to go back to. They'd lived their whole life in Kalaupapa, and the arrangement was that they would be supported by the state until they died, and then the site would become a national historical landmark and turned over to the Park Service. So I was probably there the last window where you could actually go down the cliff face, and the residents of the colony would take you on a tour. They were treated at the time, so it was a different disease in that era. But it was really fascinating to be taken to Father Damien's chapel and the other kind of historical aspects of the town that they built there by the people who had lived their whole lives there. So today it's a national park and that story is largely historical. But I got that

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experience because I lived in Hawaii and I had the chance to kind of do things that were outside of the ordinary.

[00:35:32]

***Tacey Ann Rosolowski, PhD***

[00:35:33]

Why was that so important to you?

[00:35:34]

***Thomas Burke, MD***

[00:35:35]

Well, I think it goes back to wanting to learn about places that you happen to find yourself and people different than you and trying to appreciate the cultural history of the people that you, in that sense, were kind of living side by side with.

So my wife was an army nurse. We met during my training out there. We decided to get married while we were out there. We actually were married in Hawaii, so we've always had a connection to that place as a special time in our lives. I go back for two weeks every summer. We rent a house, we kind of hide out on the beach, and our retirement plan is to spend three months a year in Hawaii, and I think we'll probably do that.

[00:36:30]

***Tacey Ann Rosolowski, PhD***

[00:36:30]

That's neat. A real center of gravity for you. Yeah.

[00:36:32]

***Thomas Burke, MD***

[00:36:33]

Yeah, it is very different than anything I grew up with, otherwise lived with, or kind of did.

I think the other thing I would say about those experiences is the military is a very good teacher for where I ended up because it puts people in responsibility positions at a relatively young age because they have to. It forces you to work in teams because you have to, and you have to depend on other people, and you have to be able to predict what they will do in situations. Many of the scenarios are stressful. So as I think back about what it was like to become a surgeon and to do some of the other things, a lot of the lessons that kind of came out of a military experience, irrespective of medical, translates very well into kind of what I've subsequently done in my career. You know, my wife and I always joke that on some level it would have been great if all of our kids could have been in the military, because there's a chain of command, and sometimes you just do what you have to do and you don't get to question, you don't get to opt out, you

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don't get to make other choices, this is kind of where you're going.

[00:37:58]

***Tacey Ann Rosolowski, PhD***

[00:37:59]

Yeah. You've mentioned your wife a number of times. And her name is?

[00:38:02]

***Thomas Burke, MD***

[00:38:02]

Her name is Cathy.

[00:38:03]

***Tacey Ann Rosolowski, PhD***

[00:38:03]

C-a or K-a?

[00:38:05]

***Thomas Burke, MD***

[00:38:05]

C-a. So Cathy's an interesting woman, and she grew up in a family that was relatively modest in terms of their resources, and she had three brothers, and so getting to college was going to be complicated for her. She was sitting in high school—she's from New Jersey—and she heard an army recruiter say, "We have something for you."

She went down to the recruiting station, she was, what, seventeen or eighteen, and said, "What do you have for me? I want to be a nurse." So they had a very interesting program. Her story matches well with mine. They were trying to train nurses to go to Vietnam because they needed army nurses to support the medical services there, and so they would pay for you to do two years of undergraduate college and then two years at Walter Reed, and then you would graduate and they would deploy you to Vietnam.

So she joined in '74, probably a year before I joined, I in medical school, and the war ended while she was in training. So she joined, I don't know, probably knowing what the plan would be to do, but she joined and ended up just having some military assignments. So it was her way to finance a college education in a way that wouldn't have otherwise been possible.

So she did her payback time, and she didn't really have anything to do after that, so she decided she was going to reenlist. Then the army, when you reenlist, the choices are yours because they know to keep you, they're going to have to send you to a desirable place. So she said, well, her first choice was actually, I think, San Francisco, and she put Hawaii second. She said, "I'm not

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going to put a bad place. I'm going to make them send me to a bad place. I'm going to give them a list of good places and see what I can come up with."

So she drew Hawaii, and it was sort of fate that she drew that. She had done cancer nursing in her first three years in the army, and she got to Hawaii and it was a time when there was almost no chemotherapy drugs, just a handful. Most people did not do very well. And she said, "You know, I'm young and I spent the last three years with people who always died, and I was in the hospital so I saw the sickest group of people. You know, I want to do something where people go home." So they assigned her to a surgical unit, but it happened to be the GYN tumor surgery unit, and that's where I was a senior resident. So we met when we were both working on that facility.

Our first date was I took her out to dinner with some friends, and then we were having a good time, so we split off from them. And I said, "How about if we get a Mai Tai at the Royal Hawaiian Hotel?" They have a beautiful bar on Waikiki Beach. We were already downtown. I said, "It would just be great to spend the evening out here." So our first date, we had Mai Tais at the Royal Hawaiian bar.

There was a great show at a gallery right next to the hotel of a Hawaiian Chinese artist that I love, I'd seen his work in Hawaii, named David Lee. He painted with sort of traditional Chinese paints, but sort of had a more modern interpretation of Chinese themes, just some absolutely beautiful, beautiful work. So after we had a drink, I said, "Let's go over to this gallery, because they're open late. It's nighttime on Waikiki. I want to just show you—." He was having a show. "I want to show you the show."

So we walked over. It was half a block. We walk in and the people recognized her. I said, "Well, how do they know who you are?"

She said, "Well, you know, I came out here a couple months ago and I saw this show by David Lee, and I fell in love with his paintings, and I had no money but I bought two."

[00:42:46]

***Tacey Ann Rosolowski, PhD***

[00:42:46]

Oh, my god.

[00:42:47]

***Thomas Burke, MD***

[00:42:47]

"And they're being paid off on time." So she said, "Could you bring them out and show them to my date?"

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And I said, “You know, this is an unbelievable connection, because I’ve always wanted this artist’s work in my house, and I never got to place where I could either afford it or put it together in a way.” And here I just met this woman, we’ve gone out on our first date, and she kind of connected in the same way. So we literally decided within about a week of that date to be married, and we got married probably about five months later by the hospital chaplain, because I was leaving for a different assignment and she couldn’t go unless we were actually married. So we were married in the hospital in Hawaii by the chaplain.

[00:43:39]

***Tacey Ann Rosolowski, PhD***

[00:43:39]

Wow.

[00:43:40]

***Thomas Burke, MD***

[00:43:40]

And we still have those David Lees in our living room, and we’ve bought a couple more since then. But what a unique set of circumstances that just kind of—

[00:43:50]

***Tacey Ann Rosolowski, PhD***

[00:43:50]

Brought together by Mai Tais and art. (laughs)

[00:43:51]

***Thomas Burke, MD***

[00:43:51]

Yeah, Mai Tais and art, and we both happened to be in military healthcare.

[00:43:57]

***Tacey Ann Rosolowski, PhD***

[00:43:57]

That’s amazing.

[00:43:58]

***Thomas Burke, MD***

[00:43:58]

So pretty wild—

[00:43:59]

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***Tacey Ann Rosolowski, PhD***

[00:43:59]

That's a great story.

[00:44:00]

***Thomas Burke, MD***

[00:43:59]

—personal connections.

[00:44:01]

***Tacey Ann Rosolowski, PhD***

[00:44:01]

Yeah, great story.

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## **Chapter 4**

### **A: Overview**

#### ***On the Importance of Relationships in Medicine and Medical Care***

Story Codes

A: The Clinician

A: Inspirations to Practice Science/Medicine

A: Character, Values, Beliefs, Talents

A: Professional Values, Ethics, Purpose

B: Institutional Mission and Values

B: MD Anderson Culture

C: Evolution of Career

C: Professional Practice

C: The Professional at Work

C: Leadership

***Tacey Ann Rosolowski, PhD***

[00:44:01]+

So tell me about during this time how you selected your surgical focus at Tulane and then how that evolved into cancer study later.

[00:44:12]

***Thomas Burke, MD***

[00:44:13]

You know, I think I was always drawn to the surgical side of experiences, but I didn't like the—we talked a little bit earlier about some of the toughness of a surgical environment, and it was just personally difficult for me to kind of match up to that. So I sort of saw obstetrics and gynecology as a hybrid because obstetrics was kind of a happy time, people who were healthy and you were doing good things, and you were sort of in a partnership, and you saw the same patients repeatedly over time. So it wasn't, "I have appendicitis, I see you, I have an operation, and I move on to somebody else." These were people you formed long-term relationships with, and so I saw that as an attractive aspect of that specialty.

And then as I kind of got into the training piece, I said, you know, the really intense relationships you form are with people that have cancer, and you sort of become risk takers together. You're sort of partners in care and outcome. I saw that as a really rewarding personal experience, because I think I was drawn initially to the relationship piece, and then I moved over to a way to match the technical with sort of the intensity of the relationship, and that was a way to bring together the cancer part.

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And for whatever reason, I personally am able to deal with life and death scenarios with people I know and have treated in a way that doesn't wear me down. I've worked here for twenty-five years. The people who do well here and get attracted to MD Anderson have that as a core capability. They're able to meet people at various disease stages and adjust their style and their interactions and their support to match wherever those people are, and if you can't do that, you don't survive here, you know. You get worn down by the wear and tear, the personal toll of the emotional things of doing it.

So I think the people who kind of get to the point of saying, "You know, I want to push the envelope, I want to do unique things, I want to find new discoveries and bring those to people," also see the side of it's just as good and rewarding to help people at the end of their life as it is when they're fighting for it. So if you can make those transitions, you don't abandon people who don't survive their treatment, you're able to stay connected to the people you've formed relationships with. I mean, some of the patients I've treated for, you know, five, ten, fifteen years, if you look back at the times in your life at the people you've stayed the closest with, it was always sort of an intense time where you sort of had to come together. I have people from college, I have people from medical school, I have people from my residency training that forty years later I still interact with because it was a really intense time when we all kind of came together. And I see that same thing with patients that I take care of. It's an intense time. It's a strong relationship. You depend on each other to make things happen, and so that kind of reinforces kind of where I went.

I see it in lots of people that I work with and work around, and the people who can kind of adjust their personal style to the needs of their patient at whatever point in the disease they are will really thrive, and they will be energized whether they're planning for an operation or giving curative chemotherapy or whether they're doing palliative care for somebody they've taken care for a long time. The personal relationship is still the same issue.

So that's how I sort of shifted away from—I have the same philosophy. We've worked really hard. You know, if you think about people who come through nursing school, they're all young people, and a lot of them gravitate toward either happy areas or what they perceive to be happy areas, so obstetrics and pediatrics get a lot of play from people coming through nursing school. Or they go for sort of the high-tech environment, the Emergency Center or the ICU, where things are kind of hustle and bustle and there's sort of a skill and almost a bravado that kind of moves you through that. So one of the challenges is how do we get people that want to be cancer nurses, you know, and I knew this from my wife, obviously, but also how do we get people to see that you can build really strong relationships with people that what we do is really rewarding, that we somehow need to get in front of people before they've made a decision to do something else.

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So when I was in an administrative role among the clinical areas, we spent a lot of time trying to bring nursing students into the Cancer Center because we thought if we could just get them on our units for an elective time or a clinical experience, they would sort of see that and gravitate toward cancer as an area they wanted to practice in. I think that's been highly successful, that kind of getting in front of people at a time where they're sort of shaping their agenda and ideas is, I think, important.

[00:50:46]

***Tacey Ann Rosolowski, PhD***

[00:50:48]

Yeah. I was having a conversation this morning with Lewis Foxhall [Oral History Interview] about, I mean, a related issue of getting people to become interested in family practice and also getting family practitioners to think about cancer, you know, how do you get your head around that, and that there's no exposure, so, again, talking about how do you expose people to the possibilities that this may be very rewarding, and what are the ways in which it could be really rewarding for you personally as a career.

[00:51:22]

***Thomas Burke, MD***

[00:51:22]

And it's not something that just happens. It's something that you have to kind of think through a strategy on and articulate a plan.

[00:51:31]

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## **Chapter 5**

### **A: The Clinical Provider**

#### ***Coming to MD Anderson to For Surgical Innovation***

##### **Story Codes**

A: The Clinician

A: Joining MD Anderson

B: MD Anderson Culture

C: Evolution of Career

C: Professional Practice

C: The Professional at Work

C: Mentoring

C: This is MD Anderson

A: Personal Background

A: Professional Path

A: Influences from People and Life Experiences

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

[00:51:31]

Yeah. You mentioned earlier about the development of your own surgical style, and I was interested in that phrasing. When I've talked to pathologists, they talk about their eye, and that's the phrase among pathologists which I learned in my interviewing folks like that. And I was wondering about what you meant by that, what did you mean when you said a surgical style, and how did you develop your own style. What is it?

[00:52:00]

##### ***Thomas Burke, MD***

[00:52:01]

Well, I think it goes a little bit to, if you will, kind of an amalgamation of everybody who's trained you, and, you know, you ultimately become a composite of all of them, and that's at the point you start. So at the point where you're kind of launched on your own, you've sort of accumulated everybody who's taught you along the way.

So I think the really great surgical people that I know don't stop there, so then they challenge the, "Well, why do we do it this way?" Or these are things that were sort of taught over time but were never sort of scientifically evaluated or in other ways decided. So then you start to think about, "Well, I can't resect this tumor in this scenario. What could I develop as an option for people with this problem?"

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So one of the great things about coming to MD Anderson—and it was an intentional one on my part—is I had been for two years a general OB/GYN at Fort Leavenworth, Kansas, a twenty-six-bed hospital where I kind of did everything, I did two-year training in cancer in Washington, and then I ran a tumor service in San Antonio for two years, paying back some time to the army before I came to Houston. And so I said, you know, I've done a lot of routine stuff, and if you think about things like straightforward operations, after you've done two or three or four hundred, there isn't a lot of innovation and creativity for how you're going to do that the next time. And so I wanted to be at a place where you were challenged to do stuff beyond what was possible or defined at the time, and I liked the challenge of I want to do the stuff that nobody else will do, because that's what pushes you to the next step.

So, I mean, MD Anderson has always had the reputation as a place of very unique expertise and people who would sort of push that environment further. And so I came here as an assistant professor. I had a little more experience than most people because I'd had some military time out, so I wasn't coming right through a training program. And, actually, I was the first person in my department on the faculty who had not trained here. So it was a very interesting start because I came from a pretty big surgical tradition in the military. The guys who trained me had been surgeons in Vietnam, had done incredible things out of necessity, and so the people I learned surgery from with were pretty skilled people.

And MD Anderson was a much more balanced place at the time. They had great surgeons, and a lot of the surgical traditions in my specialty were developed here, but they also had a huge radiation component, and it had been one of the first places to embrace chemotherapy for GYN tumors. So there was a much bigger balance than the kind of environment that I came out of. So one of the things I had to reconcile was how am I going to take my personal style, based on how I've been trained and how I've worked for the last ten years while I was in the army, and kind of fit it into what was expected of me as a new faculty member at MD Anderson. So I struggled with it for the first year I was here, and I finally said, you know, they recruited me to bring skills that I have, and I need to just go with what I know and kind of push that and adapt along the way to the things that I see being done here and not worry so much about what the tradition was.

[00:56:33]

***Tacey Ann Rosolowski, PhD***

[00:56:33]

Right.

[00:56:34]

***Thomas Burke, MD***

[00:56:34]

And so I got to a really nice blend of what I could bring to the group and what they could sort of modify in me that made us all better for that process and so—

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[00:56:47]

***Tacey Ann Rosolowski, PhD***

[00:56:47]

Tell me who called you. How were you recruited? How did you end up making the decision?

[00:56:53]

***Thomas Burke, MD***

[00:56:53]

Well, this is a tragic story, from my wife's perspective. My closest mentor in the military was a navy officer named Bill Hoskins [phonetic], who probably taught me everything I knew as a fellow and a surgeon, and we operated together for two years in Washington. He was retiring from the navy and he was going to Memorial Sloan Kettering, and he had been recruited to be ultimately the chairman of the GYN Tumor Service there, but there was a year or two where he was the second-in-command to a very autocratic chief who had been there for his entire career and who was fairly notorious as a traditional surgical personality.

So my time in the army, my obligation had ended, and I was invited to come back to Washington and run the service at Walter Reed and have a fellowship program, all the kind of things that academic surgeons like to have. And my wife said, "Well, you know, we're going to have to move anyway. You ought to at least look at what else is available."

So I interviewed at two places. I interviewed at University of Southern California, terrific surgeon and GYN oncologist there named Paul Morrow, who had been one of the sort of grandfathers of the specialty, and I had met him at some meetings. They were looking for a junior faculty member, and so I was invited to interview in Los Angeles.

So we went out, and I loved the group, I loved the hospital and the team. The issue, it was so expensive to live in California, and after we had kind of been around and spent the three or four days we were out there, we were sort of shown the kind of starter house that we could afford for \$800,000, you know.

[00:59:13]

***Tacey Ann Rosolowski, PhD***

[00:59:12]

The shack. (laughs)

[00:59:12]

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***Thomas Burke, MD***

[00:59:12]

I'm an army major, I barely pay my bills, and I'm sitting there, we're looking at—you know, it's an 800-square-foot house, and we say, "This wasn't quite what we were hoping to sign on for."

So at the same time, my mentor was in New York, and Bill said, "We're going to be hiring somebody. Why don't you come up and interview." So I went for the interview, and it became very obvious very quickly that my interview was a power play between those two individuals, and it was sort of like the old guard is, "I'm not quite done and I'm not going to take your guy just because you want him," and Bill trying to navigate the way for me to come and be his partner going forward. So there was a horrible presentation, and I have a lot of close friends in GYN oncology who to this day say, "Tom, we remember the day you came and gave that talk, and there were all these awful comments made by our chair, and everyone in the room knew it was about him and Bill." (laughs) So that sort of became notorious at the time.

So I got back on the plane to come back with my wife, and I said, "I can't work for somebody like that. Life is too short. I just can't."

And she said—well, she'd witnessed some of it. We'd been out at dinner and some other things, and she said, "Well, no, I understand that you can't."

So I came in that night. There was a message on the phone from my mentor, Bill, who said, "You know, Tom, you have to make a choice based on what you want to do, and you shouldn't do it based on what I might or might not get to do or any guarantees that I could make. You need to make your own choice." And I understood that, because he knew the personality stuff would be an issue. And he called the guys here the same night and said, "You know, there's a great guy who's coming out of the army who you might be interested in, because I don't think he'll come to New York." And I got a call the next day to interview at MD Anderson.

[01:01:25]

***Tacey Ann Rosolowski, PhD***

[01:01:25]

Who called you?

[01:01:26]

***Thomas Burke, MD***

[01:01:26]

Dave Gershenson. We've worked together for the whole time I've been here.

And Dave said, "Well, we heard you might be on the market, and we have a space that's opening up, and we'd like to have you come over and talk to us."

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So my wife—we lived in San Antonio at the time—said, “You can do whatever you want, but I will not live in Texas.”

And I said, “Okay. Well, it’s MD Anderson. I have to go for the interview. I just have to. I have to do it. It’s not something I could say not to. We could go to Los Angeles. I know we’ll get an offer there. It’s not New York where you grew up. So that’s just the way it’s going to be.”

So I came and I had just a wonderful experience. I met Taylor Wharton, who was the chair at the time, Felix Rutledge, who was sort of the godfather of GYN oncology, was still in the department, and some great radiation oncologists, so a really terrific group of people who I knew professionally and respected and felt like I would fit in well with.

So I came home and I told my wife, I said, “You know, this was a great opportunity that we should really think about.” So the next trip, she came, and, obviously, the recruitment was aimed at her to do it, and we both decided that this was a good opportunity for us. It kind of goes back to what I talked about at the very beginning, about making a decision based on an opportunity, not on a geography or a preconception, and, thankfully, she agreed to come and try it out.

We’ve lived in Texas now for thirty years. We have a ranch in the Hill Country. We’re building our retirement house in the Hill Country. We have longhorns. I mean, we are the traditional Texans. (Rosolowski laughs.) She fires a shotgun. She drives a truck. I mean, it’s so far different than it was thirty years ago when we first did this. So it all played out right for us, and when I think about it, it was her willing—I would have just gone back to Washington. I was fine in the army. I’d done it for ten years. I knew what was expected. It was easy to just say, “I’ll go back to Washington. I have everything that you could possibly want to do.” And it was her that said, “You should look at other opportunities because we’re going to move anyway,” and it was her that said, “Let’s go try this in Houston.” So that was a huge decision for us that obviously played out for the rest of our lives.

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## **Chapter 6**

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

#### ***The Late Eighties: Clinical Services in Gynecologic Oncology and Reproductive Medicine***

##### **Story Codes**

A: The Clinician

C: Understanding the Institution

B: Institutional Processes

C: This is MD Anderson

B: MD Anderson Culture

C: Evolution of Career

C: Professional Practice

C: The Professional at Work

C: Mentoring

C: This is MD Anderson

A: Personal Background

A: Professional Path

A: Influences from People and Life Experiences

C: Discovery, Creativity and Innovation

C: Patients

##### ***Thomas Burke, MD***

[01:01:26]+

The other thing I did when I came was I decided that the way to really build the program, and my own personal experience was to just do everything, so I told the fellows, I told the people in the clinic, "I will pick up the phone if anybody calls. I will take any patient that anybody doesn't want." So I established a reputation that I would be the sort of last-resort guy, and it was a great strategy. I got a very busy practice in a short period of time. It's a unique opportunity here that a lot of people don't appreciate, is that a lot of patients either come by choice or at that time were referred by their doctors to the place more than to a specific person. So if you were sort of the guy who said, "I'll take the calls and I'll take whatever happens," it was pretty easy to get busy in a short period of time, and so probably for the first ten or fifteen years of my career, I was extraordinarily busy clinically. I operated two or three days a week. I had a huge clinical practice of very complicated cases and patients that you never would have gotten to take care of in another location, so that kind of takes your skills and moves them in a very quick way forward.

[01:06:03]

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***Tacey Ann Rosolowski, PhD***

[01:06:04]

Can you give me an example of how that happened with a case when you were in the early years? How did MD Anderson kind of turbocharge your capacities?

[01:06:14]

***Thomas Burke, MD***

[01:06:16]

Well, they used to assign cases either to a specific faculty member if you request it, so everybody obviously over time built up partnerships of community doctors who knew them and had sent patients and got good reports back in exchange. But then there was also a large group of patients, maybe half or more, who were just being referred to the institution that we took in rotation, and so those were sort of just assigned by whoever was sort of next up on the list. So if you were the new guy, you didn't have that referral network, and so the way to build your practice and make those connections was to be the next guy.

And if you took—I always took the stuff—I always say it was the stuff nobody wanted to take because they were difficult cases, and a lot of times they were cases that just needed somebody to accept responsibility for. They were sick patients or patients with complications or patients who you knew weren't going to do well, and for whatever reason, their home doctor was uncomfortable taking care of them or they didn't have the facilities to manage it or there was a complication that was beyond their capability. So I always saw that as a unique service. "Okay, you don't want to have the difficult conversation with the patient or their family? I'm willing to do that." I could provide a service by managing a very complicated case or a surgical complication that you had, and the patient hopefully would get a better outcome because it would be a team that was more skilled and willing to do it and kind of would take it on.

So if you think about it, the risk to us was much less, you know. I'm willing to take the risk. It wasn't my complication, or I wasn't responsible for the treatment that led up to that point, or I was taking somebody who had failed three or four other options, and so the expectations on me were to just do the best that I could and to bring together a team that could kind of do what was appropriate for the patient.

[01:08:49]

***Tacey Ann Rosolowski, PhD***

[01:08:49]

What did you learn from taking on those cases?

[01:08:52]

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***Thomas Burke, MD***

[01:08:52]

Oh, you learned an incredible amount. You learned the technical stuff, obviously, but you learned a lot about medical management, in addition to surgery. You learn a huge amount around interpersonal skills and communication. You learn how to build relationships with the people who refer to you. I think probably the difference in perspective is I'd worked at a twenty-six-bed army hospital in a town of ten-thousand people, and I knew what it was like to have something go really bad in that environment, and there's not a lot of backup. So it kind of goes back to what I was talking about, the military would put you in a situation probably that was way ahead of where you otherwise would have been, so we had—

[01:09:46]

***Tacey Ann Rosolowski, PhD***

[01:09:46]

And maybe the military experience even prepped you to handle that kind of situation.

[01:09:52]

***Thomas Burke, MD***

[01:09:52]

Yeah, it probably did. Well, I worked at this hospital for two years. There were five surgeons there, two [unclear] surgeons, two general surgeons, and an orthopedist, and we took care of the people who lived on the military base, but we took care of the prisoners. There was a big federal penitentiary in Leavenworth, and so there were a lot of injuries from prison fights and other things that were traumatic, and we were the only federal healthcare facility nearby.

So, actually, my partner, [unclear], and I agreed to share call with the general surgeons that were there. If you think about a two-man practice, either you're on call or you're off, and you don't want to pull your partner in when he's off. So we said, well, if the general surgeons had an emergency at night, the GYN person would come in and be their assistant, and if we had an emergency at night, the surgeon on call would come in and be our assistant.

So it was a great decision. We're all young guys in our thirties, probably. I wanted to do cancer surgery, so I would come in for knife wounds, liver lacerations, all kinds of horrendous surgical things that happened at the prison, and I'd be operating with a pretty talented general surgeon, and those were great experiences when you became a cancer surgeon for critical care and management.

But it was sort of the same thing, a small group of people figuring this out and being in a position where they had to kind of devise their own options for how they would manage this. There was a really insightful guy at the time who was the chairman of OB/GYN at Kansas University in Kansas City, which was about an hour away from us. So one of the big fears in obstetrics is that

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you would have a premature baby or some issue that in a small location you just didn't have the capability to manage. So they had a creative strategy way beyond their years at the time. They had one of those old silver Airstream motor homes that you used to see. Well, you probably still see some, but at the time they were pretty classic Americana, people who went to the national parks and kind of lived in an Airstream motor home.

[01:12:24]

***Tacey Ann Rosolowski, PhD***

[01:12:24]

Right. Those old things.

[01:12:24]

***Thomas Burke, MD***

[01:12:25]

Well, they had gutted it and equipped it as a neonatal Intensive Care Unit on the road, and so all through the small towns in eastern Kansas they would say, you know, if you have a baby that's sick, that you can't move the mother before she delivers, you know, obviously we'd rather deliver her in a medical center than in a small place, but if you get caught, we will dispatch this motor home, and it comes with a senior pediatric resident and a nurse from their neonatal Intensive Care Unit. So I said, "What a creative way to solve a problem." So that was another solution of we went down, we met him, we said, "We'd like to be on your network list," and two or three times out there we used their services.

[01:13:16]

***Tacey Ann Rosolowski, PhD***

[01:13:16]

Wow.

[01:13:16]

***Thomas Burke, MD***

[01:13:17]

But, again, it was sort of forcing the creativity of a very complicated situation. So to come back to MD Anderson, those cases teach you to be innovative beyond what you sort of know at the time. So I credit a lot of the things that were developed here. We do a huge amount of two- and three-team surgeries today, because we were challenged by clinical situations where what a urologist or a GYN oncologist or a thoracic surgeon knew was not enough for that patient.

[01:14:03]

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***Tacey Ann Rosolowski, PhD***

[01:14:03]

I don't mean to interrupt you, but just so I understand. I've never heard that term, "two- or three-team surgeries." What does that mean? What kind of case are you addressing?

[01:14:12]

***Thomas Burke, MD***

[01:14:12]

So, sort of the typical operation is there's one surgical team and they take out your appendix. So to do some of the tumor things, there might be a part of a GYN cancer that I didn't have skills to remove because it went up into the diaphragm or it was long nerve roots, or it had required expertise that I had never trained to do, or it was in a body part that I wasn't skilled at. So we would start to use other surgical teams to extend those capabilities, and so I could remove this pelvic tumor if somebody could deal with this lymph node mass that was over here. So, thinking about neurosurgeons or thoracic surgeons or someone else who had a different training who could come in and do what you couldn't do or remove a chunk of a major vessel and replace it. So that would be a two-team case.

Then a three-team case would be you'd remove a portion of a body that needed to be reconstructed and so you would need a plastic surgeon or reconstructive surgeon to kind of repair a defect. So now as you think about it, you're not constrained by traditional anatomic boundaries or your training, but you've extended those by bringing people with other experience in, and then you have a third set that's figured out a way to pretty much replace anything you could take out.

[01:15:43]

***Tacey Ann Rosolowski, PhD***

[01:15:45]

How long did it take? Was that kind of approach already in place when you came to MD Anderson in '88?

[01:15:51]

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***Thomas Burke, MD***

[01:15:52]

You know, it was very limited. I don't know the exact statistics. There were plastic surgery procedures at the time, mostly related to breast reconstructions and skin grafting, were probably the two biggest issues. Then as rotational flaps, tissue flaps, and transplantation flaps were developed in plastic surgery, then other opportunities arose, and so it kind of built out of that experience. But I would say we have probably quadrupled the number of two- and three-team cases, and so the opportunity to get surgical treatment extends to a much wider group of people. And the other side of that is the sort of anatomic recovery of fairly large things is incredibly better—

[01:16:51]

***Tacey Ann Rosolowski, PhD***

[01:16:53]

Oh, really?

[01:16:53]

***Thomas Burke, MD***

[01:16:53]

—than it was at the time. The options for replacement, repair, reconstruction are considerably better than anything we started with.

[01:17:03]

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## **Chapter 7**

### **A: The Administrator**

#### ***An Overview of the Gynecologic Oncology Clinic: Offering Multi-Disciplinary Care Before it Was an MD Anderson Norm***

Story Codes

***Tacey Ann Rosolowski, PhD***

[01:17:06]

Now, when you arrived, you were a faculty member. Were you also appointed in any kind of administrative role when you arrived?

[01:17:12]

***Thomas Burke, MD***

[01:17:13]

You know, at the time, no. I just came in for practice. My first administrative role was to be the medical director of our clinic, and that happened in—I think it was in the early nineties, '93 or '94. It was an assignment not a lot of people wanted, because you had to sort of be the interface between everybody who worked in the clinic. And like everything, space was tight and so you had to negotiate all of the issues around who was working where.

[01:17:55]

***Tacey Ann Rosolowski, PhD***

[01:17:55]

Now, what was the specific clinic you were [unclear]?

[01:17:57]

***Thomas Burke, MD***

[01:17:58]

So, at the time, our clinics were named by numbers, so I worked in Station 82. That was the GYN Clinic, and it was one U-shaped hall that was very convenient. It was one floor below our offices. At the time, we literally just had to run downstairs and we could see patients. So in terms of the complex that's on the ground today, it was considerably different logistically.

[01:18:24]

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***Tacey Ann Rosolowski, PhD***

[01:18:24]

So how did you end up with this? Did someone say, “Oh, we need the director of clinic,” and everybody else [unclear]?

[01:18:28]

***Thomas Burke, MD***

[01:18:29]

Well, we needed someone to run the clinic, and I was pretty much nominated because no one else would take the assignment and—

[01:18:35]

***Tacey Ann Rosolowski, PhD***

[01:18:36]

There you go. Okay. And why was that? Why did they nominate you?

[01:18:38]

***Thomas Burke, MD***

[01:18:42]

I think they thought I would probably have a reasonable chance getting consensus around some of the issues and—

[01:18:50]

***Tacey Ann Rosolowski, PhD***

[01:18:50]

What were the issues?

[01:18:51]

***Thomas Burke, MD***

[01:18:52]

Well, mostly it was around the equitable distribution of space and people, and so it was sort of the scheduling—and it’s really the logistics of how you see patients. So we would always fight for how many rooms am I assigned and how many nurses are working with me. So the clinic director was the person who would kind of make that happen and was, with the chairman, probably the ultimate decider of how those get played out. And you can imagine it was pretty traumatic if you had to change your clinic day. I mean, these are schedules that are built weeks and months in advance, and people were always used to, you know, this is my surgery day.

That was another issue I took on, is that surgeons don’t like to operate on Friday because you wanted some freedom over the weekend, and so I signed up for Friday when I came, because I knew it was going to be hard for me to break into the early week schedule because there were

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lots of people more senior than I was, and I thought I could get better control of the time on Friday. So I took Fridays as my operating day, and it actually worked out great. It was a wide-open schedule. Everybody would kind of concentrate on the front end of the week. So it was a great way to kind of build a surgical practice at that time.

But I used the administrative role of managing the clinic as probably my initial administrative assignment. It was also a time where we were transitioning from specialty clinics to multidisciplinary clinics, so one of the hallmarks of how we practice today is that we practice by disease site rather than by surgery or medical oncology or radiation oncology, and GYN was a little bit unique because they had always operated that way.

[01:21:08]

***Tacey Ann Rosolowski, PhD***

[01:21:08]

Oh, really?

[01:21:09]

***Thomas Burke, MD***

[01:21:09]

And I've thought about how that was, and I think a couple of things came together, because the GYN Service was always different than everyone else because the two people that sort of founded the program here were Felix Rutledge, the sort of surgical gynecologist who had an interest in cancer, and Gilbert Fletcher, who was a radiation oncologist and one of the pioneers of radiation oncology, whose interest was treating GYN tumors. So he and Felix were really similar ages and sort of temperaments and mentalities in terms of what they were trying to accomplish as they built the program, so I think it was just fortuitous that those two personalities and experts came together and just said, "We should be doing this together." So they always [unclear] together, they shared patients, they had discussions. So all of the things that today are sort of the hallmark of multidisciplinary care just sort of started naturally between the two of them.

And if you think back to the time, this was the 1950s, there was no chemotherapy. So the two modalities were surgery and radiation. Then in the late fifties, some of the first chemotherapy agents became available, and some of the early ones like methotrexate and cisplatin and those first drugs that came forward had some GYN applications. So the two of them said, "We're going to need somebody who specializes in drug treatment," because there wasn't a specialty of medical oncology at the time. So they recruited someone to come in and pick up that part of the practice and develop it.

So the chemotherapy piece got rolled in to the surgery and the radiation, and so GYN oncology always sort of from that very beginning included people who did surgery, people who participated in radiation, and people who gave chemotherapy, and I still do that today. So I think

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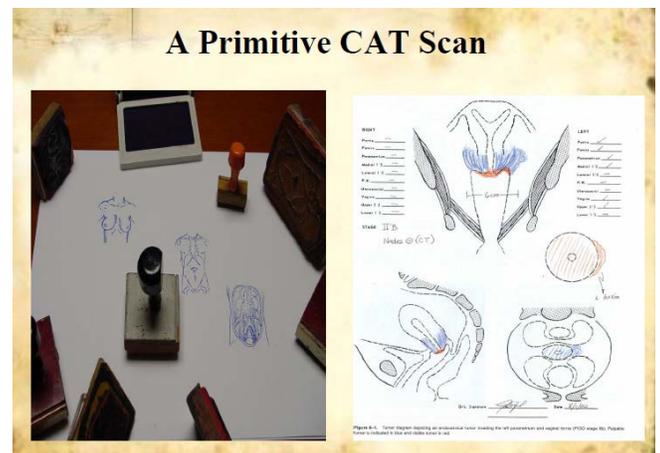
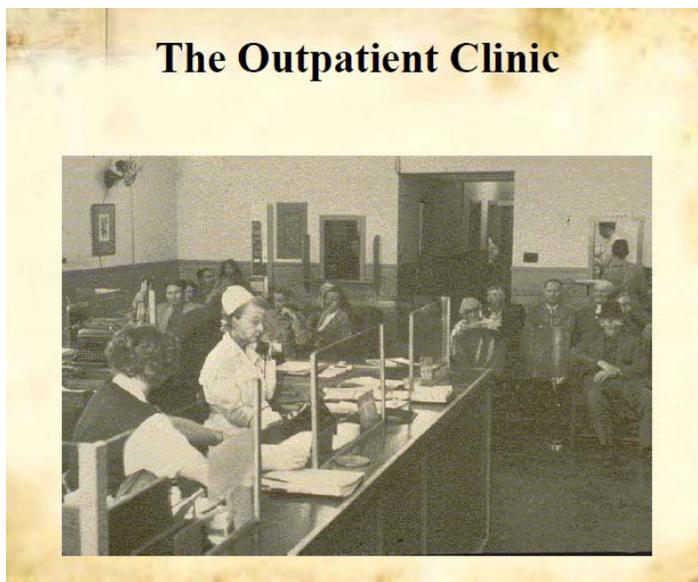
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that actually came out of MD Anderson, and it was their model that they exported around the country.

So when we came to the multidisciplinary launch of clinics at MD Anderson, it was sort of de facto for the GYN Service because they already had a conference, they already had a time that they met together. It's great. I've shown in some talks that I've given—you know I'm the old guy now, so I do the historical perspective talks, and so it's interesting, as we're launching an electronic health record, to kind of look back at that time and see the system that those guys had built. We didn't sit down in our clinic, we stood up, and there were workstations that were wall-mounted, so if you were in the clinic, you were on your feet the whole time. There wasn't a sit-down workroom.

We had a fold-down table and a cabinet with all the forms above it that you would need to order things and to do the charting, and then each of these little work platforms had a telephone next to it so you could do that and then also had a drawer, and in the drawer were little rubber stamps of all of the female anatomy. So there was a breast stamp, there was an abdomen stamp, there was a cervix and uterus stamp, an ovary stamp, and a little inkpad. So you would literally have a progress note where you were writing your description of the exam, and then you would pull out a stamp and you would stamp it, and then you would draw on the diagram your examination findings.

[01:25:31]



Images taken from Dr. Burke's presentation, "Historical Perspectives on the Treatment of

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Cervical Cancer” (request file: 50 Burke, T\_ Ppt\_Historical Perspective on Treatment of Cervix Cancer2014)

***Tacey Ann Rosolowski, PhD***

[01:25:32]

Wow.

[01:25:32]

***Thomas Burke, MD***

[01:25:32]

And they had colored pencils, blue and red, so any tumor that you could see, you would sketch in in red, and any tumor that you could feel, you would sketch in in blue. So if you think about this, every progress note, every visit, there was an anatomic diagram and description of what that patient had at the time, so this was a terrific resource. I think about CAT scans and digital images and all of this, and I said this is really a primitive version of how that happened. And then—

[01:26:10]

***Tacey Ann Rosolowski, PhD***

[01:26:12]

Do those records still exist?

[01:26:13]

***Thomas Burke, MD***

[01:26:14]

They do. They're in a warehouse somewhere—

[01:26:15]

***Tacey Ann Rosolowski, PhD***

[01:26:15]

I'm sure.

[01:26:15]

***Thomas Burke, MD***

[01:26:15]

—or they're scanned in an archive. I kept a couple just as examples to show.

[01:26:19]

***Tacey Ann Rosolowski, PhD***

[01:26:20]

Yeah, very, very neat. Yeah.

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[01:26:21]

***Thomas Burke, MD***

[01:26:21]

Then the other innovation is they had what they had what they called—it was essentially a planning conference where they discussed patients together in a group setting, exactly as we do today, and then you would actually physically go down to the clinic and examine that patient. So you had sort of discussed their evaluation and their findings as a group, and then you would go down and two or three people would examine the patient together and arrive at the treatment plan. And the same stamps were used, but that was on a blue page. So as you think about somebody's chart starting to become inches thick, you could always flip to the blue page, because you know that's where the discussion of the treatment was. So it was an amazingly sophisticated strategy for tracking people over time.

[01:27:16]

***Tacey Ann Rosolowski, PhD***

[01:27:16]

And you said you've done a presentation on how this all worked?

[01:27:20]

***Thomas Burke, MD***

[01:27:21]

Yeah. I have some slides of the stamps, I think, and—

[01:27:23]

***Tacey Ann Rosolowski, PhD***

[01:27:23]

That's cool.

[01:27:23]

***Thomas Burke, MD***

[01:27:23]

—I wish I had some originals. I think they're probably gone at this point.

[01:27:26]

***Tacey Ann Rosolowski, PhD***

[01:27:26]

Well, if you would like to share that to connect to your [unclear]—

[01:27:32]

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***Thomas Burke, MD***

[01:27:32]

Okay. Great. Sure.

[01:27:33]

***Tacey Ann Rosolowski, PhD***

[01:27:33]

—or to your interview, that would be great, because we can do that.

[01:27:36]

***Thomas Burke, MD***

[01:27:36]

Yeah, those would be fun to see.

[01:27:38]

***Tacey Ann Rosolowski, PhD***

[01:27:39]

Yeah, be very neat. Yeah.

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## **Chapter 8**

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

#### ***Developing Multi-Disciplinary Care Within the Department and in the Institution***

Story Codes

A: The Administrator

B: MD Anderson History

C: Discovery and Success

C: Understanding the Institution

B: Institutional Processes

C: This is MD Anderson

B: MD Anderson Impact

B: MD Anderson Culture

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: Professional Practice

C: The Professional at Work

C: Patients

C: Patients, Treatment, Survivors

***Tacey Ann Rosolowski, PhD***

[01:27:39]+

Yeah, it's amazing some of the stories of how it all worked and then how—I mean, what was the next step, I mean, as you were developing the multidisciplinary—I mean, as the institution said, “Okay, we're going to launch this. We're going to become multidisciplinary,” how did your service become more sophisticated in what it was already doing?

[01:28:00]

***Thomas Burke, MD***

[01:28:01]

So I think it was very interesting to—we spent a lot of time planning. I was on part of the administrative team that did the work for this at the time. I had an assignment mostly tied to medical staff function. So we have a bunch of medical staff committees that sort of govern practice, and because of that, I had gotten pulled into some of the planning groups for multidisciplinary care.

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The way it originally unfolded was that we had decided in the early nineties that we needed to be sort of more patient-centric, and rather than having patients move throughout our campus, it would be better if everyone who treated a given disease was located in the same place. So that was the concept. The administrative team that was working on this put some pedometers on some breast cancer patients and just tracked how far they walked getting a CAT scan, you know, labwork, coming to the medical clinic, seeing a surgeon, and it was over a mile or a mile and a half. So we're sitting there sort of saying these are sick people who have enough trouble negotiating the things they have to do to get evaluated and then we're making them walk all this space.

[01:29:32]

***Tacey Ann Rosolowski, PhD***

[01:29:32]

Yeah, and get lost.

[01:29:32]

***Thomas Burke, MD***

[01:29:33]

Sure.

[01:29:33]

***Tacey Ann Rosolowski, PhD***

[01:29:33]

And all of that.

[01:29:34]

***Thomas Burke, MD***

[01:29:34]

Well, and if you think about how it plays in the community, I mean, we're at least in one complex, but in the community, you would be driving and it would take you weeks to kind of get through that maze. So that was the impetus for how would we put this together, so a lot of planning about how we would do this and what would go together and what would sort of stay as it was.

So the decision was that the doctors who treated lung cancer, breast cancer, prostate cancer would come together in a location, and they would all see their patients there. And then you'd go out to radiology or the lab, but we'd try to collocate those across the campus. So these were teed up as a series of transitions, and so literally you would go home on Friday, and you had worked in the surgery clinic, and you would show up on Monday and you were in the Breast Center and you had a completely new set of colleagues, environments. Over the weekend, guys had come in and boxed everything and moved it in, and so the transition was literally instantaneous. So

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[01:30:47]

***Tacey Ann Rosolowski, PhD***

[01:30:49]

How did people take that?

[01:30:50]

***Thomas Burke, MD***

[01:30:51]

You know, I think, like anything, once you get over the change and sort of the flow of how you work, it was incredibly better, you know, and so that was the ultimate proof that this was a good decision, because instead of calling somebody or having to be at a conference, the colleague you wanted advice from was in the next work area, and so you could both look at the films at the same time, you could both examine the patient at the same time, even though it was scheduled to one person. So it facilitated all of the sort of second effort of asking questions, bringing people together, getting somebody else to look at something, because it happened in real time, which was incredibly valuable to the patient, as you might imagine, because they didn't have to do three or four different appointments, and they got the mental input of four or five people, not just their primary doctor, and so I think that's what really stimulated the growth of it.

And then the outreach of this over time, not appreciated by everybody, is that everything else got disease-linked, so the original was just based on the patient piece, so it was the surgeon, the medical oncologist, and the radiation oncologist worked in the same location, and you always came to the same center. If you were the patient, you parked in the same place, you knew how to get here, so all the logistical stuff was pretty straightforward but on the back end. So the pathologist started to become specialized and attached to the team, same for imaging, so now you had people who were expert in head and neck imaging and head and neck pathology. And then, of course, everybody had connections to research laboratories and so the research programs started to build out around a much broader disease site and input site.

I think the decision to do that purely from a patient convenience perspective really jumpstarted discovery process, and so one of the reasons that MD Anderson became very successful at competing for multiple program grants and other things is because they had organized this way. So you could put together four or five teams in head and neck cancer, each of which was doing something a little bit differently because they all worked based in the same center and sort of the same interest group.

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The other piece of this is—and then if you thought about the schedulers and the people who got your insurance authorizations and the nurses who saw you also became expert in your disease. If I'm a head and neck patient, you're worried about how you can swallow and how are you doing calorie-wise. So everybody kind of got focused on those issues, so when you came to the center, the specialty expertise went way beyond what your doctor knew. You didn't have as much trouble with your insurance company because the team working the back side of the clinic knew how to get you authorized for what a head and neck cancer patient needs, and the team in the breast center knew what to do for those people, and on down the line.

So we ended up with really specialized services that I think incrementally improved outcomes for people. You're much better at looking for problems, at knowing the unique problems of a group of patients with certain diseases. And so that single decision to kind of collocate the doctors really blossomed in ways that probably for the last twenty years have been a very unique asset for MD Anderson, I think one of the reasons that it really gelled to the level it has, because those people were put together.

[01:34:57]

***Tacey Ann Rosolowski, PhD***

[01:34:59]

It's an amazing story, yeah.

[01:35:01]

***Thomas Burke, MD***

[01:35:02]

So I was a small cog in that wheel, running the GYN Center, which largely had already done a lot of this stuff, so for us it was moving the same batch of guys across the street to the Mays Clinic when we opened the GYN Center.

[01:35:15]

***Tacey Ann Rosolowski, PhD***

[01:35:19]

And it sounds like you already had the mindset, so was it easier, do you think, for the faculty in GYN to assimilate that?

[01:35:28]

***Thomas Burke, MD***

[01:35:28]

Yes, because they already worked that way, so we had it easier than some of the ones that had very traditionally been separate in terms how they worked.

[01:35:36]

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***Tacey Ann Rosolowski, PhD***

[01:35:37]

Right.

[01:35:37]

***Thomas Burke, MD***

[01:35:37]

And I think part of the strategy was that it wasn't all done at once, it was done sort of center by center, so it was staggered so you could absorb the change that occurred. And then I think people started to hear, you know, this is working really well, and as people kind of got comfortable in the process, nobody today would go back.

[01:35:58]

***Tacey Ann Rosolowski, PhD***

[01:35:58]

Right.

[01:35:59]

***Thomas Burke, MD***

[01:35:59]

I mean, they believe so—I mean, it's ingrained that this is absolutely the best way to be doing it, and a lot of the care-delivery models that are being proposed as part of healthcare reform are exactly, exactly this.

[01:36:13]

***Tacey Ann Rosolowski, PhD***

[01:36:13]

So MD Anderson was really the first to make the institutional decision to organize in this way?

[01:36:18]

***Thomas Burke, MD***

[01:36:18]

I think so, that I know of. Certainly in cancer it was.

[01:36:21]

***Tacey Ann Rosolowski, PhD***

[01:36:23]

Mm-hmm. Mm-hmm. Interesting. We've got about, like, twelve, thirteen minutes left. I wanted to—I mean, you've obviously had a really important administrative career, but I kind of wanted to—

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[01:36:46]

***Thomas Burke, MD***

[01:36:47]

We can do that next time.

[01:36:47]

***Tacey Ann Rosolowski, PhD***

[01:36:47]

Yeah, to kind of get that whole story.

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## **Chapter 9**

### **A: The Researcher**

#### ***Bringing Experience With Surgery and National Trials to MD Anderson; Research on Endometrial Cancer***

##### **Story Codes**

A: The Researcher

A: Professional Path

A: Military Experience

A: Joining MD Anderson

C: Collaborations

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

D: The History of Health Care, Patient Care

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

[01:36:47]+

But you've also had a really active research career, and I was wondering if maybe in the time remaining you'd start telling that story. How did you get started in conducting research? What was your interest in conducting research?

[01:37:06]

#### ***Thomas Burke, MD***

[01:37:08]

You know, actually, I got started in, when I was a fellow at Walter Reed, one of the large NCI-funded cooperative groups was the gynecologic oncology group. In the late seventies, early eighties, that was a group that was doing a lot of the large Phase 3 trials in the United States, and there were dozens of centers and hospitals that were part of that group, and so they typically did the large Phase 3 randomized clinical trials looking at—if you think about the historical perspective, it was times when we were sorting out the roles of radiation and chemotherapy and new drugs were coming in, and which people did better with radiation and chemo and so on, and so that was just sort of a natural backdrop to big questions that needed to be answered.

So my two mentors in the military were some of the founding people in the GOG, and Walter Reed was a major clinical site for a lot of the protocols that came forward. I always found it interesting that an Army Medical Center was at the forefront of gynecologic cancer, and you sort of say, well, how the hell did that happen, because there weren't a lot of women in the military in—

[01:38:41]

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***Tacey Ann Rosolowski, PhD***

[01:38:41]

I was thinking that myself. So what is the [unclear]?

[01:38:43]

***Thomas Burke, MD***

[01:38:43]

So the army was really good at something we probably need to do today, was bringing people to centers of excellence, irrespective of distance. So they concentrated resources in Washington [D.C.], and if you were anywhere in the eastern United States or Europe and you had a GYN tumor, and you were either active duty or a dependent or retiree of the U.S. military, you were flown to Walter Reed. And so our service, our Tumor Service, had a catchment of probably a third of the world, if you think about the sort of military distribution.

So they do those logistics really well, and they had a flight system of moving people in a regular kind of schedule that would—you know, I had people fly in from Germany who were admitted to our service. We'd have a call of who was coming when, and it was just expected that that's how we would do it.

[01:39:45]

***Tacey Ann Rosolowski, PhD***

[01:39:45]

Which means, I guess, that you would see an amazing array of tumors.

[01:39:48]

***Thomas Burke, MD***

[01:39:49]

You do. So it lends itself to those clinical trials development, because you have a pretty broad patient base.

So the gynecologic oncology group was a great way to get started with clinical trials, so I learned a lot about—and it was a much simpler time, but they still had institutional review boards, you still had to write protocols, you had to do other things. And when I came here, there were still a lot of unanswered basic questions about treatment modalities, and so it was relatively easy to produce a protocol that would answer a legitimate question, and the regulatory overlay of how hard it was to do that was much less than it is today.

[01:40:41]

***Tacey Ann Rosolowski, PhD***

[01:40:41]

Now, you said earlier that the people at MD Anderson were excited about you joining the

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department because you brought something that was going to meld with what they did. What was it that you were bringing in this area?

[01:40:55]

***Thomas Burke, MD***

[01:40:56]

You know, I think most of the experience was I was the only one who had participated in a national trials program. All the trials that had been done here were very specific to MD Anderson and they had not been in the tradition of recruiting outside partners or looking at trials outside of the main campus.

[01:41:16]

***Tacey Ann Rosolowski, PhD***

[01:41:16]

So that was what the issue was, you had a skill of attracting partners. What were they looking for?

[01:41:23]

***Thomas Burke, MD***

[01:41:24]

I think they were looking—the two things I brought, I think, that were different was I had a very strong surgical training background, and I had that sort of more generalized experience with outside connections and relationships. And things were becoming more national at the time, and so branching out was an agenda for the group, and I think some diversity of skills and training, you know, makes for richer experience.

So I think the other research piece when I came here is I came at a time where three or four of us came into the department at the same time or similar, within a few years, and so I think one of the strategies that was highly successful was you don't want your young faculty members getting in each other's way, and so you have to provide everyone with a career track that lets them develop an academic interest and expertise without interfering with their colleagues.

So we were at the time, each of us had a disease area of interest, so Mitch Morris, who was a professor with me, who trained here, came on the same time, and Mitch was sort of assigned to the cervix cancer area, and I took the uterine cancer piece and vulvar cancer, and we had other people that took preinvasive disease, and we had another group that looked it over. So there was sort of a natural opportunity, if you will, built in for me to develop the clinical trials around uterine cancer, for Mitch to develop the trials around cervix cancer. So each of us, while we shared writing papers and manuscripts and taking care of patients, the responsibility for those programs and having the trials that were appropriate to those patients kind of were separated. So it was a great way to sort of develop an area of interest and expertise.

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## **Chapter 10**

### **A: The Researcher**

#### ***Research on Gynecologic Cancers; the Impact of Research on How a SPORE is Administered***

##### **Story Codes**

A: The Researcher

A: Overview

A: Definitions, Explanations, Translations

B: Discovery and Success

C: Offering Care, Compassion, Help

C: Patients

C: Cancer and Disease

C: This is MD Anderson

C: Patients, Treatment, Survivors

C: Funny Stories

##### ***Thomas Burke, MD***

-[01:44:02]

So a lot of the early things I worked on were in endometrial cancer and trying to define—at the time, it wasn't clear what you should do for staging operations to learn about lymph node spread in other areas.

[01:44:02]

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

[01:44:03]

Could you talk to me a little bit about what that means? I'm not a surgeon. I don't know [unclear].

[01:44:08]

##### ***Thomas Burke, MD***

[01:44:08]

So, traditionally, if you had uterine cancer, we took out your uterus, and so the people whose tumors were just confined to their uterus did well with that treatment, and then there was a whole group of people who had microscopic disease already spread from the uterus at the time of the diagnosis, and taking out their uterus would not cure them. So there's a whole era of probably a decade or more where combinations of lymph node biopsies and abdominal examinations and other tissue samples were used to try to define could we figure out who those people were who

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were likely to have spread and who would benefit from treatment beyond surgery. So that was the conceptual piece. So I've done a lot of work in that area.

Then I also did a lot of work in—some people ahead of me had started to—vulvar cancer is a very rare cancer of sort of the vulvar skin. It is a skin cancer. Dr. Rutledge was one of the pioneers of a very radical operation used to treat that, that essentially removed all of the skin of the groin in the vulvar area. That had been the traditional way to treat people. It was usually a disease of elderly people in their seventies and eighties who neglected early cancers and came in with late cancers, so these were very difficult patients to treat.

So a lot of what I did was to try to reduce the radicality of that treatment. So a lot of our early work was around combining radiation with surgery, more limited surgery, to try to reduce the physical impact of treatment. And then as chemotherapy became available, we added some chemotherapy agents to the radiation treatment, which enhanced its impact. So, over time, the surgical treatment became less and less and less aggressive and had similar outcomes. So those are very rare disease patients. You know, there's a couple of hundred a year in the United States, but being at MD Anderson, you had a unique opportunity to collect larger experiences and so—  
[01:46:22]

***Tacey Ann Rosolowski, PhD***

[01:46:23]

And what—I mean, despite the fact that those tumors are so rare, those tumors or conditions are so rare, what does resolving or improving a problem like that teach you about other forms of cancer?

[01:46:36]

***Thomas Burke, MD***

[01:46:36]

Well, for this, it was an opportunity to drive that across the country. I mean, we radically changed the management of people with this disease. And the other issue is it started to become a disease of younger women because of the HPV virus. Both cervix and vulvar cancers are driven by HPV viruses, and so as more people in our population became infected by HPV, the disease has moved into a younger age group. So having less radical treatment options and earlier diagnosis for those people was really a valuable input.

So then we used that experience to compete for some of the early uterine SPORE grants. SPORE grants are the large, multi-team grants. Maybe I'll finish with the story on our first one, which is probably almost fifteen years old, maybe twelve. We had two young faculty members, Karen Lu, who was recruited here after training in Boston, and then Russell Broadus, who's a pathologist and also a PhD scientist, who had come forward. The SPORE grants were just coming out. At the time, the total research investment in uterine cancer in the United States was probably under

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\$20 million.

[01:48:22]

***Tacey Ann Rosolowski, PhD***

[01:48:23]

Wow.

[01:48:23]

***Thomas Burke, MD***

[01:48:23]

And, you know, when we looked at it, big diseases like prostate cancer or breast cancer had millions of dollars, hundreds of millions of dollars of research investment, because they had a patient base that was very politically astute and proactive, and so the patient base was able to essentially drive the research agenda. Women who got uterine cancer are usually older and they're often obese and diabetic and hypertensive, and it's not a group that's politically active and out there agitating, and a large amount of them were cured by surgery, so there wasn't a disease driver for research.

So Karen and Russell came forward, and they said, "We really would like to apply for one of these SPORE grants, because we think we could really jumpstart research in uterine cancer that has really been ignored, and we don't have the sort of experience horsepower to successfully compete for the grant." So I didn't have the basic science background that would drive a big project, so they said, "Would you work with us? We've recruited George Stancel [Oral History Interview]," who was at UT Health and the dean of the School of Biomedical Sciences at the time, and had done a lot of work in estrogen-receptor research.

So George and I said, "We'll be the front guys who have sort of the bigger profile, and you guys can be the science generators kind of below the radar." So we had a couple of conference calls with the team at NCI that was sort of sponsoring SPOREs, and we said, "You know, you're really not investing any money in this disease, and we think we could put together a group. There's not a lot on the ground that we could kind of start with, but here's our ideas." And they actually helped us to craft a program that came forward, and we successfully got the first uterine cancer SPORE.

Karen and Russell have done a phenomenal job. They were the horsepower behind it, and George and I kind of did the administrative piece. But a lot of new discovery and new concepts and projects have come forward from that, and because of the seed money that comes with the SPORE grant, they were able to attract a lot of young investigators who previously wouldn't have thought about doing that. So I think it was a really valuable contribution to generate interest.

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I'll tell one funny story. We may have to edit it out if it's too inappropriate. (Rosolowski laughs.) One of the concepts that we had proposed was we wanted to have some patient advocates as part of our program, and the SPORE program was trying to do that, was trying to connect patients with research teams. So we ended up, as we started, with two people who were terrific volunteers for us. One was Irene Hunsicker, whose husband, Jerry, used to be the general manager of the Astros, and Irene was a uterine cancer survivor. She's ultimately died of another cancer, but at the time she was a great advocate for us. We also recruited Fran Drescher, who was a movie star of the television show *The Nanny*, and she had had cancer also. I don't remember exactly how we got connected to her, but we did.

So the Astros have agreed to sponsor a Uterine Cancer Night at Minute Maid. I think it was probably called Enron Field at the time. Irene had arranged for the Astros to provide their favorite recipes in a cookbook, and we were selling the cookbooks for twenty bucks a pop, and the money went to the uterine cancer program. So all the people in the department and all the people in the program were selling cookbooks on the concourse and—  
[01:52:44]

***Tacey Ann Rosolowski, PhD***

[01:52:44]

That's great.

[01:52:45]

***Thomas Burke, MD***

[01:52:45]

—and it was a great publicity for the thing. There was a public service announcement on the big screen.

But the highlight of the evening was Fran Drescher was going to throw out the first pitch. We had a lovely box and a reception ahead of the game that Irene and Jerry had arranged for, and so we're all getting ready to sit down and watch the game. Fran is wearing this low-cut blouse, and I said, "She wants to be on the big screen in this provocative outfit." (Rosolowski laughs.) And I said, "I know exactly what's going to happen." Irene has arranged for the Astros to produce a jersey with her name on it, so I said, "Irene wants Fran to walk out and throw the pitch out wearing the Astros jersey with her name, and Fran wants to walk out and throw out the first pitch in this low-cut outfit. So I want to see how they resolve this dilemma." (Rosolowski laughs.)

So her publicist and others, they're talking it over in the back, and so she puts on the jersey and she walks out to the mound and takes it off and throws the pitch. So she accomplished both events.

[01:53:58]

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***Tacey Ann Rosolowski, PhD***

[01:53:58]

Both missions. (laughs)

[01:53:59]

***Thomas Burke, MD***

[01:53:59]

I said, “This was a good cooperation.” And the two of them were absolutely wonderful—

[01:54:04]

***Tacey Ann Rosolowski, PhD***

[01:54:04]

It’s all about spectacle. (laughs)

[01:54:05]

***Thomas Burke, MD***

[01:54:05]

—advocates, you know, advocates for our program and kind of got us jumpstarted in getting that done.

[01:54:12]

***Tacey Ann Rosolowski, PhD***

[01:54:12]

Excellent.

[01:54:12]

***Thomas Burke, MD***

[01:54:12]

But what a great way to sort of link a discovery agenda with a great group of people with some—

[01:54:20]

***Tacey Ann Rosolowski, PhD***

[01:54:20]

With the public.

[01:54:21]

***Thomas Burke, MD***

[01:54:21]

—patients and the public and community, and it just kind of worked out that way. Okay?

[01:54:26]

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***Tacey Ann Rosolowski, PhD***

[01:54:26]

Thanks so much for that story. And, yes, why don't we quit for today.

[01:54:28]

***Thomas Burke, MD***

[01:54:28]

Good.

[01:54:29]

***Tacey Ann Rosolowski, PhD***

[01:54:29]

And I look forward to talking [unclear].

[01:54:30]

***Thomas Burke, MD***

[01:54:30]

All right. So this was easy.

[01:54:32]

***Tacey Ann Rosolowski, PhD***

[01:54:32]

Yeah. It's five minutes after three, and I'm turning off the recorder. Thank you so much.

[01:54:38]

***Thomas Burke, MD***

[01:54:38]

Great. Thanks.

[01:54:38] (End of Audio Session One)

Thomas Burke, MD  
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**Chapter 0:B**  
**Interview Identifier**  
**[00:00:00]**

*Tacey Ann Rosolowski, PhD*

[00:00:00]

Okay. Now we are recording, and the recorder is moving, which is always a nice thing. And I'm Tacey Ann Rosolowski, and today is March 18, 2014. The time is 1:32, and I'm in the Mid-Main Building on the tenth floor interviewing Dr. Thomas Burke for our second session. And thanks again for making the time to do this.

[00:00:26]

*Thomas Burke, MD*

[00:00:26]

My pleasure. Always fun.

[00:00:27]

*Tacey Ann Rosolowski, PhD*

[00:00:27]

Yeah?

[00:00:27]

*Thomas Burke, MD*

[00:00:27]

Yeah, this has been good.

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## **Chapter 11**

### **B: Institutional Change;**

#### ***Maintaining MD Anderson Culture Despite Institutional Growth and Financial Challenges in Healthcare***

##### **Story Codes**

- B: Multi-disciplinary Approaches
- B: Growth and/or Change
- B: Controversy
- B: The Business of MD Anderson
- B: Institutional Mission and Values
- B: MD Anderson Culture
- D: Fiscal Realities in Healthcare
- D: The Healthcare Industry
- C: Understanding the Institution
- C: The Institution and Finances

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

[00:00:27]

Good. I'm glad. Well, we had a question, as I mentioned before we started the recorder, that I wanted to follow up on from last time, because you had mentioned that when you arrived at MD Anderson, it took a little while for you to adjust your style to MD Anderson. And I wondered if you'd talk a little bit about what that—what was the gap there and what was involved in you adjusting?

[00:00:50]

##### ***Thomas Burke, MD***

[00:00:53]

I think maybe I'd approach this from the broader perspective of what sort of view does the MD Anderson culture, because a lot of the conflict that arises in any organization, and ours in particular, is when things seem to run counter to sort of the cultural view of the place.

So at the time that I came to MD Anderson, it was a much smaller environment, and so the culture was based upon face-to-face communication and time working together in clinical and research environments, and so it was a much more traditional informal relationship between people. You kind of gathered around some common goals of excellent patient care, discovery, innovation, and sort of the free exchange of ideas and concepts.

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As the organization has grown bigger, those have become more formalized into kind of what I would say are the main themes of MD Anderson today, which are sort of multidisciplinary care. That had its start way back, twenty-five, thirty years ago, maybe even beyond that, but from my perspective, that far back. And then the other piece was that research questions and clinical trials opportunities were automatically married to the clinical environment and injected into the everyday work that people did. So it's been hard to sort of keep the personalized version of that framework as you grow to an organization with, you know, 1,500 faculty and 20,000 employees from one that was, you know, at that time maybe 200 faculty and 2,000 employees.

So I think that's a challenge, and I think the core pieces of that have always remained intact, and they've been facilitated by having a completely employed workforce, so that no therapy decisions, no sort of nudging patients toward one treatment or another were ever directed by personal financial gains. It kind of connected back to my time in the army where you just sort of made the best decisions because there was never a financial stake in what happened with those decisions, and it kind of led to a really clean way to provide care to people because you really were recommending what you thought was the best treatment without the overlay of finances.

So, MD Anderson, because they employed nearly all of the people that work here, was never really in a position of making treatment decisions based on personal financial stakes of any of the care team, and I think that supported the culture a lot because it kept the exchange of ideas and the freedom of where to recommend treatments and other things pretty clean. So I think that got embedded over time.

I think one of the really hard things for MD Anderson over the time that I've worked here is we've had to become increasingly more financially aware. You know, at a time twenty years ago, there was a lot of money in healthcare, our agenda was perhaps less expensive, and it was possible to fund and subsidize the kinds of things we wanted to do as an organization from the revenues that we made, and, of course, just taking care of people and being paid for those services. And then over time, that's become increasingly more difficult. The clinical revenue side has become increasingly tight. I mean, that's a national perspective that just plays out here.

But the same has happened on the research side and the education side, and sort of if you look at all of the mission areas of the institution, the revenue trails of those have been squeezed, so a lot of the, I think, current issues around culture and the connection to mission are being framed around the financial realities of what it's like to survive in a healthcare and research environment today, and we're going to have to figure that out. I don't think we have completely.

[00:05:51]

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***Tacey Ann Rosolowski, PhD***

[00:05:52]

Can you give me an example of that tension between culture issues in relation to mission with this financial piece?

[00:06:01]

***Thomas Burke, MD***

[00:06:02]

We just never talked about money. You know, money was never part of the conversation twenty years ago. It was, “Here’s an idea. We think this is a great thing. We’re just going to do it, and we’ll put in place the people and the infrastructure to make that happen.” And so the budget was a very high-level framework that didn’t have the detail that it has today or the complexity that it has today, so I think everyone got used to working from the idea and the best outcome and the best care for patients concept rather than, oh, and we have to pay for it, and then we have to have ways to support the other agendas of the institution.

So one of the things I think that Leon Leach [Oral History Interview] brought to the organization when he came, what, a dozen or so years ago as our chief financial officer was some financial clarity and transparency around how the organization performs financially, where the money comes from, how we spend it, and today we take for granted that all of us know literally month by month how we’re performing as an organization from the financial side. And I think that’s a good thing. I think we should understand that and we should make intelligent choices about what we’re going to invest in or not invest in, understanding that we have to remain financially viable as an organization.

And I think that’s where some of the cultural angst arises, is that we always grew up making decisions on what we thought were the best ideas, the best care for patients, the best training environment, irrespective of the costs of those, and now we have to have that overlay. So I think that’s been difficult to adjust to as an organization, and you hear a lot of the people that have worked here a long time kind of be uncomfortable about we’re being driven as a business as opposed to a healthcare environment. Well, the truth is if you look anywhere in the United States, everybody’s being driven as a business and going to have to survive on that because we can’t, as a country and a people, spend what we spend today on healthcare. So—

[00:08:21]

***Tacey Ann Rosolowski, PhD***

[00:08:22]

Can I ask you a question? Because, I mean, I don’t know if you have enough information at this point to answer this question, but I’m thinking about generational differences, you know. I mean, you came in 1988. I mean, most of the people that I’m interviewing, who have certainly echoed

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much of what you just said here, have watched the institution grow from that small, more—some people called it a mom-and-pop kind of scenario, to a corporation, in a sense, with all of those tensions with culture and finances. But you certainly have people coming in at lower levels who have been raised in a different kind of model, who maybe understand or they take it as a given that it is a financial operation. Do you foresee differences in the kind of leadership they're going to bring? I'm just wondering if you have inklings of that generational change.

[00:09:12]

***Thomas Burke, MD***

[00:09:14]

I've always looked at this from the perspective of what really makes the institution unique is when all of the mission areas are in the right balance. I have a longtime perspective, and so I've seen times where I thought the research side of the house was overemphasized and the clinical side got out of whack, or we focused way too heavily on revenue generation off of the clinic, to the hindrance of our training and research agendas, and so at the very high strategic level, I think the trick has always been to keep those in balance.

I think the younger people and those coming into the institution have probably a much greater appreciation that healthcare is a business, because that's the way they've grown up and come through training programs. I think they understand that much better probably than the older component of our workforce that kind of has been here for twenty-five or thirty years, but I think they lack the strategic view of what that really means, because if you just take the business perspective, then you would be led to make decisions, well, we only want to have clinical trials for people that have diseases with insurance coverage, or we don't want to invest in things that won't track to a revenue source. So screening services, prevention, education, things that are large mission pieces of MD Anderson, don't track to a good revenue source, and so if you start to make all of your decisions on that perspective, it will lead you to make us look like any other healthcare entity, and then we're not the institution that we are.

So I think that's the kind of pressure against it. So at one level, you have to kind of keep the strategy to the core of the missions and the agenda and understand the money, but you don't want to be completely driven to make decisions on the financial side, or you don't want to be such bad managers that you end up in a place where you're forced to do that as a survival choice.

[00:11:38]

***Tacey Ann Rosolowski, PhD***

[00:11:38]

Absolutely. Absolutely. Thanks for clarifying that. I'm sure we'll come back to this topic a number of times since, obviously, you know, you've had really extensive experience dealing with these issues. (laughs)

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[00:11:50]

***Thomas Burke, MD***

[00:11:50]

Well, you know, it's a great transition. We all used to be in—at the time I was talking about the two hundred faculty, we all used to live across the street on Holcombe Boulevard in three connected buildings. They were the original buildings of the institution. When we decided to build the first Faculty Center, it was a revolt. We couldn't possibly walk across the street. How could our offices be across the street from our clinical environment? And then I look today, and we're stretched across a huge campus, a research campus a mile south, places around the city, around the country, and clearly we got past the issue of we couldn't walk across the street.

[00:12:34]

***Tacey Ann Rosolowski, PhD***

[00:12:34]

But change is always hard. (laughs)

[00:12:35]

***Thomas Burke, MD***

[00:12:36]

So the reality, when you're talking about cultural conflict, is there has been a huge cultural shift on a more subtle level that has acknowledged growth and sophistication and complexity and kind of embraced those things while fighting against some of the sort of economic pressures of doing the other things that we talked about. So I would say that while you will hear references back to we've sort of lost that original culture, we probably haven't on the core things. That's still there. It's just the size, complexity, and the deployment of those things is much different today than it was twenty or twenty-five years ago. And it's always nice to reminisce and remember when you sat in an office with your friends and it was a core group of committed people who had a pretty focused agenda, and it was just fun to work under that kind of an environment.

[00:13:46]

***Tacey Ann Rosolowski, PhD***

[00:13:46]

And the realities are different.

[00:13:47]

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***Thomas Burke, MD***

[00:13:47]

The realities are different today, and, frankly, you couldn't do well if you had that small a group and just a small core. You have to be broader to encompass what you need to do today.

[00:14:00]

***Tacey Ann Rosolowski, PhD***

[00:14:02]

Would you like to shift gears at this point?

[00:14:04]

***Thomas Burke, MD***

[00:14:04]

Sure.

[00:14:04]

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## **Chapter 12**

### **A: The Administrator**

#### ***Medical Director of the Gynecologic Oncology Center: Developing Processes and Faculty Talent***

Story Codes

A: The Administrator

A: Character, Values, Beliefs, Talents

B: MD Anderson History

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

B: Institutional Processes

C: Understanding the Institution

C: The Institution and Finances

C: Leadership

C: Mentoring

***Tacey Ann Rosolowski, PhD***

[00:14:04]

Okay. We began talking last time about some of your roles as medical director of the Gynecologic Oncology Center. Am I getting the name correct?

[00:14:13]

***Thomas Burke, MD***

[00:14:13]

Right.

[00:14:13]

***Tacey Ann Rosolowski, PhD***

[00:14:14]

Okay. That was from 1989 to 1998. But I wanted to make sure that we really talked about, you know, what you envisioned for that. I mean, I think that was the role you said that no one else wanted the job, so you were tapped for it. (laughs)

[00:14:31]

***Thomas Burke, MD***

[00:14:33]

You know, it was a really good job to kind of get your feet wet in an administrative role. You

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know, I think that the things that are required, the skill sets are required there are sort of you have to learn to build consensus, you have to be an integrator both across faculties, because we had different departments and faculty from different locations that worked in the centers, so you had to find ways to bridge that, but then also nursing and clerical people and the teams that were making insurance clearances, and so it all kind of came together in the center. So it was a little broader than just sort of a traditional either physician or faculty kind of management place.

[00:15:27]

***Tacey Ann Rosolowski, PhD***

[00:15:27]

Where did you acquire those kinds of integrative consensus skills?

[00:15:33]

***Thomas Burke, MD***

[00:15:32]

You know, I learned a lot of that in the army. I think the army is really good at that, and they teach teams from the very beginning. Unfortunately, their hierarchy is usually based on your rank, but most teams very quickly understood who the most experienced people were on the team and relied on them. It's sort of a tradition of who becomes a sergeant and who the lieutenant is or the captain is, and then if you weren't smart enough to fall back on the expertise of the people that had been on that team a long time, you would fail, and the team would fail, actually. So I think I learned a lot of those things when I was in the army.

[00:16:10]

***Tacey Ann Rosolowski, PhD***

[00:16:11]

Now, when you took over that position—and you talked last time about the qualities that people saw in you, fairness, being able to divide up resources very equitably. When you stepped into the role, I mean, what did you foresee? I mean, what did you want to accomplish with this center?

[00:16:30]

***Thomas Burke, MD***

[00:16:31]

Well, the center was really cramped and inefficient, and it was a different time in healthcare. We didn't have the regulatory and documentation requirements that we have today. It's almost horrible to describe today what that was like, but we basically ran the clinic as a free-for-all, and so patients had very loose assignments to the faculty, that you would come into the clinic with an entourage of fellows and residents and people, and then you would be given a hallway, and all the patients were appointed within the first two hours of the clinic, and you just sort of slugged through the day.

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So you could come with three or four people who were helping you, you would have people under your name, but not all of whom you had to see dictate a note for, the things we take for granted today, that, you know, faculty virtually is going to see every patient, they're going to record what happened, they're going to work with a fellow and a mid-level provider and the nurse and everyone else. At the time, it was, you know, you're just in and out of rooms and I might come in on Monday and have forty patients assigned to my clinic, all of whom came between eight and ten, and we just worked till we were done, and so—

[00:17:56]

***Tacey Ann Rosolowski, PhD***

[00:17:57]

Well, how long did it take you—I mean, did you go into that leadership role thinking, “Wow, this is inefficient. I need to do something with it,” or was that kind of a realization, “Oh, my gosh, things can be different”?

[00:18:07]

***Thomas Burke, MD***

[00:18:07]

I think most of us really didn't like working in that environment. It was stressful and it wasn't enriching to either the people we took care of or ourselves, so I think it was a pretty fertile ground to start to bring in some change.

But a lot of what became our quality improvement and process efforts kind of grew out of that sort of dysfunctional start, and so we started to look at how long do appointments last for, what's a realistic schedule that you can accomplish with the people that are there for the day. And then external forces were also there. I mean, there were requirements that if I'm billing for service as a faculty member, I actually have to have seen that patient, dictated a note that indicates that. So the rules about what was required changed, so that also forced different ideas about how you were going to organize your clinic. So instead of everybody's dictating, everybody's writing, everybody's examining patients, and I'm just sort of managing the day as it unfolds, it had to be I had to touch each of those patients throughout the course of the day, and then that forced a little more effort to make it user-friendly on both ends of the equation.

[00:19:31]

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***Tacey Ann Rosolowski, PhD***

[00:19:31]

So what did this quality control and process development—what did that look like as you went about changing the center?

[00:19:38]

***Thomas Burke, MD***

[00:19:38]

Well, in the earlier days, it was just sitting around at the department meeting and kind of getting the teams together and saying how are we going to do this better. I mean, we really did control the schedule. We booked our own templates and laid out a schedule that the clinic used to bring people in. So it was, in that regard, simpler than it is now, and you didn't have computer systems and other things. Those were largely handwritten schedules and printed out from a primitive computer screen, but certainly nothing like what happens today.

[00:20:14]

***Tacey Ann Rosolowski, PhD***

[00:20:15]

I'm just smiling because I'm remembering some of the documentation systems that you talked about last time.

[00:20:20]

***Thomas Burke, MD***

[00:20:20]

Yeah, they're pretty limited compared to—they worked and they worked well in a smaller environment, but they don't translate to scale, and so that's just part of the transition that had to happen.

And then I think quality and process improvement issues became more institutionalized, and as I had higher institutional roles, we built departments and brought in experts that did those things that worked with our clinical teams to continuously upgrade the kinds of services that we provided. But at the time, it was really local group, decisions about how could we work in a better way.

[00:21:06]

***Tacey Ann Rosolowski, PhD***

[00:21:06]

Now, you were in that role for ten years. What did you feel you were able to accomplish for the center during that time?

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[00:21:13]

***Thomas Burke, MD***

[00:21:14]

Well, I think we probably tripled our—not the size of our space, but the throughput of the patients that we had. There was a pretty significant increase. We probably had 8, 10, 12 percent increase in growth every year, so we over that time probably gained quite a bit of patient activity. We did a couple of remodels to make the space as efficient as possible, but ultimately we exceeded the envelope of the room, and that happened across the institution. So a lot of the movement across the street was driven by the growth of the institution, was such that you couldn't use the existing building structures to meet the needs of the patients we were seeing.

[00:22:05]

***Tacey Ann Rosolowski, PhD***

[00:22:06]

What about the financial piece of this? Because it was—

[00:22:09]

***Thomas Burke, MD***

[00:22:09]

It was never a part of it.

[00:22:10]

***Tacey Ann Rosolowski, PhD***

[00:22:11]

Really?

[00:22:11]

***Thomas Burke, MD***

[00:22:11]

It was never a part of it.

[00:22:12]

***Tacey Ann Rosolowski, PhD***

[00:22:12]

Really?

[00:22:12]

***Thomas Burke, MD***

[00:22:12]

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Yeah. It was—  
[00:22:13]

***Tacey Ann Rosolowski, PhD***

[00:22:14]

Tell me how that happened. How did that not become a part of it? (laughs)

[00:22:16]

***Thomas Burke, MD***

[00:22:17]

The finances of the institution at the time were a black box, so they were at a very high level. I was never privy to it. We would advocate for resources based on the growth of our patient care level, and there weren't hard metrics or comparative metrics across the institution that I'm aware of as to how those were assigned, so—

[00:22:46]

***Tacey Ann Rosolowski, PhD***

[00:22:46]

Even tracking the revenue generation for the center?

[00:22:50]

***Thomas Burke, MD***

[00:22:50]

Had no clue.

[00:22:52]

***Tacey Ann Rosolowski, PhD***

[00:22:52]

Really? Wow. That's amazing.

[00:22:53]

***Thomas Burke, MD***

[00:22:53]

So we managed without knowing any of the financial.

[00:22:56]

***Tacey Ann Rosolowski, PhD***

[00:22:57]

I mean, that really underscores the point you made about Leon Leach's arrival and how that provided some clarity.

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[00:23:03]

***Thomas Burke, MD***

[00:23:04]

Yeah, it was a very dramatic shift.

[00:23:05]

***Tacey Ann Rosolowski, PhD***

[00:23:05]

Yeah, yeah. Huh. So, I'm sorry, I kind of derailed you from talking about, you know, what that ten-year span was like. You talked about 8 to 12 percent increase in growth each year. I mean, what else was occurring over that period?

[00:23:21]

***Thomas Burke, MD***

[00:23:22]

Well, I think obviously growth of our faculty, growth of our staff to match that, and complexity, because in the time intervals a lot of new things were coming into cancer, and there was a lot of growth in the chemotherapy side, more sophistication in radiation, and a lot of the surgical emphasis was on de-radicalizing sort of traditional surgical operations, so the era of the fifties and sixties was about big operations and very complicated procedures because there weren't other modalities that could be employed. So as radiation became more curative and chemotherapy was added into the mix, there was a pressure to make those surgeries less radical. So that was kind of the era at the time.

[00:24:20]

***Tacey Ann Rosolowski, PhD***

[00:24:20]

Now, did this include the two- and three-team surgical procedures [unclear]?

[00:24:24]

***Thomas Burke, MD***

[00:24:24]

No, those were different, so those came on later as more sophistication, and because you could then extend surgery to a whole group of patients that you would not have considered that an option for before. But I think a lot of what I learned in the clinic was a really growth area for administrative skills at a time where you were still very clinically connected to the group, and so most of the people, even today, that we use in the roles of clinic leadership at that level are sort of mid career, early career clinical people that are very busy and have a lot of credibility amongst their peers as skillful clinicians and people who understand patient care. So many of them bring

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dimensions today of sort of process and business because those have become part of what we do, but their major skill set is still clinical care, recognition amongst the care teams that they are expert at that, and probably the other dimension is that they're consensus-builders across the team, because the fairness issue around resource assignment and utilization is an important piece for outpatient clinics to work in.

[00:25:52]

***Tacey Ann Rosolowski, PhD***

[00:25:53]

How would you describe your evolution of your skill set, philosophy of leadership during this ten-year period?

[00:26:02]

***Thomas Burke, MD***

[00:26:04]

You know, I got much better at dealing with conflict. I think many of us are conflict-averse. We don't do well in conflict situations. I got much better at managing that, and I got a lot better at identifying individual agendas and separating them from what should be the agenda of the group or the clinic. And so people always advocate for what's important for them, so part of the distinction of kind of being in a more leadership role is to decide what's the individual advocating for and what are the things being advocated for that help all of it. So being able to distinguish those is important, and being able to tolerate conflict within the team, I think, is important.

[00:27:00]

***Tacey Ann Rosolowski, PhD***

[00:27:01]

Now, when we were talking about your selection of surgical specialty, you said a number of times that you kind of intentionally set out to become a certain kind of presence in the operating room and crafted that. And I'm wondering did you do the same kind of thing in a leadership role. Did you decide what kind of leader you wanted to be?

[00:27:24]

***Thomas Burke, MD***

[00:27:25]

You know, I think initially I tried things out. I don't think I set out—when I became the physician-in-chief at MD Anderson, I had a very specific strategy I was trying to accomplish, probably in between, and as I was kind of moving toward that part of my career, I was less focused on a specific strategy and agenda. And I got a start in most of the—I moved out of the clinic and really did—I took roles in our organized medical staff structure, so I was on and then

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was the chairperson for some of the medical staff committees that kind of run the medical practice pieces of any hospital in America, really, and that actually led to my appointment as the head of, first, the Credentials Committee and then the Executive Committee of the Medical Staff. So those are the two sort of lead practice committees, and that was sort of a channeling of an administrative role. I did a lot of that while I ran the clinic. I started as I was still the head of clinic, but that was kind of a shift and—

[00:28:45]

***Tacey Ann Rosolowski, PhD***

[00:28:45]

Why were those key committee appointments for you as a leader?

[00:28:48]

***Thomas Burke, MD***

[00:28:49]

I think the really great learning pieces of those assignments is it gives you a network much wider than your departmental one. So the clinic one is pretty narrowly focused. It's my department, a few others, it's the people that treat the diseases that I treat, and it's a more collegial kind of family group. And if you start to think about the entire medical staff, then you really start to build a network that kind of reaches all of the departments and divisions, and you really get the perspective of other practice environments. So the way a medical oncologist works is very different than the way a surgeon works, and the same for a radiation oncologist or someone who works in imaging or pathology. So being in those medical staff groups exposes all of those different—they work in different ways. They have different styles. They have different needs.

[00:29:56]

***Tacey Ann Rosolowski, PhD***

[00:29:56]

Can you give me an example?

[00:29:57]

***Thomas Burke, MD***

[00:29:58]

Well, if you're in medical oncology, most of your work is in an outpatient clinical environment, and everything you do is tied to I'm seeing a patient today in the clinic. If you're a surgeon, the big component of your work is in an operating room, and you partition your week so that you're in the clinic to see the people that you need to move to the operating room and then as they recover as they kind of move out. And that's a different workflow and environment and kind of how you think about organizing your week than everything as an outpatient piece.

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In radiation oncology, at the time everybody was geographically connected to the equipment because we didn't have electronic systems to transmit things, so it was important that you were physically located where treatment was taking place. Because of the shielding, it's always in the basement so that you could support the weight of the equipment and the walls in those rooms. So that's a different work environment, where your office is right next to the equipment that your patients are being treated on, and you're really only managing a segment of what happens. So if you think about planning your week in that environment, it's different than somebody who floats between a clinic and an operating room, different from somebody who's in the outpatient side all the time. So, understanding those different perspectives, I think, is something that you gain from those sort of broader institutional things. And the other is, as I said, the network of people that you build is also different.

So, for me, those were really good opportunities, and, frankly, the hospital and the physician workforce can't function without those things. We are so regulated today that those things all have to be in place and work, and it's an underappreciated role. It's a great role for young people coming in, I think. I look for a lot of opportunities to put young people on those committees and then hope that some of them will grow with the leadership roles, because it gets them out of their sort of comfort zone of their own department and their own treatment area.

[00:32:27]

***Tacey Ann Rosolowski, PhD***

[00:32:27]

I was going to ask you earlier, when we were talking about generational differences, how you mentor some of the younger faculty from this different generation so that they understand the culture issues and not just the financial issues, and I'm wondering is this the place. Would putting a young faculty member into a committee like that help them make the connection?

[00:32:52]

***Thomas Burke, MD***

[00:32:55]

I think the real value of that is that gives people a chance to develop themselves. I mean, ultimately, if you're going to be successful, you own part of that. My view was always I would like to look for people who I thought had great potential from whatever dimension. They were great communicators. They were really thoughtful clinicians. I saw them build consensus around the work team. I heard of things they did. Later in my career, we had formal training programs, so I looked for people who were in those programs. But then, you know, you need to put them in a role and see if they gravitate to it. So some people say, "You know, I really don't want to do this, and I was perfectly happy just taking care of people, running a clinical trial, whatever I did as my work assignment, and I don't really need the other piece," or, "It doesn't fit me." And so that's fine, that's a choice, and they'll take a different direction.

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But some of them would say, “I really enjoy this,” or that would be a way to move faculty and clinical people into some administrative roles. And, you know, the reality of working here is that faculty have to take those positions. You know, you cannot do everything that we do run through an administrative-only structure, and so if you don’t have a steady stream of people who are committed to the clinical and the research and the teaching components of what we do who assume administrative roles, you won’t embed that in what we build and how we go forward. You just divorce those things, and it’ll just be a different organizational change because of that. By the same token, you want to acknowledge that some of those areas of administration and management and leadership bring unique expertise that you wouldn’t traditionally find in clinical people.

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## **Chapter 13**

### **A: The Administrator**

*Serving as MD Anderson's Chief Medical Officer and Physician in Chief.*

Story Codes

A: The Administrator

B: Growth and/or Change

B: MD Anderson History

B: MD Anderson Snapshot

C: Professional Practice

C: The Professional at Work

C: Understanding the Institution

C: Leadership

***Thomas Burke, MD***

-[00:35:30]

So this is probably a good place to interject how I plan to build my team as the physician-in-chief, is that I wanted—

[00:35:30]

***Tacey Ann Rosolowski, PhD***

[00:35:30]

Just for the record, let me say physician-in-chief for 1998 was [unclear].

[00:35:40]

***Thomas Burke, MD***

[00:35:40]

Actually, I was in a different role in '98. I was a part-time—at the time we called it a chief medical officer, and it was sort of a half-time position. I worked out of the sort of clinic operations. Clinic and Hospital Operations is what it was called.

[00:36:00]

***Tacey Ann Rosolowski, PhD***

[00:36:00]

And what was this role? What was your—

[00:36:02]

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***Thomas Burke, MD***

[00:36:02]

It was sort of an extension of the role I had as the medical staff lead. So I was asked by the people who were in charge at the time—Dave Hohn was the vice president—and it was getting too complicated for one physician to kind of run all of the practice issues, and so I had had these other medical staff assignments, and so I had been recruited to come into that group.

I needed to protect my clinical practice, so I carved out some assignments that I thought I could compartmentalize into a schedule so that I could both manage the clinical side and manage the administrative piece. So I took off sort of being the administrative director of the medical staff functions, so the medical staff roles are all filled by clinical people who are practicing medicine, and I sort of became the administrative connector for those. Then I took on also probably the prerunner of patient satisfaction and support groups. We always had a patient advocacy team. We had a group at the hotel who facilitated patient interfaces. So there were a bunch of groups that kind of worked as the patient face of the organization. And then I also took on the medical liability side.

So those were things that I could schedule into sort of half-day blocks of my week, and I could have predictable time to manage. So I just negotiated with Dr. Hohn that, “I’ll unload these pieces from what you’re doing,” and then you can focus on other things that were a little more firmly defined and really what you wanted to be spending your time with. And so that was kind of the way I started in that role.

[00:38:07]

***Tacey Ann Rosolowski, PhD***

[00:38:08]

Now, what was that year that you started in that role?

[00:38:10]

***Thomas Burke, MD***

[00:38:12]

You know, I probably don’t—it’s probably in the late nineties.

[00:38:14]

***Tacey Ann Rosolowski, PhD***

[00:38:14]

I’ll look on your CV. Yeah, late nineties.

[00:38:15]

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***Thomas Burke, MD***

[00:38:16]

Yeah, I think it's in the late nineties.

[00:38:17]

***Tacey Ann Rosolowski, PhD***

[00:38:17]

Okay. I'll look on your CV.

[00:38:19]

***Thomas Burke, MD***

[00:38:19]

So I did that fifty-fifty for probably five or six years, and I gradually took on a few—you know how these work. You take on a little more and a little more. Then I got to place where we had a fairly large administrative restructuring of the institution. I had been working at the end of that time for a chief operating officer named Kevin Wardell, who was recruited from Chicago to come in, and really was the first—not the first, but was one of the early healthcare administrators who came into the institution, and so I worked for him as the chief medical officer. So the structure at that time was we had sort of a chief operating officer, that was his role, and then I worked under him to kind of do the medical pieces of that. Then we had a chief academic officer, and the chief financial officer was sort of the trilogy, if you will, of the leadership underneath the president. It was right after Dr. Mendelsohn was named as the president, and a couple of people in that mix had been candidates for president, and so there was sort of a changing of positions, and some people left the institution and some restructuring. So ultimately—

[00:39:47]

***Tacey Ann Rosolowski, PhD***

[00:39:47]

This was in 1996?

[00:39:48]

***Thomas Burke, MD***

[00:39:49]

Yeah. So it ultimately shifted around, and I sort of stayed in that chief medical officer role while the upper levels of the administration were sort of redefined. And then David Callender became the chief operating officer and he had been working on the academic side, so I started out staying in the role of chief medical office, but working for him instead of Kevin Wardell. And after a while, he said, "I need you to come full-time."

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So I had always kept a perilous balance at that point between half administration and half patient care, and so I had always resisted further reductions in my clinical environment. So I really—I took a couple weeks to think through it, because it was a major shifting point, and I knew that I couldn't continue at the level I was and do well on both sides, because when people are sick, you need to be completely committed to them, and on the administrative side it would take me six weeks to get the right decision group in a room together at the same time, and I couldn't have a patient emergency derail that. So I was at a point where it was not possible to make all of that work, so I—

[00:41:20]

***Tacey Ann Rosolowski, PhD***

[00:41:20]

So why did you shift to the administrative side?

[00:41:22]

***Thomas Burke, MD***

[00:41:22]

Well, I decided that you only get so many of these opportunities in your career, and when they come your way, you should be willing to take them. And I decided also that while I completely loved the interchange one-on-one with people, that I could influence what happened in a much broader way to a much larger group of people if I had an administrative role than if I was one-on-one as their doctor.

[00:41:56]

***Tacey Ann Rosolowski, PhD***

[00:41:56]

What did Dr. Callender see in you? I mean, why—I mean, obviously, you've been in the role, you've been working closely together, but, you know, why you?

[00:42:08]

***Thomas Burke, MD***

[00:42:09]

Well, I think, in retrospect, I think it was because he was planning to depart. (Rosolowski laughs.) So the way it actually unfolded is I spent a couple weeks, I told him I needed to think it through. I came to him, and I said, "You know, I'm willing to do this."

And so a month later he announced that he was going to be the executive vice chancellor at UCLA and left Houston to that assignment. I haven't talked to David about it since that event, but I suspect part of the motivation was he needed somebody to be able to backfill some of that role, so I took an interim role at the point that that happened.

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[00:42:53]

***Tacey Ann Rosolowski, PhD***

[00:42:53]

So just to make sure that I know, what was that role, what was your title, and what year was this?

[00:42:58]

***Thomas Burke, MD***

[00:42:58]

We'd have to look up the year.

[00:43:00]

***Tacey Ann Rosolowski, PhD***

[00:43:01]

[unclear]. (laughs)

[00:43:01]

***Thomas Burke, MD***

[00:43:01]

Yeah, I'm going to have to look up the year. I did all this fuzzy—

[00:43:04]

***Tacey Ann Rosolowski, PhD***

[00:43:05]

I can put it in. But your title was?

[00:43:07]

***Thomas Burke, MD***

[00:43:07]

The title was sort of the interim COO at the time.

[00:43:11]

***Tacey Ann Rosolowski, PhD***

[00:43:11]

Okay. So what was the scope of your responsibility? (laughs)

[00:43:16]

***Thomas Burke, MD***

[00:43:17]

So at that point, it was mostly hospital and clinic operations. Margaret Kripke [Oral History

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Interview] was then the chief academic officer, so she ran the education and research pieces, and Leon [Leach, Oral History Interview] ran the business functions of the organization.

So then we decided to restructure that role and change the sort of COO role into what became the physician-in-chief role and was essentially a flip of sort of a chief medical officer who worked for a COO and it got flipped to a chief physician who had a COO that worked for them.

[00:44:02]

***Tacey Ann Rosolowski, PhD***

[00:44:03]

Why? Why was that change made?

[00:44:04]

***Thomas Burke, MD***

[00:44:10]

I think it was partly the recognition that the clinical environment really should be led by a physician, and I think there was a sense across the institution that that was a good transitional time to make that change. And I think, frankly, a lot of faculty were worried about being disenfranchised, that if that became a totally administrative role, that a lot of the agenda that tracks to the clinical people would perhaps be superseded by administration functions and other things.

[00:44:54]

***Tacey Ann Rosolowski, PhD***

[00:44:54]

Now, am I correct in assuming, because this would have happened after John Mendelsohn arrived—

[00:44:58]

***Thomas Burke, MD***

[00:44:58]

Right.

[00:44:59]

***Tacey Ann Rosolowski, PhD***

[00:44:59]

—and when there was a huge amount of corporatization, if you will, or moves in that direction at MD Anderson, and so there was—am I correct in assuming that was the environment, fear among the faculty that the business model might take over?

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[00:45:11]

***Thomas Burke, MD***

[00:45:11]

Yeah, I think there was some concern about that and where your voice was in the higher levels of management of the institution. You know, the other reality is the place was just too big to manage in the family-business way. You talked about a mom-and-pop earlier, and you couldn't possibly make it work with that kind of a style.

So I had that role as an interim assignment for probably a year and a half, and at first everybody assumed that I wouldn't be a candidate for the position, and after a few months I decided I was already doing the job and I probably should be a candidate. So it still, like all searches here, took a long time to resolve, so I have sympathies for everyone who's participated in an MD Anderson search, because we don't seem to be able to accomplish those in an expeditious time frame. So I was in an interim role for probably a year and a half, which is a really difficult position because you have the assignment, but you don't have the authority—

[00:46:26]

***Tacey Ann Rosolowski, PhD***

[00:46:27]

And no mandate [unclear].

[00:46:27]

***Thomas Burke, MD***

[00:46:28]

—to make the decisions, and you know that especially if you're competing for the job, that you can't make a lot of difficult decisions and survive the search process. So there's the conflict of how that goes.

Dr. Mendelsohn ultimately made the decision and offered me the position full-time, and I don't know what finally got his decision process. I told him it was time to make the call. I was doing the job. If he wanted somebody else, he should just say so, and kind of forced the issue of kind of getting there. So that ultimately led to I think in 2007 I was named as the physician-in-chief full-time as a permanent position.

[00:47:20]

***Tacey Ann Rosolowski, PhD***

[00:47:22]

Wow. That is a long time. I'm just looking at the other kind of entries of roles in between that, and that is a very long time.

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[00:47:35]

***Thomas Burke, MD***

[00:47:35]

So I think I was in that sort of chief medical officer role probably for seven or eight years in various configurations. One of the other things I learned from that was adaptability, because everything above me would change or I would have sort of new relationships, and navigating how you would kind of work through that is part of the—

[00:48:00]

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## **Chapter 14**

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

#### *As Physician in Chief: Addressing Needs in Pharmacy and Quality and Safety*

##### Story Codes

A: The Administrator

B: Growth and/or Change

B: MD Anderson History

B: MD Anderson Snapshot

D: The History of Health Care, Patient Care

C: Research, Care, and Education

C: Leadership

C: Discovery and Success

C: This is MD Anderson

C: Understanding the Institution

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

[00:48:01]

I have a number of kind of areas that you worked on, which I'd like to get some detail on, unless you have kind of more—

[00:48:14]

#### ***Thomas Burke, MD***

[00:48:14]

No, that's fine.

[00:48:14]

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

[00:48:15]

Okay. Well, let's list them, and I'll let you kind of decide which one makes sense to start with to tell the story, because I'd like to get your sense of, you know, you walk into this role and, you know, as you did in the Gynecologic Oncology Center, I mean, here's the way things operate, well, how can we improve quality, how can we improve process, so I assume that was the mindset you brought in this new role as well.

So, determining patient confidence in care and treatment is one, and just managing all of the increasing numbers which were so dramatic in the nineties. I have survivorship and the Life After Cancer Program and also expanding the multidisciplinary model of care throughout the institution, expansion to ambulatory clinics and cancer prevention buildings. I mean, just the

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institution's expanding, expanding. I thought maybe we would—well, faculty burnout, and then perioperative enterprise, which I wasn't quite sure what that was, so I'm anxious to hear. So that's sort of in the first pass of some of the topics I have. Where would you like to start?

[00:49:23]

***Thomas Burke, MD***

[00:49:24]

The first things I tried to do was to sort of step back and kind of get the major categories that I thought we needed to be invested in. So, nursing is obviously a huge component of what we do, inpatient, outpatient. We were just beginning to get master's-trained nurses. We didn't really have nurse practitioners at that time. That's a relatively new role. And so—

[00:50:01]

***Tacey Ann Rosolowski, PhD***

[00:50:00]

And so this, in the year that you're kind of contemplating the nursing issue, was that in 2008 or prior?

[00:50:09]

***Thomas Burke, MD***

[00:50:10]

No, that's as I'm coming in to the role. And we wanted to bring in pharmacy. We decided to hire a separate lead for operations that would manage the ambulatory side, so we separated the inpatient and the ambulatory side. So the inpatient side fell to nursing because most of the workforce was nursing, and then we recruited Jared Coleman to lead the ambulatory side. At that time, it was largely distributed in departments and divisions. It wasn't a centrally managed component.

[00:50:53]

***Tacey Ann Rosolowski, PhD***

[00:50:54]

What was the issue with pharmacy? I mean, where were the inefficiencies or problems?

[00:50:57]

***Thomas Burke, MD***

[00:50:58]

Well, it became much more complicated. The numbers of drugs was burgeoning. The clinical trials and investigational agents all were managed by the pharmacy. So if you thought about just the clinical care and the research infrastructure of the institution had huge components of pharmacy to manage, and we also had inpatient and outpatient operations, and so those are very

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different in terms of—and we had retail pharmacies. We had patients who filled their prescriptions at MD Anderson, so we needed to be thinking about all of the places that that occurred.

Then we also brought in Quality and Safety. We had a lead for that at the time, Sherry Martin, who really built our program and started to embed that in the team.

[00:51:54]

***Tacey Ann Rosolowski, PhD***

[00:51:54]

Now, why—what was that about? I remember seeing that, and I was thinking, huh. Quality and Safety, those seem like a given, you know. So what was going on there?

[00:52:02]

***Thomas Burke, MD***

[00:52:03]

Well, I think they were always a given but not a measured given, and they always didn't have a science behind them. So at the time, we were just starting to adapt some of the things that came from industry in terms of process design, process improvement, quality and safety coming out of auto manufacturing and other businesses completely unrelated to healthcare. So a lot of that was being translated into healthcare at the time.

[00:52:34]

***Tacey Ann Rosolowski, PhD***

[00:52:35]

Now, is that where the Lean Manufacturing started to come in?

[00:52:37]

***Thomas Burke, MD***

[00:52:38]

Right, right. So now we have a huge group that has industrial engineers and modelers and mathematicians and statisticians, so that's become a huge resource for the institution in terms of managing flow and growth and volume and so on, but the starts of it were back probably a decade ago.

[00:53:01]

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***Tacey Ann Rosolowski, PhD***

[00:53:01]

Interesting.

[00:53:02]

***Thomas Burke, MD***

[00:53:03]

And then I also wanted to consolidate all of the patient-facing services. So we had those groups that I'd mentioned around advocacy, the hotel, we had some patient facilitators, and they were separately managed groups, and so I wanted to kind of bring those in as an umbrella.

[00:53:24]

***Tacey Ann Rosolowski, PhD***

[00:53:24]

Why was that so important?

[00:53:25]

***Thomas Burke, MD***

[00:53:27]

Because I thought they were disconnected, you know, and as I stood back, I thought these are really all direct patient-facing services that ought to be seamless, and we ought to be able—you know, on one I'm handling your complaint, on another I'm trying to facilitate your schedule, I'm trying to get you into the hotel, and, you know, kind of manage from that. It's really all the same process. I'm just trying to make it easier for patients to find their way into the organization and maneuver, and so having those be all together made a lot more sense than separate places.

[00:54:05]

***Tacey Ann Rosolowski, PhD***

[00:54:06]

And all of this, obviously, is direct fallout from amazing increase in size in the organization, just handling so many more patients, and the size of the institution.

[00:54:16]

***Thomas Burke, MD***

[00:54:17]

Well, and I had to replace myself as the chief medical officer, so that was sort of the transition time, sort of building out that team. I did have a strategy we alluded to. I had a strategy for this. I wanted a group of people who were different than me and who brought different skills than I could bring, and so I sort of saw myself as more the physician faculty member who had kind of done clinical trials work and understood that piece. But all of these other things I've alluded to

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were really developing pretty quickly, very specialized things. So nursing was a completely different piece. Pharmacy's a completely different piece. Patient satisfaction and services, quality and safety, the chief medical officer and medical staff functions were all kind of rapidly escalating in terms of their sophistication and the science behind those things. So I wanted people who were expert at those things, and I would not have to be the expert at those things. So

as I recruited people to the team, I tried to fill those different roles.

[00:55:38]

***Tacey Ann Rosolowski, PhD***

[00:55:40]

What did you look for in people, I mean aside from the skill sets?

[00:55:42]

***Thomas Burke, MD***

[00:55:45]

I looked for people who I thought could build their own networks, because I thought we built a much stronger team because everybody had their own internal network that we could leverage. I tried to recruit people who were respected both for their ability to build consensus and kind of work in a complex environment, but also who wanted to drive the science of their area.

I worked in the place long enough to know that you would not be able to influence decisions and build confidence across the faculty unless you brought equal expertise to the table, and so it would be very difficult to get to a plan or a decision if I didn't have people who were absolutely expert at what they did and would force the discussion to, you know, this is a process question and we have people who are absolute experts at process, they have master's and PhD degrees in those areas, and you should respect what they bring to the table, just like we respect the expertise that you bring to the table, treating a patient with diagnosis [unclear].

So I tried to build groups that presented at national meetings, that published papers, that kind of competed on the same academic agenda that our traditional faculty did, that belonged to the professional organizations, had the right certifications, so that we built a group of sort of operations team that could compete, if you will, from an expert perspective on the same criteria. And I think that worked really well. I think we had a really sophisticated group of people. They built some terrific things. We built a Quality and Safety Program that's very unique. Sherry started it by—she had some really good connections around the country. Actually, probably the best connection we made was with Brent James, who was the quality officer at Intermountain Health in Utah, a very large hospital system, probably covers most of the state and beyond, but was sort of nationally recognized for what they had done in quality and—

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[00:58:28]

***Tacey Ann Rosolowski, PhD***

[00:58:29]

And just so I'm getting her name correctly, Sherry?

[00:58:31]

***Thomas Burke, MD***

[00:58:31]

Sherry Martin.

[00:58:32]

***Tacey Ann Rosolowski, PhD***

[00:58:32]

Martin. And it's S-h-e-r-r-i? [note: MD Anderson website and elsewhere spells her name as Sherry, so it's spelled Sherry in the transcript.]

[00:58:34]

***Thomas Burke, MD***

[00:58:35]

Right.

[00:58:35]

***Tacey Ann Rosolowski, PhD***

[00:58:35]

Okay, Martin.

[00:58:36]

***Thomas Burke, MD***

[00:58:36]

And so we talked to Brent. Brent had a fairly detailed course that he taught in Utah around patient safety and quality, and he took teams that had to come to Utah for a week a month for four months, and they had to have an agenda and a project, and they had to develop data and present it by the end of the four months. So we said this would be a really great way to build that agenda and get some expertise on some of our clinical teams around what people were doing in this area. And so what we chose to do was we took things we knew were problems and we built a team and we sent them to Utah.

[00:59:29]

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***Tacey Ann Rosolowski, PhD***

[00:59:30]

So what were the things you identified as problems?

[00:59:31]

***Thomas Burke, MD***

[00:59:31]

Well, we had issues around wait times and turnaround times in our laboratory. At the time, our Emergency Center was way over in the corner of the complex, probably as far from the hospital site as you could put it, so it was completely misplaced. And so the movement of patients during their evaluation and admission—so we had a team built around transportation and emergency services.

But we built these teams and we used the principles of it was the complete team, so we had physicians, nurses, administrators. We had the right mix of people, just like we were trying to do on the leadership team, and we brought them together and we said, “We’re going to pay to send you to Utah for a week a month for four weeks, and we want you to fix this problem and use Brent’s course and so on to learn how to do these things.” So my view is I would fix a problem that we had using the team, and then they would come back and fix ten other problems because they knew how to do it.

[01:00:42]

***Tacey Ann Rosolowski, PhD***

[01:00:42]

Good investment.

[01:00:43]

***Thomas Burke, MD***

[01:00:43]

And they had a network they built because they lived together for a week, they were in a class, they were doing project work. And it was highly successful. We had some great stuff come out of that. I think we ended up doing five or six of the courses and teams that we had sent out, and a couple of us went out and Brent had an abbreviated course for executives, so we went out for a weekend and kind of got the high-level view. He’s really an inspiring person and had accomplished a lot and had never worked with an academic center and I think had never believed that an academic center would be interested, willing, want to try to do the kinds of things that they were doing in a large-scale clinical environment.

So ultimately we talked to him, we said, “Why don’t you help us transplant your program to MD Anderson, and we could structure it differently.” So we ended up doing this by our course was

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two days a month on site with multiple teams, and Brent brought the faculty. So he would fly in, he would bring the speakers from his course, they would lecture and teach for two days. And then our teams would go and they would do four cycles of the two days. But we started out with five, six, eight teams, so you could really start to leverage in a quick way.

It became a very popular course, because people really saw how they could change their own work environment. And we pretty much gave them free rein, and so they did a lot of very good things. They started to publish stuff. They started to present at national meetings. We grew the program over time, and then—

[01:02:54]

***Tacey Ann Rosolowski, PhD***

[01:02:54]

I just wanted to ask. I missed Brent's last name.

[01:02:59]

***Thomas Burke, MD***

[01:02:59]

James.

[01:02:59]

***Tacey Ann Rosolowski, PhD***

[01:03:00]

James. Okay, thank you.

[01:03:03]

***Thomas Burke, MD***

[01:03:03]

So it was about the time Sherry was talking about retiring, and so I recruited John Bingham to come from Vanderbilt as our new Quality and Safety leader. Sherry wasn't quite ready to retire, so Sherry took an assignment at UT System, working for the vice chancellor of health affairs, which was Ken Shine, and convinced him to invest in a Quality and Safety Program for all of the University of Texas that would essentially be a growth of what we had transplanted. So he agreed to that and he put some money into it, which was obviously important.

But we started out, then we leveraged our internal course, so we invited initially the other UT Health components to send a team to our course, and that continued to grow. So a good part of them now have their own courses and they're training teams two or three times a year, and then there's now an annual University of Texas Clinical Safety and Effectiveness meeting. It's a two-

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day meeting, national speakers, everybody presents their work. So it's really done a huge amount to change the safety and process culture of the institution.

And when John came, he brought people that kind of drove that further. We now do two or three sessions a year. We have a whole bunch of online resources. Some of our safety teams have won national awards from Health and Human Services. We've competed in industrial engineering competitions. So a lot of people have gotten terrific academic and career credit for the work they've done. I think we've probably trained close to 1,000 people now, so if you think about a

clinical workforce of 10,000, 10 percent have had formal quality safety training in a course environment and have done a project in their MD Anderson work environment.

[01:05:16]

***Tacey Ann Rosolowski, PhD***

[01:05:16]

Wow.

[01:05:17]

***Thomas Burke, MD***

[01:05:17]

So that's a huge resource that's been built over time.

[01:05:21]

***Tacey Ann Rosolowski, PhD***

[01:05:22]

And a huge thing that's being built into the culture and passed on. Yeah.

[01:05:25]

***Thomas Burke, MD***

[01:05:25]

Right, right. And they've all done, as I said, lot of little local subprojects and felt like they could change. You know, it's never quite where you want it to be, so you're hoping to go to the next level.

But it also let us invest in a consultative group in performance improvement and quality and safety where we could bring in people with those kinds of expertise, who would then be essentially internal consultants to our clinical team. So we have industrial engineers, performance engineers, statisticians, other people who do project support across the institution and have the expertise to do the sort of underlying pieces that let the clinical teams make decisions. So that—

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[01:06:20]

***Tacey Ann Rosolowski, PhD***

[01:06:21]

Was there any pushback, you know, with bringing these people in? I mean, and it's a different way of running a clinical environment, so how was it received?

[01:06:31]

***Thomas Burke, MD***

[01:06:31]

I think initially with some suspicion, just because you don't want other people kind of managing your clinic, you know. I felt like I could manage my clinic, so I'm sure there were people that thought that. But, you know, I think as the group grew, they just saw more and more people who were doing some pretty neat work, and we used a lot of public forums to demonstrate what was being done, and I think it just got—you know, at a competitive place, people always gravitate to things that are good, and so if somebody's doing something better or has a unique idea and you say, "Gee, that might work for me," then you'll adopt that.

So I think just being in a place where we could get people to adapt to those things, we drew people into the process. Today I think we have people asking for those resources, you know, "I've got a project. I want to rebuild some schedules. I need some help in managing it." So it's become much more ingrained in the kind of everyday work. Initially, I offered some prizes for the best projects, so we had—I think it was 5, 3, and \$1,000 prizes for the best projects, so there was some competition to kind of be recognized for who had done the best stuff. There was a lot of internal credit for doing that.

[01:07:55]

***Tacey Ann Rosolowski, PhD***

[01:07:55]

What were some of those? What were some of the projects you recall?

[01:07:58]

***Thomas Burke, MD***

[01:07:59]

Oh, we had some really neat ones, and then a lot of them, the simpler things are the better. We had a great surgical project where a team of GI surgeons reduced the number of instruments that you brought into a case just by taking a look at what really got used and what was necessary for a given case. So they probably carved about 50 percent of the instruments out of the trays that got brought into an operating room for their cases.

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We had another one in imaging where they completely just rebuilt the sequence for what studies got read, based on who had the soonest appointment. So instead of just doing it as the studies were done, the names at the top of the list are the people who had the closest appointments so we would have reports ready in time for that.

Some really great wait-time things, just by studying flow. One of the biggest teams was in the lab around some redesign of their workspace so that things would flow more easily and cut down the time it takes to get test results. We had some redesign of our blood-drawing stations. You know, a lot of patients wait to get their blood drawn, and it's real heavy the first part of the week and early in the morning, and so trying to even that out and plan for how to get that done. So a lot of really neat projects have come out of the group.

We didn't try to restrict what people did. If you had a good idea, we kind of let you run with it, so the project list is pretty robust and kind of all across the map. So there were a lot of research and training projects in addition to clinical ones, although the focus of the courses and the training was clinical.

[01:09:46]

***Tacey Ann Rosolowski, PhD***

[01:09:47]

Huh. A really neat story. Yeah.

[01:09:50]

***Thomas Burke, MD***

[01:09:50]

I'm very proud of what that group has done, and that was a huge success.

[01:09:56]

***Tacey Ann Rosolowski, PhD***

[01:09:57]

Did it have a name within MD Anderson?

[01:09:59]

***Thomas Burke, MD***

[01:09:59]

The name of the courses was the Clinical Safety and Effectiveness Program, and that was modeled on Brent's. We stole completely from him, with his support. [Rosolowski laughs.] I think he's pretty proud of it, because it's really nice if you've developed that kind of a program and been able to transplant it.

[01:10:21]

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***Tacey Ann Rosolowski, PhD***

[01:10:22]

Yeah, exactly.

[01:10:22]

***Thomas Burke, MD***

[01:10:23]

And we transplanted it again to the rest of the University of Texas.

[01:10:26]

***Tacey Ann Rosolowski, PhD***

[01:10:27]

I mean, it's huge kudos for the solidness of that process.

[01:10:29]

***Thomas Burke, MD***

[01:10:30]

Yeah, and everybody has kind of gained from it, so I think that was a really positive, positive project.

[01:10:38]

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## **Chapter 15**

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

#### ***Building a Highly Skilled Nursing Service***

##### Story Codes

- A: The Administrator
- B: Building/Transforming the Institution
- B: MD Anderson History
- C: Leadership
- C: Discovery and Success
- C: This is MD Anderson
- C: Understanding the Institution
- D: The History of Health Care, Patient Care
- C: Education at MD Anderson
- C: Mentoring
- C: Leadership
- B: MD Anderson Culture
- B: MD Anderson Mission and Values

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

[01:10:39]

Well, we have about fifteen minutes left, and I know you need to stop at three today. What's the next area that you attacked in this role?

[01:10:50]

#### ***Thomas Burke, MD***

[01:10:50]

I think the other place we have really spent a lot of effort was on the nursing side. A huge amount of the interface that patients have with us as an institution are our nurses. Finding ways to attract people to cancer nursing is not easy. I think a lot of young people who go into nursing sort of pick happy areas that they want to be in, and cancer is not usually one of those. And if you think about the clinical experiences at most nursing schools, they aren't exposed to a cancer hospital. They're in a general acute-care hospital, so they work all different areas, and then they sort of sub-select as they do their clinical rotations.

So we targeted all kinds of ways to both bring people into cancer as nurses and then to upgrade their skills once they were here. So with Barbara Summers [Oral History Interview] and a lot of other people on her team in administration, over the time we partnered with all of the nursing schools to offer rotations at MD Anderson so we could try to get young people in to see it,

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because we knew people would like the personal connection to patients, they'd like the intensity of the sort of support that goes around taking care of people and families that are dealing with cancer, but we just had to get them to see it, so we kind of focused on the front end of, you know, how do we get people at the decision-making time to see that.

[01:12:45]

***Tacey Ann Rosolowski, PhD***

[01:12:45]

You know, it's funny, I'm in the process now of interviewing Barbara Summers, and I realized after doing the background research, and I told her when I walked in, I said, "You know, I have no idea what you do. None." And I imagine, I mean, why would I? I mean, why would a nursing student who had never been exposed? And so to hear her speak so eloquently about the complexity of the relationships, the intellectual complexity of what a nurse does, I mean, it's very inspiring and exciting.

[01:13:12]

***Thomas Burke, MD***

[01:13:12]

So you've got to get people to see that. If they see it, they'll come and they'll stay, you know. So that was a huge piece.

And then we've embarked on a lot of programs to bring more skilled nurses into our environment. So, earlier in the time interval, master's-level training for nursing became much more prominent and those people became clinical experts. So we tried to build each of our units with one or more of those clinical experts attached. So they were—

[01:13:48]

***Tacey Ann Rosolowski, PhD***

[01:13:48]

Now, is that phrase, "clinical expert," is that an official title or—

[01:13:53]

***Thomas Burke, MD***

[01:13:53]

I think the official title was clinical nurse specialist, but it was basically master's-prepared nurses who had additional training and clinical experience, and so they would become sort of a senior resource on a clinical work team. That was largely clinically based.

And at the same time, a number of nurses were moving into management levels and getting more traditional business training, so MBAs and master's of healthcare administration, other kinds of

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sort of management-side degrees. So if you look across the organization, it's been a huge transition on the administrative side of the management skills of nurses who lead our outpatient units, a lot of our inpatient units, a lot of management people have come out of nursing as an initial degree. So that was a career shift for a large number of nurses.

It's actually been really good because it brings both the clinical and the administrative piece together, and keeping those two kind of married is a challenge going forward, so we developed a large group of nurses who have administrative roles and training. And then the master's-prepared nurse became supplanted by the advanced practice nurse, so it was just a role shift over time and there were specific training programs for those roles, and the difference was that they could practice independently. So physician assistants and advanced practice nurses became sort of where today term "mid-level providers," but they kind of became popular as a way to extend what the physician workforce could accomplish, some of it independent and some of it indirect partnership.

[01:15:55]

***Tacey Ann Rosolowski, PhD***

[01:16:00]

How were those new roles accepted within MD Anderson? I mean, it's kind of a difference in allocating of responsibility and—

[01:16:10]

***Thomas Burke, MD***

[01:16:10]

I think there's huge acceptance on this for a couple of reasons. One is at the same time those roles were being developed, there were greater and greater restrictions on physician residency training hours, and we don't have our own residency program, so we would always be an outside rotation for other training programs around the city or other places, and so when they had to begin to contract the service hours of their trainees, we were one of the first places to lose those rotations, and so at that time, mid-level providers, both PAs and advanced practice nurses, became terrific stand-ins for our residents in terms of extending work capabilities and covering larger things.

[01:17:07]

***Tacey Ann Rosolowski, PhD***

[01:17:08]

And I suppose what they bring is quite different because they're not going to leave.

[01:17:13]

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***Thomas Burke, MD***

[01:17:13]

Right. So they're essentially in a preceptor role, and they become experts. You know, if you've done this for six months plus those six years or ten years, you've seen as much as anybody else on the team, and so you really become expert. So it upgrades the quality of care that we provide, it builds an experienced workforce that's really valuable, and so that was an easy acceptance for both of those roles in the institution. Today we probably hire more mid-level providers than any other healthcare environment that I know of, and they cover a much broader role across the institution.

[01:18:04]

***Tacey Ann Rosolowski, PhD***

[01:18:11]

It occurred to me, too, because so many healthcare institutions are facing the physician shortage, is that also a piece in this?

[01:18:19]

***Thomas Burke, MD***

[01:18:19]

Sure. So these people obviously are—those roles were designed to extend you, let you do more [unclear]. You know, I think the other thing we brought to the nursing side was we would fund all of your expert certifications. So we wanted you to be oncology-certified, we wanted you to have the special credentials that that would bring, and so we paid your registration fees and your certification fees for you to get those things. Today we're going to require it, but ten years ago, we were just fostering that and facilitating it because we wanted people to have the credentials of expertise in addition to the experience.

[01:19:08]

***Tacey Ann Rosolowski, PhD***

[01:19:09]

Right. Interesting.

[01:19:09]

***Thomas Burke, MD***

[01:19:10]

And the other thing that's been done that I think was really forward-thinking was we funded people to upgrade their education. So if you came into MD Anderson as a licensed vocational nurse or a two-year nursing program, we would facilitate your education to upgrade to a bachelor's degree or from a bachelor's degree to a master's degree. So we would find ways for you to stay at MD Anderson and upgrade your training and your skills and, obviously, your

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ability to work at a higher level. So there's been some very nice cohorts of people who have taken advantage of that and upgraded their degrees and their capability, and that was all facilitated by the nursing team and the institution.

[01:20:05]

***Tacey Ann Rosolowski, PhD***

[01:20:05]

Interesting. Wow. Hmm. And, you know, fosters a lot of loyalty and goodwill for an extremely skilled workforce.

[01:20:12]

***Thomas Burke, MD***

[01:20:13]

Of course. And then replacing somebody with that experience is difficult.

[01:20:19]

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## **Chapter 16**

### **A: The Administrator**

#### ***As Physician-in-Chief: Building the Survivorship Program and Pharmacy Support***

Story Codes

A: The Administrator

B: Building/Transforming the Institution

C: Patients

C: Patient, Treatment, Survivors

C: Offering Care, Compassion, Help

C: Discovery and Success

C: This is MD Anderson

C: Understanding the Institution

D: The History of Health Care, Patient Care

B: MD Anderson Culture

B: MD Anderson Mission and Values

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

[01:20:19]

Yeah, yeah. What other area have you been working on? I mean, I'm looking at some of the expansion issues, and survivorship I know is an issue that's come up.

[01:20:33]

#### ***Thomas Burke, MD***

[01:20:33]

Yeah, I think we've spent a lot of time building a survivorship program. Alma Rodriguez has been the point person on that from the medical leadership side. Alma became my chief medical officer.

[01:20:47]

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

[01:20:47]

Is that Alma?

[01:20:48]

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***Thomas Burke, MD***

[01:20:48]

Alma.

[01:20:49]

***Tacey Ann Rosolowski, PhD***

[01:20:49]

Alma. Thank you.

[01:20:50]

***Thomas Burke, MD***

[01:20:50]

She's the one I recruited to replace myself. Alma's a medical oncologist, she specializes in lymphoma, so completely different than me, going back to the strategy of I wanted somebody from other areas to be on the team. And I gave her the assignment of starting to build out the survivorship program.

You know, our thought was that—we talked to a lot of patients. I think in the simplest way it was most patients who were long-term survivors of cancer would like to be out of the mix of people in active treatment because it brings back what they went through, and they'd like to be past that. So they would like to be cared for in an environment different than an active treatment area, yet they didn't want to be completely released, because if they had a problem, they wanted to feel like they could jump right back. So we wrestled with so what does that look like, you know, how do you do it.

And on the other side of that equation was that the profiles—and these go back probably five or six years ago—were that about 20 percent of our activity was taking care of people who were long-term survivors of cancer, and so we were doing that with our active treatment teams. So if you think about it, survivors have a completely different set of needs for their care. They need to be worried about complications of their treatment that were years ago. They need to have routine screening services for other cancers different than what they had. They have other social needs. They have depression, anxiety, you know, things that surface as a result of their diagnosis and treatment, and those are different areas than our oncology teams are typically providing.

So we were trying to build resources that support that aspect, so we recruited Fran Zandstra. Fran was the lead nurse in the GYN Clinic when I was the medical lead for the clinic, so we worked together as a team for the ten years or so that I was in charge of the GYN Clinic. And then I asked Fran to lead one of our patient services groups, which was one of the groups I was trying to bring together under one umbrella. The woman who had run it had retired, and I was

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transitioning the team and I needed somebody to cover it for a little while, so I asked Fran to take that role and then ultimately to move on to the survivorship thing.

So she and Alma became a really terrific pair and probably with others, but they led the group, built everything we have in cancer survivorship. So today that is thousands of patients, many of whom are seen in special survivorship clinics on the main campus, so they come at a separate time, they see different providers who are focused on survivorship issues.

It has been our hope to build a freestanding survivorship center at MD Anderson. We were close twice, and finances closed it down both times. So I still think it's a place that we really would like to go, but it's going to have to be the right time. But as we've thought about it, the right model is to have cancer prevention and screening and cancer survivorship collocated, because they're essentially well populations who use the same services, mammography, colonoscopy, chest screening, PSAs, you know, all the screening things we know about are equally applicable to survivors, and also the psychosocial support services. So if you thought about a center that you could construct, it would be completely outpatient, it would support those two populations, it would be a very nice mix, and it would allow you to efficiently use the resources that would be attached to it.

So our patients have told us they don't want that to be far away, so geographically I was looking for something where you could see the top of the main building from the location of the center. But maybe someday we'll get there, but we haven't—the times we were close, we had financial pressures, and while it's a priority, it's not our top priority.

So what we've done is we've integrated our survivorship programs and we've built a lot of the supporting pieces, both electronic and kind of the planning pieces, even though those patients are still seen in different areas on the main campus. So it's a pretty robust program that's been well thought out and managed, and we have guidelines and pathways for how to manage survivors of all different cancers. So if you transition back to a family doctor or a home environment, we have a whole set of things that would go with you to help make that work and be what you need. So I think they've done a fabulous, fabulous job in that area.

[01:26:35]

***Tacey Ann Rosolowski, PhD***

[01:26:35]

I've been talking to Dr. Foxhall [Oral History Interview] about survivorship.

[01:26:38]

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***Thomas Burke, MD***

[01:26:39]

Yeah, Lewis has been instrumental in that. I should have mentioned him. He's been a great partner with them. Lewis is a family practitioner, so he provides a great interface with sort of a primary-care community outside of the Cancer Center.

I think probably the last area on the operations side for what we should talk about is kind of the pharmacy piece. I think pharmacy's been analogous to what's happened in nursing, that cancer pharmacy has become incredibly complicated, the numbers of agents, the investigational uses and other things have really grown. Joel Lajeunesse has done a terrific job of managing the multiple dimensions, so everything from research protocols and very controlled environments to a huge portfolio of cancer agents that are used in regular practice.

A whole group of clinical pharmacists that work on our clinical teams every day, our inpatient or outpatient units, they've really increased the safety of drug delivery, brought unique expertise to clinical environments on site, so they actually work in the teams. There's probably close to a hundred people who do that today, so just like the physician assistants and advance practice nurses, that role has become very important and large. And they also manage our distributive sites, so all the regional centers around Houston have a pharmacy delivery component that kind of comes through the main pharmacy.

At least for the last four or five years, shortages of drugs in the United States have really impacted treatment significantly, and so they've had to proactively manage a huge portfolio of drugs that become unavailable. Then we have to scrounge for supplies. We have to stockpile. We have to look for other manufacturers. But drug-shortage management has become a large part of what they do.

[01:28:47]

***Tacey Ann Rosolowski, PhD***

[01:28:47]

Wow.

[01:28:47]

***Thomas Burke, MD***

[01:28:49]

They also build training programs. They have a residency and fellowship program in cancer pharmacy, so we're trying to use them as a pipeline for people going forward.

[01:29:00]

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***Tacey Ann Rosolowski, PhD***

[01:29:05]

Would you like to leave it there for today?

[01:29:06]

***Thomas Burke, MD***

[01:29:06]

Yeah, why don't we break here and we'll come back—

[01:29:07]

***Tacey Ann Rosolowski, PhD***

[01:29:07]

Okay, sounds good.

[01:29:08]

***Thomas Burke, MD***

[01:29:09]

—and do one more wrap-up session and do maybe the network stuff then—

[01:29:12]

***Tacey Ann Rosolowski, PhD***

[01:29:12]

Yeah, sounds good.

[01:29:13]

***Thomas Burke, MD***

[01:29:13]

—pick up any of the last ones we didn't get on this.

[01:29:15]

***Tacey Ann Rosolowski, PhD***

[01:29:15]

Great. I appreciate your time today.

[01:29:16]

***Thomas Burke, MD***

[01:29:17]

Good. Thank you.

[01:29:17]

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***Tacey Ann Rosolowski, PhD***

[01:29:17]

Yeah. I'm turning off the recorder at about one minute after three.

[01:29:20]

***Thomas Burke, MD***

[01:29:20]

Perfect.

[01:29:21] (End of Audio Session Two)

III – MDA-RML\_Burke\_Thomas  
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**Chapter 00C**  
***Interview Identifier***

***Tacey Ann Rosolowski, PhD***

[00:00:00]

All right. Now we are definitively recording, and it is about two minutes after one p.m. It is the 29<sup>th</sup> of April, 2014, and I'm in the Mid Main Building in the office of the MD Anderson Cancer Network, talking to Dr. Thomas Burke. Today is our third session.

So, thank you, Dr. Burke, for making this time for me.

[00:00:26]

***Thomas Burke, MD***

[00:00:27]

Good. This has been lots of fun.

[00:00:28]

***Tacey Ann Rosolowski, PhD***

[00:00:29]

Yeah, it has been fun.

[00:00:30]

***Thomas Burke, MD***

[00:00:30]

Yes, it's a good project. It's a good project.

[00:00:32]

***Tacey Ann Rosolowski, PhD***

[00:00:32]

Well, thank you. I'm glad you're finding it, you know, useful.

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## **Chapter 17**

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

#### ***Comprehensive Approaches to Faculty Burnout in a Complex, Growing Institution***

##### **Story Codes**

B: MD Anderson Snapshot

B: Growth and/or Change

B: MD Anderson Culture

C: Understanding the Institution

C: Dedication to MD Anderson, to Patients, to Faculty/Staff

D: The Life and Dedication of Clinicians and Researchers

A: The Clinician

A: Personal Background

A: The Patient

C: Patients

C: Patients, Treatment, Survivors

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

C: Mentoring

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

[00:00:32]+

Well, we kind of plotted and planned before the recorder was turned on, and we had a number of issues kind of lingering from discussion of your roles as physician-in-chief. So one of the things that surfaced was the issue of faculty burnout, and I wondered if you could speak to that problem at MD Anderson and then some of the initiatives that you undertook to address that.

[00:01:04]

#### ***Thomas Burke, MD***

[00:01:07]

You know, I think the real issues of working long-term at the Cancer Center are that you see sort of an ongoing series of patients who have life-altering diagnoses, and many of them don't survive their treatment, and so I think it wears on everybody. So certainly the faculty piece is at the front end of this as the sort of decision-makers and the main interface, but it also plays out in nursing and pharmacy and all the support people who kind of have to deal with difficult patients and family situations from a health perspective.

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And I really believe that people who choose to work here and stay are so connected to the mission and the caring of those people that they build their own mechanisms for managing the stresses of complicated patients and difficult decisions, and the people who aren't successful in finding their way through that, I think, don't stay, and so I think there's sort of a self-selection process. So I would say that the people who form the clinical workforce here really see the bond with patients. I've always thought helping somebody through end-of-life decisions and situations is just as rewarding from a personal interaction standpoint as helping them through treatment decisions and other things on the front end. So people that make those connections, I think, protect themselves, they stay authentic, they stay engaged, and even saying all that, it wears down after a while, and I think people need to find ways to sort of reconnect.

The other reality is it's a different environment than it was twenty or thirty years ago, and so people who are coming as physicians and faculty members, I think, have more pressure on them. They certainly have longer and more formal training than those of us who trained thirty years ago or forty years ago have, so there's an additional length of time for training and education. Every step of that is competitive. Many of them are in their late twenties or early thirties when they complete their training, their subspecialty cancer training. They've absorbed a pretty significant debt in that process, so you sort of come to, "I'm launching my career, but I have a huge burden of sort of financial and other things." And it's also at a time where people are having families and wanting to buy their first house and then doing all the other life things that everybody does. And so I think it's very stressful to kind of get that transition. Then you throw on top of it the stress of dealing with sick patients and making difficult decisions. So—  
[00:04:29]

***Tacey Ann Rosolowski, PhD***

[00:04:29]

And the research piece, too, must add significant—

[00:04:32]

***Thomas Burke, MD***

[00:04:32]

Right. So when you go to work, you have all of those pressures, so we're talking a little bit about the clinical one, but you're also trying to launch a research career and a teaching career and other things at once, so all of those kind of come together at once. I think everybody has to figure out for themselves how they're going to manage that and how they set the boundaries and what time they have to commit to the different components of that. If you're in balance, you do well and you can adapt, and if you're out of balance, I think that's where the burnout and the fatigue and the other things set in.

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So I think one of the biggest things to do is to help people find the right balance, and I think we've done a lot of things in the institution over time to try to help people with that, so mentorship, finding people who are doing it and a little more experienced is obviously the time-honored one, but helping people find a niche, I think. One of the really hard things about coming on to a faculty is initially you want to do everything. Somebody has a good idea and they want to hand you an assignment, you want to take it all on, because you're excited, you're exuberant, you want to get going and kind of build your career. But you can also build too much, so helping to find ways to channel the enthusiasm into ways that will ultimately build out as your career is important, I think.

In my own department, we each took a disease site, so a number of people came on at the time I came on as a young faculty member, and I was given the assignment of endometrial cancer. So that was one of the GYN tumors, someone else did cervix cancer, someone did precancerous lesions, somebody else did ovary, and so there was just a natural place for you to begin to develop your career. So all of the early research I did when I was a frontline faculty member, not administrator, was related to the treatment of uterine cancer, so we had a portfolio of chemotherapy trials that we ran, and it was my assignment to be sure that we had the right grouping of trials to meet different clinical scenarios.

Ultimately, that led into competing with a number of other teams to get a large uterine cancer SPORE grant from the NCI, but it grew out of that early activity and built a network of people who kind of did that. So that's a great strategy for how to kind of bring young people in, give them a way to get started in a more protected way, and kind of help foster the relationship.

The other thing I think that's a great way to help manage some of that stress is the way we're organized around multidisciplinary clinics and care always puts you on an interface with other faculty members, so you're working in the back room of the clinic with people who have ten, twenty, twenty-five years' experience. There's always somebody to bounce a difficult case off. There's always somebody to get advice in an informal way that doesn't require a full mentorship kind of relationship. It just kind of happens naturally. So I think those are really good strategies for helping people deal with stress.

And then at some point, I think, if you're floundering, we have outlets through an Employee Assistance Program, through more formal ways to get peer counseling and other things, if you feel like you're really having difficulty, and we've tried to make those readily available to anybody at any point and completely confidential, so that, you know, I think one of the big fears is that, you know, I'll somehow be singled out as somebody who can't cut it. And the reality is it's a stressful career and a stressful time of life, and at some point we all need those kinds of things. Some people seek that out informally, and others need something a little bit more formal. But I think the institution did a very good job kind of putting that out in front of people.

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My own personal experience was I think I handled things very well, but I probably got to a mid-career point where I didn't connect as personally as I had when I was younger, and I think that was partly a reaction to I'd seen a lot of bad outcomes and taken care of a lot of sick people—  
[00:09:31]

***Tacey Ann Rosolowski, PhD***

[00:09:32]

And you're talking here connecting with patients?

[00:09:34]

***Thomas Burke, MD***

[00:09:34]

Yes, and family members.

[00:09:35]

***Tacey Ann Rosolowski, PhD***

[00:09:35]

You were distancing a little bit?

[00:09:35]

***Thomas Burke, MD***

[00:09:36]

I was just distancing a little bit, and, you know, not that I wasn't doing what I was supposed to do, but just I wasn't personally connecting as closely as I had earlier. I had a heart issue at the time, I had a bypass in my forties, and I completely retooled my life after that, as you might imagine. And so I kind of reconnected with my family and my patients after that, and I've kind of kept that since that time. That's probably fifteen, almost twenty years ago. But you know, it's hard to get something like that as a wakeup call, so it's much better to do it as a part of your growth and your development. But I think that was a natural thing, is that you get to a point where you've built up some protections, and some of those barriers prevent you from interacting with people as closely as they might like and you might like to do.

Then I think the other thing is we brought all kinds of things into the institution to facilitate the care of ill patients. Thirty years ago, there wasn't an intensive-care team. It was you took care of your own patients in the ICU, so you kind of were responsible for all of the things that happened to them in that environment. There were some consultants, but we built a terrific Intensive Care Unit now that's very modern, managed by people who are trained in that, so that offloaded a lot of the care of those patients to appropriate specialists.

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We did the same thing in palliative care. We recruited and brought in a palliative care team that really provided for end-of-life decision-making and support for patients, again to take that sort of clinical burden off of the frontline cancer faculty. We built a huge Internal Medicine Service that managed all of the sort of comorbidities and the complications of cancer. So when I first came here, the oncologists did all of those things, and as you might imagine, that gets to be a lot to take on. Obviously, knowledge was growing and it became inappropriate for one person to be able to kind of manage all of those things simultaneously. So—  
[00:12:04]

***Tacey Ann Rosolowski, PhD***

[00:12:04]

Well, plus the enormous increase in sheer numbers of patients, yeah.

[00:12:08]

***Thomas Burke, MD***

[00:12:08]

Right. So size, complexity, all of those things kind of played into that, but not perceived as a strategy, but in reality it was, to recruit and build those specialty areas as a way to unload a lot of the really difficult care of sick cancer patients who have issues by people are specifically trained to kind of handle those segments. So I think that did a lot to allow the sort of specialty oncology faculty to focus on clinical trials, their research agenda, the specific cancer care of the patients they had, and, in a way, protected them from some of the other things. We also built out a pretty good psycho-oncology and survivorship program, so a lot of good resources in social work, physical therapy, nutrition, psychiatry, other specialists that could help pull some of that out of the mainstream.

So I think that's an ongoing issue. I don't see this getting any better. I think what we do is difficult, it's stressful, and it's complicated, and I think you're going to have to continually work at kind of adjusting people. You know, the real issue around stress and burnout is that work teams need to take care of each other. Nobody knows you better than the people who are in the clinic with you every day. So maybe not even the department chairman, but if you get too far removed from that, you really don't know the day-to-day stresses people are under. You don't know what's happening at home. You don't know how other things are going for them. So I think it really becomes incumbent on the core team to kind of take care of each other, just as you do in your family, if you think about it from that perspective.

I think the other thing we've worked hard at is to try to deal with dysfunctional and disruptive behavior. I think that really accentuates stress that occurs in any workforce.

[00:14:26]

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***Tacey Ann Rosolowski, PhD***

[00:14:26]

When you say dysfunctional and disruptive behavior, what are you referring to?

[00:14:30]

***Thomas Burke, MD***

[00:14:30]

I think people acting out, people being rude, inappropriate, just yelling, screaming, not respecting the people that work with and for them. It's always a small percentage of people, but it takes a huge burden on the teams.

[00:14:52]

***Tacey Ann Rosolowski, PhD***

[00:14:53]

Well, I know—wasn't there a survey done in 2010, if I'm correct, and what was it that kind of made it necessary to do that survey at that time, and what were the findings?

[00:15:06]

***Thomas Burke, MD***

[00:15:07]

Well, I think we've done employee opinion surveys pretty much every two years.

[00:15:11]

***Tacey Ann Rosolowski, PhD***

[00:15:12]

Oh, really? Okay.

[00:15:12]

***Thomas Burke, MD***

[00:15:12]

Yeah, so that the one in—we started—I'm trying—I don't have the precise date for the first one. It was probably 2004 or '05, somewhere in that ballpark, and it just was sort of a best practice for large organizations to test their employee workforce, and so we have done—we have committed to doing that every two years. And then at the management level and the executive level, we've designed programs that address things that come forward from that. So trust, openness, communication are kind of recurring themes that come through those surveys, some years at a higher level than others, but we've always had to develop some strategies to try to break those down, and I think that that relates in a good way to helping to focus the organization on specific touch points. So mentoring programs were a direct result of that survey process. So were concerted efforts to deal with disruptive behavior, individuals. We were pretty aggressive about

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sanctioning people and dealing with those issues. Many of those are a symptom of stress and burnout anyway, and so trying to kind of provide the background resources to help people work through those issues, as well as to set expectations about how you're going to work with others is—I mean, that's part of the reality of life no matter what you do.

[00:16:49]

***Tacey Ann Rosolowski, PhD***

[00:16:49]

Yes. Right. I was thinking, I mean, that's a commitment to transforming the culture, in a sense, to say, all right, this is not a culture in which that is acceptable, and we're going to make it—

[00:17:01]

***Thomas Burke, MD***

[00:17:02]

Yeah, exactly, and if you think about patient safety and good care and communication are all based on quality relationships between people that work on the team and who communicate well, and if you don't have that, you aren't safe and you aren't high quality. So that really needs, I think, some specific focus.

[00:17:24]

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## **Chapter 18**

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

#### *The Institute for Cancer Care and the Challenge of Value-Based Care*

##### **Story Codes**

B: The Business of MD Anderson

A: The Administrator

B: MD Anderson Snapshot

B: Institutional Mission and Values

D: The History of Health Care, Patient Care

D: Fiscal Realities in Healthcare

B: MD Anderson Impact

B: MD Anderson Culture

B: MD Anderson Mission and Values

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Industry Partnerships

B: Beyond the Institution

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

[00:17:24]

Interesting. Okay. Let's see. In 2008, the internal Institute for Cancer Care Excellence was created. Can you tell me more about that? Because it kind of goes to this evaluation of the quality of care.

[00:17:47]

##### ***Thomas Burke, MD***

[00:17:48]

Yeah, I think a lot of things came together at that time. We had already established our clinical safety and effectiveness course and a number of our quality programs. I think we've talked about that in a prior conversation. But we kind of wanted to get on the front end of the thinking, and we had gotten in touch with—we had made some good connections with people who really were kind of leading the quality movement in healthcare in the United States, and so that would be Brent James, as I mentioned, from Utah, who had helped us establish our quality course. We had done a lot with the Institute for Healthcare Improvement, which was a Boston-based collaborative with a number of healthcare organizations. We had teams that worked through there and some connections to that.

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And at the same time, Michael Porter at Harvard and one of his colleagues had published a book on redefining healthcare, and that's where the whole sort of value proposition in healthcare came from, their book, and I thought it was very interesting because they were business school professors who worked in entrepreneurship and other things, and kind of came through the back door to healthcare and were trying to put forward some ideas that really started to look at quality and safety and costs mixed together in an equation that leads to what they were defining as value, which was great outcomes at lesser cost. And that really was on the front end of the whole healthcare discussion in our country, and so it resonated at that time.

John Mendelsohn [Oral History Interview], who was the president, made the connection between Professor Porter, since they were both Harvard-trained people, and our team, and so we started to work with Professor Porter. It turns out that one of the tenets of his proposal was that the people who took care of a given disease or a given subset of patients should kind of all come together and work as an integrated unit, and that had been the way we'd been working for ten years. So that was the discussion that he and Dr. Mendelsohn had had. Dr. Mendelsohn said, "Well, that's the way we've been working for ten years." So we made that connection and then began to do some clinical work with them. Our Head and Neck Center team was kind of at the forefront of that. They were interested in doing it and—

[00:20:35]

***Tacey Ann Rosolowski, PhD***

[00:20:35]

Now, when you say you worked with them, what do you mean?

[00:20:39]

***Thomas Burke, MD***

[00:20:41]

Well, they worked with us to be a case study of what Porter had described as an integrated practice unit. We called it a multidisciplinary care clinic. So they were really the same thing, and it was all of the people who took care of a given cancer worked in the same unit in the same geography, which was exactly what Porter had proposed as a theoretical model. So we were, in essence, sort of a real-life experience of what they were defining from a theoretical standpoint.

[00:21:13]

***Tacey Ann Rosolowski, PhD***

[00:21:13]

Was he working with any other cancer centers?

[00:21:15]

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***Thomas Burke, MD***

[00:21:15]

Yeah, well, he's worked with a lot of people, so his theory is not specific to cancer. So he's worked with clinics across Europe, Cleveland Clinic here, others across the United States. So the business school model at Harvard is to develop case studies that kind of display the theory, and those are taught together, and so he did a number of healthcare courses where we became the sort of real-life environment and they taught the theoretical model.

So all of those came together, and that's sort of what led to us defining the Institute of Cancer Care Excellence and trying to plug in some of the theoretical background with metrics of quality that we were going to be asked to define. So we had a couple of great presentations at the courses in Boston, I went up, Dr. Feeley and others went as well, and we kind of taught the clinical piece after they taught the theoretical piece. So then the pushback to us is, "Okay, so what's your data?" So I think that was the challenge to us, and we formed the Institute as a way to develop that data. And we had some really good, interesting ideas, so—

[00:22:34]

***Tacey Ann Rosolowski, PhD***

[00:22:35]

Now, let me just kind of interject here, because it was interesting, when I was doing some of the background on this, that there was sort of a problem in defining what is value and what is quality of care. I hadn't really thought about that. (laughs)

[00:22:50]

***Thomas Burke, MD***

[00:22:50]

You have to really think. You kind of think about it and you say, "So what's really important?" Actually, the whole interchange caused us to kind of step back and say, you know, "So what really is important?"

So the Head and Neck team, I think, was a great example of how we started this. Porter had had a list of—he and I sat for a couple of hours, and he had a list of fifty or sixty things that he thought should be on this quality list. And I said, "You know, Mike, it's got to be three or four. We're not going to be anywhere near practical if we're looking at fifty."

So that's when we kind of got into the discussion of what really counts. We talked to the clinical teams, we talked to patients, which I think was, at the time, a more interesting approach, and we got the Head and Neck guys down to about five things. So it sort of came to be, at the end of your treatment, are you alive or dead, which was critical; how long did it take you to get your treatment completed. So if you think about one of the side benefits of putting everybody who

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takes care of you in one place, we should be able to make that happen quickly, and in some cancers, your treatment cycle time adds to your survivability. If you can be treated in a compact time, you'll do better. So instead of looking at little pieces of time, we looked at from the day you were diagnosed until the day you finished, what was that time. And then we had the patient-defined episodes, so that was, "At the end of my treatment, could I speak?" So for head and neck cancer, being able to get through your treatment and speak normally and communicate was critical. Can you feed yourself and maintain yourself calorically? And then the fifth dimension was the cost.

So I thought that was a really nice five-point, you know: alive or dead; how long did it take; can I talk; can I eat; and what was the price. So we started to play that out. And it turned out you can get to most diseases by the dead-or-alive piece is appropriate to everybody. The cost is appropriate to everybody. The timing is a pretty universal one, and then there's usually a couple of dimensions of disease-unique things. So, you know, if you go to breast cancer patients, it's "How do I look at the end of my treatment?" Pretty basic. And "What's the long-term effects on my bone and my survivability from that prospective?" And for prostate patients, it was could they pee and be sexually functional. And for the lung cancer people, it was oxygen-dependent and "How far could I walk?" You know, pretty basic things.

So I think it was a nice way to dimensionally think of how you would want to describe the outcomes of what you do. Now, the problem is, none of the national groups that started to look at quality measures were kind of going at it from that perspective. They were looking more at process metrics like did you get this within a certain amount of time. So we realized relatively quickly that we needed to get some people embedded in some of the national organizations or we were going to be stuck with a bunch of quality metrics that we didn't think really told the story of quality. They were sort of short-term things, not the bigger-picture things that we were looking for.

So the Institute was a focal point to kind of bring all of this together, so the initial part was to kind of flesh out the methodology, to build the case studies with Professor Porter, and then it morphed into can we define the metrics of quality, how do we get to those, how do we put them in front of people. And then the next iteration was can we influence the national bodies that are trying to define quality to start to look at some of those things.

And now it's morphed more into the financial side, and so we've done a big effort trying to map out the processes of care and attach costs to each step of those, and then to find ways to reduce costs by simplifying the process. So that speaks to some of the lean principle things that we were talking about from a quality perspective and that everybody who takes care of a patient or is involved in that process, you want them to be doing the piece that they're best qualified to do and not being brought in to do lesser pieces that you could do with a cheaper person or a

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different kind of person. So that's the way that you can pull some cost out of the healthcare system.

Another piece of that is to try to standardize what you do to people. So we all tend to freelance it. So somebody'd get a CAT scan every three months, somebody else would do it every six, somebody did it once a year, so what's the really right number, and can we squeeze some cost out by getting to an agreed-upon consensus for what the right sequencing of things is.

So the Institute kind of played all of those, did a lot of pilot work, and now is working on trying to translate some of the process work and the cost work into how we would come up with bundled payment strategies for cancer. So what the payers would like is if you have breast cancer of this stage, we're going to pay you  $x$  dollars, and you're responsible for all of the treatment things. Until you know all of those other things, there's no way that you could get to the point where you could say this is the price that it would take to do that.

So I think we've used that as an incubator for a lot of ideas and strategies. It's been a small group that's kind of interconnected in and out, and it's kind of evolved over time from, at the front end, a very basic definition of multidisciplinary care, then to quality measures and outcomes, then to process, and now it's kind of moved into cost.

[00:29:28]

***Tacey Ann Rosolowski, PhD***

[00:29:29]

I picked up this detail, that in 2012 an article that was published through the group, if I understand correctly, was awarded the Edgar C. Hayhow Article of the Year Award, I guess sort of formalizing how quality can be defined in this healthcare environment.

[00:29:51]

***Thomas Burke, MD***

[00:29:51]

Yeah. So we've been doing a lot of work. My comments in some of the earlier conversations is we wanted to publish a lot of the work we were doing so that we had credibility as a management team and others that were kind of doing this thinking. So a lot of articles have come out of that, as have a lot of presentations at meetings for that work.

[00:30:12]

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***Tacey Ann Rosolowski, PhD***

[00:30:14]

So what is MD Anderson's role nationally in helping drive this conversation about quality? I mean, this sounds like a very active presence. What is the institution's impact?

[00:30:29]

***Thomas Burke, MD***

[00:30:30]

Well, probably less than we'd like and more than we would have had if we hadn't gone into that. So I think the real difficulty is that most of the outcomes that you would truly like to measure are not easy to obtain, and so—

[00:30:50]

***Tacey Ann Rosolowski, PhD***

[00:30:51]

What do you mean by that?

[00:30:51]

***Thomas Burke, MD***

[00:30:52]

Well, they don't show up in a computer system or an electronic health record. They're very complicated to put together. And probably the only one that's easy to get at is the alive-or-dead question. That one's pretty straightforward. And the timing stuff you could usually get to. But the sort of personal outcomes that happen to people, you know, there isn't anything that said, "I can talk," you know, if you think about that, and so we had to go through records, really, one by one, to find out who needed speech therapy, who had a laryngectomy. But there wasn't a data stream that would support that, so I think one of the big difficulties is, especially if you start to spread this nationally, is if everybody's not collecting the same pieces of information, there's no way to generate what those metrics are unless you have a bunch of people that are kind of digging through the charts one by one, and that's just not practical to do on a large scale.

So a lot of the metrics that would come forward were metrics by default that were obtained off of electronic systems, and a lot of those were cost-driven or payer-driven because there was a bill and a way you could kind of get at that, but they weren't really the outcomes that you wanted to track. So I think that's the issue we wrestle with now, is do we want to take measures of convenience because we can get them, or do we want to really fight for the measures that we think are the important ones to be judged on. And most of us believe that those are the ones that we should go after, and we should force the issue of, okay, so how are we going to get to those if we don't have them today. Those are the benchmarks we would want to compare against anyone else, and those are the ones we would want to put forward. In front of our patients and the people

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we take care of these are the things we're trying to get happen, not, you know, you've got your first chemotherapy within a month of coming, you know, stuff that probably in the long term isn't really important to people.

So I think that's an ongoing issue. It's one that we're going to have to work hard to resolve. And I think part of the pressure of healthcare reform as we see it unfolding is the pressure to show those measures of quality and outcome, but not fighting for the ones that are really important to have. So I think we're going to have to find our way through that maze going forward.

[00:33:39]

***Tacey Ann Rosolowski, PhD***

[00:33:42]

Interesting dilemma. What was the effect of, as you said, embedding some MD Anderson representatives in these national groups?

[00:33:50]

***Thomas Burke, MD***

[00:33:51]

Well, I think it gave a reality check to the discussion, and I think the main thing is we're perfectly happy to be judged on our outcomes, but we want them to be outcomes that are important to people, both the care providers as well as the people that you care for. We didn't want to have to invest time, effort, money, and systems in tracking stuff that we didn't think would lead to better care, because then you're really just wasting the effort.

[00:34:22]

***Tacey Ann Rosolowski, PhD***

[00:34:23]

Right.

[00:34:23]

***Thomas Burke, MD***

[00:34:23]

And so I would much rather push to get to the things that we think are really critical.

[00:34:29]

***Tacey Ann Rosolowski, PhD***

[00:34:30]

Just for the record, what were some of those groups that you made those connections with?

[00:34:34]

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***Thomas Burke, MD***

[00:34:34]

So there's a number that—and that's part of the process, too, is different people were working on different metrics. So the American College of Surgeons has a group that's working on surgical metrics and surgical performance. ARQ [phonetic], which is a big national effort, had been working on trying to define some quality metrics [unclear].

[00:34:55]

***Tacey Ann Rosolowski, PhD***

[00:34:56]

And ARC stands for?

[00:34:56]

***Thomas Burke, MD***

[00:34:56]

American Health Quality—I'll have to find the right—

[00:35:03]

***Tacey Ann Rosolowski, PhD***

[00:35:03]

Okay.

[00:35:04]

***Thomas Burke, MD***

[00:35:05]

That ultimately got assigned to the National Quality Forum, NQF, so we have some people on the NQF committees who are trying to define the metrics now. And then every specialty society in our country has sort of proposed a set of things that are appropriate for whatever it is that group does, and so trying to consolidate all of that in a way that is a little simpler and more straightforward, I think is the challenge.

[00:35:39]

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## **Chapter 19**

### **B: The Finances and Business of MD Anderson;**

### ***Financial Realities in Healthcare: The Need for Investment in Healthy Behavior; Assessing the Value of Treatments Near the End of Life***

Story Codes

B: The Business of MD Anderson

A: The Administrator

C: Patients

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients

C: Cancer and Disease

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

D: The History of Health Care, Patient Care

D: Fiscal Realities in Healthcare

***Tacey Ann Rosolowski, PhD***

[00:35:42]

Over the course of these discussions, and as I mentioned to you before we turned on the recorder, I interviewed Dr. Barbara Summers [Oral History Interview] this morning, and we were talking about these quality issues, and through conversation with her, conversation with you, conversation with other individuals, I had not before been aware of just the enormous sea change in transformation of healthcare, you know. I mean, it was a very abstract kind of notion to me, but now it's like the very fundamental assumptions on which it's grounded are shifting, and I can imagine that that's controversial, uncomfortable for a lot of people (laughs), as well as just being intellectually and practically extremely challenging, I mean, as you've just outlined. And I'm wondering, you know, given kind of the controversial piece, I mean, what's—what—I'm not even sure I know how to formulate the question, but, you know, the practitioners that you were talking about earlier who are under so much stress, clinicians who are delivering care, I mean, they're kind of caught in the crossfire of this, needing to deliver the care that they know how to give and that they believe in and then feeling this transformation. What is the impact of that on the institution, I mean, and how do you manage that impact?

[00:37:10]

***Thomas Burke, MD***

[00:37:11]

Yeah, I think this is a really complicated time and environment for all of those reasons, but I think the hardest is that as a country we have never been willing to confront the realities of

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healthcare from the perspective of the investment in healthy behaviors. Prevention, lifestyle things have impacts way beyond any of the things that we do on the treatment side, and so we traditionally have not paid for those things, not embedded them in our kids, you know, not done the things that really would over decades change radically the health of our people and the costs of taking care of them. So we've always been focused on the pay for taking care of sick people rather than teaching people to stay well and avoid illness, and I think you're starting to see the change in that now. So it's a whole different workforce, it's a whole different set of strategies that work on teaching kids to be active, to avoid sun, not to get hooked up to tobacco, you know, to do the things that we know over years will lead you to be healthier and more productive. So—  
[00:38:44]

***Tacey Ann Rosolowski, PhD***

[00:38:44]

Is there more of an investment in that now than there was?

[00:38:47]

***Thomas Burke, MD***

[00:38:47]

I think there is, but it's just starting. I mean, you see a lot more discussion in the press and in public venues about childhood obesity, sun exposure, tobacco, a lot more than we saw ten, fifteen, twenty years ago for sure, and then now you're starting to see companies that invest in wellness programs for their employees because it's more important to keep them on the job than to help take care of them when they're sick. So there's a lot more willingness to put some money into that side of it, and, frankly, a lot of the requirements for the plans in healthcare reform are that those services are covered and paid for.

So I think that's a big shift to the sort of front end of healthcare, and the problem before was always that the people who invest in those things, your insurance company, your employer, whatever, were not going to be the people that saw the benefit twenty, thirty, forty, fifty years later, so there was no way to make an economic connection to investment in those areas. So I think that's a change that's starting that really will be dramatic for the country as a whole. You know, probably a third of cancers today are tied to smoking. If we just bit the bullet and said you can't smoke anywhere in America, we would cut it in a third literally overnight. But we haven't been willing to do that as a population, so it's a [unclear].  
[00:40:22]

***Tacey Ann Rosolowski, PhD***

[00:40:22]

So when you say "we," are you including MD Anderson in that? Where is the institution on the [unclear]?

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[00:40:27]

***Thomas Burke, MD***

[00:40:28]

Well, the institution has always been an advocate for healthy behaviors and preventive strategy. We've had a prevention program for two decades. But it's very hard to run national policy for 350 million people from a single institution in a single location in a specialty area. So we can be advocates for those things, but not have the heft to make that a national priority. It has to come sort of at grassroots and a much more broad strategy perspective.

And I think the other place that as a country we haven't dealt with is, you know, what's end of life look like. A lot of the debate around the healthcare reform legislation was tied to "You're going restrict care for me when I'm old." And I think there's a distinction between old and dying. So if you think about a lot of the statistical analyses say we spend a huge amount of money on people in the last thirty to sixty days of their lives that is not value-added from anybody's perspective. So as a country, we've wrestled with individual choice of "I should have access to any treatment that might be available that might help me, irrespective of the cost," against "What's the right thing to do?" It would be much better to invest that money on the front end for preventive strategies and other things than to spend it on the last thirty to sixty days of your life.

So that's the part we haven't really gotten good at discussing, and yet if you took it aside and you asked people what would you want, you know, well, I'd want a reasonable try at being healed and getting better. If that's not going to happen, I'd rather be at home with my family for whatever time I've got and as much function as I can manage. And so the reality is we don't play that. We get sucked in. We haven't had a good conversation with patients, their family members. We haven't set it up. And so we get sucked into the play of, you know, "I want everything done," and we just pile up the cost and the other things, knowing that you're not really doing a lot of good. So we've started to generate some data on that to frame the discussion.

[00:43:05]

***Tacey Ann Rosolowski, PhD***

[00:43:06]

What kind of studies have you done?

[00:43:08]

***Thomas Burke, MD***

[00:43:08]

We have some great studies of looking at of the people that went into our ICU who went home, so starting to look at what are the subsets of patients who got admitted to an Intensive Care Unit

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that actually got better and went home. I mean, that would be the outcome I would want if it were me, you know. And what were the subsets of patients that went into the ICU and died in the hospital. Those would be patients—I would not want to make those choices. So you're starting to be able to pick apart these are the people who have a single event, you can manage it, you can effectively deal with it, they will get better, they will work their way out of the hospital and get out, and those you want to continue to care for. The ones that you know are not going to get out, you'd like to stop that process before they got to the Intensive Care Unit. So those are the ones you want to have an earlier conversation with or their family members or have living wills or other things that sort of set up that process.

We've also looked at some studies of who got chemotherapy in the last thirty days of their lives. So should we really be doing third-, fourth-, or fifth-line treatment in somebody who you know has a lifespan that's very short? So, again, starting to define who are the groups of people who get good extension of their life with that kind of a treatment, and who are ones that it doesn't impact, and you really just subject them to the morbidity of that treatment and extra cost and time in the hospital and all kinds of things that they probably don't want.

So those are, I think, ways to start to frame a discussion. I mean, if you go in front of a family and can sort of take them away from what's happening to mom or dad and say, "You know, of 100 people that are where they are that went into our ICU, nobody went home." That's a different discussion than "You have to do something to help my parent now," or my family member now. And so if you don't have the ways to kind of frame that conversation, it doesn't get real for people.

So I think those are the two biggest areas that we need to really think about as we kind of work our way through, so how are we going to shift the emphasis to the front side of the equation, and how are we going to deemphasize the back side that probably none of us really want, and I think that's an ongoing conversation. We'd like to be a participant in that conversation. We'd like to have the data and the information that helps people make good choices about how to do that, helps *us* make good choices. I mean, we're part of the reality of where things are now.

[00:46:09]

***Tacey Ann Rosolowski, PhD***

[00:46:10]

Yeah, absolutely. Absolutely.

[00:46:12]

***Thomas Burke, MD***

[00:46:16]

That's a very philosophical discussion. (laughs)

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[00:46:18]

***Tacey Ann Rosolowski, PhD***

[00:46:18]

Oh, no. No, I think it's very, very illuminating. I mean, it's—you know, adds a facet to some of the kind of very pragmatically focused sound bites that come out about what the healthcare discussion is about, you know, and this is the broader context in which, you know, everyone who's in these groups, I mean, they understand these issues, and I think it's enormously helpful for people that understand, you know, the broader—the broader scenario in which people are talking about these practicalities. And I think a lot of people don't know how little information there is about the effectiveness of treatment.

[00:46:57]

***Thomas Burke, MD***

[00:46:57]

I think that's true, or what it costs.

[00:46:59]

***Tacey Ann Rosolowski, PhD***

[00:46:59]

And how that information has to be gathered.

[00:47:00]

***Thomas Burke, MD***

[00:47:00]

Or what it costs.

[00:47:01]

***Tacey Ann Rosolowski, PhD***

[00:47:01]

Yeah. I mean, I think a lot of people—and as you were talking, I was thinking, wow, I mean, I wonder how many family members are asking for certain kinds of treatment because they want to feel like they've done everything, and not that, you know, they don't have the information in front of them, well, if we do this, there's going to be pain, there's going to be cost, there's going to be time of agony and emotional pain for a family, that's really—there's no need for it.

[00:47:32]

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***Thomas Burke, MD***

[00:47:33]

Right.

[00:47:33]

***Tacey Ann Rosolowski, PhD***

[00:47:33]

No need to put anyone through this, and so it's an emotional reason to choose this.

[00:47:37]

***Thomas Burke, MD***

[00:47:38]

Yeah, it really is, and I think that's sort of the assignment of having a big palliative care program and an understanding of what you could accomplish with Hospice and other ways to manage. I mean, we're all going to die. It's a pretty natural event.

[00:47:52]

***Tacey Ann Rosolowski, PhD***

[00:47:52]

Right, right.

[00:47:53]

***Thomas Burke, MD***

[00:47:54]

So, you know, how we deal with that in a large mass is, I think, important.

[00:47:59]

***Tacey Ann Rosolowski, PhD***

[00:47:59]

Yeah, and that creating that body of information that helps, as you said, frame the conversation for patients and families so that they can make good decisions is really key.

[00:48:08]

***Thomas Burke, MD***

[00:48:08]

And it's always easier to deal with this in the abstract than it is to deal with it one-on-one, you know. It's easy to say, man, wouldn't you like to be spending all that money on fifth-line chemotherapy on helping to kids from smoking, and that makes great sense, except when it's my relative or my friend—

[00:48:28]

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***Tacey Ann Rosolowski, PhD***

[00:48:28]

Right. Or your child. (laughs)

[00:48:29]

***Thomas Burke, MD***

[00:48:29]

—or my partner, you know, whatever. So it gets hard.

[00:48:32]

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## **Chapter 20**

### **B: The Finances and Business of MD Anderson**

#### ***Financial Realities in Healthcare: The Affordable Care Act***

Story Codes

B: The Business of MD Anderson

A: The Administrator

D: Fiscal Realities in Healthcare

D: The History of Health Care, Patient Care

B: Institutional Processes

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

***Tacey Ann Rosolowski, PhD***

[00:48:32]

Yeah, absolutely. Absolutely. Well, I'm looking at some of the other issues. I guess one thing that we haven't talked about at all but has a bearing on this conversation is the impact of the Affordable Care Act. Have there been some dimensions of that that we haven't covered in these other conversations?

[00:48:54]

***Thomas Burke, MD***

[00:48:55]

You know, I think we still don't know, and I think one of the really hard parts is that our state has chosen to be a nonparticipant largely, and so a lot of what we're seeing is pretty early and pretty minimal, and I think it's going to take a while to shake out and really see what the impact is. There are pieces that I think are really critical. Access to care and services, you know, we ought to espouse that. I mean, why would we want people to have illnesses or diseases or other things that we have treatments for that are effective, that are good? Why wouldn't we want that to happen? So how we figure that out is, actually, it's a dollar-and-cents thing more than anything else right now. So that part I see as really good.

It's always when you get down into the details and the mechanics and all the little bits and pieces that it really gets complicated and difficult, and there's always going to be a time because we're trying to do it while we're rooted in a payment system that won't survive. So today if you do the wrong things, you make more money than if you do the rights things. So—

[00:50:22]

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***Tacey Ann Rosolowski, PhD***

[00:50:23]

Can you give me an example?

[00:50:24]

***Thomas Burke, MD***

[00:50:24]

So the right things are, you know, I should have a completely laid-out strategy of how much testing to do, you know, and I only do the sequencing that I know is effective and manages a patient. So on the other hand, every CAT scan we do as a hospital, we get paid for. So we would actually get paid more if we were the every-four-month CAT scan people than if we were the once-a-year CAT scan people. And so the strategies that might be the right things to do and that there's data to support don't provide the resources to keep the organization ahead.

So who absorbs that difference in the sort of in-between time while we're working our way through the payment methodology before we come out on the other side? So who's going to pay for all those prevention strategies and the screening things and the other things when there right now isn't enough money flowing on that side to make it work? Even though that might be the right thing to do, and even though the ten-year or twenty-year economics make great sense, you know, you've got to survive as an organization today and pay your people and run your services. So that's sort of the business reality of trying to work from a system that's been in place for decades to one that's really a completely different model.

[00:51:49]

***Tacey Ann Rosolowski, PhD***

[00:51:49]

Wow.

[00:51:51]

***Thomas Burke, MD***

[00:51:51]

Everybody's wrestling with that. That's not unique to MD Anderson.

[00:51:53]

***Tacey Ann Rosolowski, PhD***

[00:51:54]

Right, right. Right. But a very, very interesting portrait of how, you know, this organization is being, you know, steered or (laughs) shoved or—I don't know how you want to say it. (laughs)

[00:52:07]

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***Thomas Burke, MD***

[00:52:07]

I think, you know, the big picture's you have to be balanced in the missions that you have and make sure you're addressing all of those, you have to be financially prudent with the resources that you're given, and you have to try your best to anticipate where things are going and to set up those moves. And it used to be easier to do that. It was more predictable.

[00:52:38]

***Tacey Ann Rosolowski, PhD***

[00:52:39]

Interesting. Is there anything else that you wanted to add about that, you know, life you led at MD Anderson as physician-in-chief and, you know, and in that administrative capacity?

[00:52:52]

***Thomas Burke, MD***

[00:52:52]

No, I mean, we've hit a lot of places for that, I think.

[00:52:55]

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## **Chapter 21**

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

#### ***The MD Anderson Network: Origins, Mission, and Lessons of MD Anderson Orlando***

##### **Story Codes**

A: The Administrator

B: MD Anderson History

B: Beyond the Institution

B: Institutional Mission and Values

B: MD Anderson Snapshot

B: The Business of MD Anderson

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Growth and/or Change

C: Healing, Hope, and the Promise of Research

C: MD Anderson Impact

C: Understanding the Institution

C: The Institution and Finances

C: Research, Care, and Education

C: Education at MD Anderson

C: Cancer and Disease

D: Fiscal Realities in Healthcare

D: The Healthcare Industry

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

[00:52:55]

Okay. Well, of course, the next role is that earlier this year you were made executive vice president overseeing the MD Anderson Cancer Network, which was kind of a huge, huge shift, or maybe it wasn't. I mean, on paper, to me, it looks like a huge shift. (laughs) Maybe you have another kind of perspective on it. (laughs)

[00:53:13]

##### ***Thomas Burke, MD***

[00:53:15]

Well, you know, it's actually a great assignment, and most of the things—MD Anderson wrestled for a long time with whether we should do something in other places with other people, and it was sort of like we were very insular. You know, you couldn't deliver what we delivered anywhere other than right here on the main campus, and in some areas that's true. There are

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some things that can't really be delivered anywhere else but here. But the reality is there's a lot of people with cancer that get treated in a lot of settings outside of what we do here. And one of our missions is to eliminate cancer, and so if we're unwilling to be in other places and be with other partners and do other things, we're never going to deliver on that promise.

So the Network really started as a series of things, and I used to—in my old assignment, I had clinical responsibility for those, but one was the regional network that we have in Houston, a series of outpatient centers around the Houston metropolitan area. We have a program at LBJ Hospital, which is a county hospital for indigent care. We had a long-term relationship in Orlando, Florida. We have partnership relationships now in Phoenix and in Camden, New Jersey, with Banner Health and Cooper University. We have probably a dozen or more sort of lower-level quality relationships with hospitals in communities and cities across mostly the southeastern and midwestern United States.

But those had all sort of grown as separate programs, so there was the what we called the sort of certified community member program under one team, we had the Houston group as another team, and then we had the sort of partner group as a third team. And in addition to all that, on the research and academic side we had a number of sister institution relationships across the world that were not really clinical collaborations, but research and educational things, and these were all hugely successful.

So we had huge growth, they all had vibrant agendas and lots of exchange, and I think it sort of reached a critical mass where it was not possible to really develop those relationships as a sideline from my other job, and so that's when it was split into two assignments. So I essentially went from largely focused on what happened in Houston—or on the main campus to completely focused on everything not happening on the main campus. But I still had a basis in all of those areas from when they launched.

[00:56:15]

***Tacey Ann Rosolowski, PhD***

[00:56:16]

Now, why were you appointed to this position, I mean *you* appointed to this position?

[00:56:22]

***Thomas Burke, MD***

[00:56:23]

I think Dr. DePinho was looking for someone who knew those areas, could connect quickly. These are growth areas for the institution. I think it was a good time to make a switch on the internal side, that he needed to bring in some additional leadership so we could partition out the Management Committee a little bit larger and more broadly than it had been. And it's a good

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time to provide some other people with leadership roles in the institution, so—  
[00:57:04]

***Tacey Ann Rosolowski, PhD***

[00:57:05]

Why did you take the appointment?

[00:57:07]

***Thomas Burke, MD***

[00:57:08]

Because I thought this would be a lot of fun, I thought it was a group of people who I had already recruited and put in place, and I think it ultimately will be what allows the institution to survive. You know, the reality of delivering on our mission is that we have to reach more people than we were able to reach just as a single research institution. So we would like to have maybe three, four, five large partnership relationships in a decade, we'd like to have maybe two dozen certified members across the United States, we'd like to have some international relationships. Then you're talking about having an MD Anderson partner in places that reach 10, 15 percent of the people in our country, and those would be places where you could come and access clinical trials, where we've trained people, we have standards about how they deliver drugs, how they manage survivorship, how they manage their treatment algorithms, and we have partners with us in those communities who are committed to providing better care for people.

So I think that's a huge delivery on the promise of the organization that you could never do if you stayed kind of walled up on the main campus. It's going to be harder for people to get here. Their insurance plans may not allow them to travel. There's all kinds of barriers around cost and expenses of going somewhere for treatment. So unless we're in a position to be in different locations, people won't have access to what we do. So what I really think the Network provides is a platform that we could take high-priority clinical trials, other things directly to people through other relationships that we have across the country without having to rebuild seventy years of MD Anderson in those locations.

And then the other side of it is that we'd like all those people to participate in new discoveries, so part of where our research teams need to go is we need your blood, we need some samples of your tumor, we want to know the genetics and the molecular basis of those things. We want to use your serum to see if we can develop new tests. And so if you're a cancer patient at our program at Cooper in New Jersey and you say, "I'm willing to consent for my tissue and my blood to be sent to Houston," then our research teams have access to huge groups around the country that we would never bring to the main campus. So I think it's a great exchange. It's a

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way to drive the care discoveries out, and it's a way to bring in the things that we'll need for new discovery, and hopefully we can fast-forward some of that process.

The other thing I wanted to mention is that it takes a long time for changes in the standard of care to get disseminated. So, you know, we're kind of working here on the front end, we go to all the meetings, we hear about all the newest stuff, we're developing things, and so we put those in the clinic right away, and we're moving on to the next thing. But if you live in a small town and your oncologist trained twenty years ago, it takes years for that practice pattern to change. So the other leverage of a large network is that you can drive those changes across a really broad swath in a very short period of time. So if we had something that got a 15 percent improvement in survival, we would be doing that at twenty locations at once, not just on the main campus, and we'd be moving on to the next idea. If you just let it percolate out in the usual academic process, it gets presented at a meeting, it gets published a year later in a journal, it kind of gets talked about, and it's a decade before it actually gets to people. So part of the network is to also move things more quickly.

[01:01:51]

***Tacey Ann Rosolowski, PhD***

[01:01:53]

I have a question about what happened with Orlando, because it was a long relationship, the relationship ended, and I wondered if you could tell me a little bit about why and then the lessons that were learned from that, given that now the idea is, well, we're going to establish a lot more close partnerships.

[01:02:12]

***Thomas Burke, MD***

[01:02:12]

So Orlando was sort of our very first partnership, it lasted twenty-some years, and it was driven largely by the interest of a small core group at Orlando that wanted to establish that relationship and to find ways to bring some aspects of MD Anderson to people in Central Florida. It was a small cancer center, it's not a large place like here, but we built a core group with them over time. It had some research activities, not large but some, and it was largely a clinical program.

I think the real benefit was that there was a great opportunity to embed some people that had trained at MD Anderson or that we recruited embedded into a core group in Florida that then delivered both high-quality care, but also brought some clinical trials and other things to that environment. And I think it was difficult because the main campus group was still embedded in, "If you can't do it the way we do it in Houston, why would we do it?" So there was a lot of sort of pushback to, "Well, you don't have what we have in Houston on the ground in Orlando. How can you possibly be delivering MD Anderson care?"

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I think it took a long time for the institution to kind of come to grips with, you know, the real goal—and I think we talked about this before, is the real goal should be we want the care to become better for the people where we are with our partners, and being better than what they have is an acceptable goal. It doesn't have to be to the depth that it happens on the main campus in Houston. And so I think that was the internal transition and then—

[01:04:07]

***Tacey Ann Rosolowski, PhD***

[01:04:07]

How—what is that—what is accepting that like for MD Anderson? I mean, because I can really see both perspectives, you know.

[01:04:13]

***Thomas Burke, MD***

[01:04:13]

Sure, sure.

[01:04:14]

***Tacey Ann Rosolowski, PhD***

[01:04:13]

The individual says, “No, MD Anderson is this, and if we change it, it's diluting what MD Anderson is.”

[01:04:20]

***Thomas Burke, MD***

[01:04:21]

Right.

[01:04:21]

***Tacey Ann Rosolowski, PhD***

[01:04:21]

So how do you reconcile that?

[01:04:24]

***Thomas Burke, MD***

[01:04:24]

So I think the practical reality of that is that probably 80 or 85 percent of cancer can be well treated by good trained people who do it all the time, who work in a team. There's not a lot to offer you by coming to the main campus that would be different than you could get in a great

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place in a lot of places in the United States. There's probably 15 percent of the people where if you got that diagnosis, you ought to come here, and I think that still plays. So that's one of those transitional points.

The other is why wouldn't you want to influence what happens to the 85 percent? Why wouldn't you want those people treated along your guidelines, with your input, with you updating yearly what happens to them, you know, what's the diagnostic workup, what's the treatment sequence, you know, how is the pathology reviewed? Wouldn't you rather be engaged in that happening, as opposed to just saying, "Whoa. I don't want anything to do with it"? So I think that was sort of the transitional thinking.

And the other piece is I think there's a lot of great partners out there. Everybody's trying to get better in healthcare, you know, that's across the country. And everybody's being subjected to standards and criteria. Even just the certification of the people, you know, you have to have physicians that are board-certified, you have to have people that have got subspecialty training, you have to have nurses that have done oncology nursing training or chemotherapy delivery. So all of those things are getting better at other places. Why wouldn't we want to take advantage of that? So I think that was a big learning.

And then I think the other big learning is that a multidisciplinary system works best when the doctors work for the center, that it's really hard to have private-practice relationships and build a collaborative center that does multidisciplinary care, because then you take the economic factor out of the decision-making. So our thinking around the partner-level relationships shifted to, you know, if you want to do this, you really need to talk about employing the doctors that are going to participate. And you can have metrics around performance and activities and all of that, but it ought to be an employed model. And, frankly, a lot of doctors are looking for that today. You know, they want the job security of an employment relationship as opposed to a private-practice one.

So I think the problems in Orlando that led to us dissolving that relationship were that the leadership drivers on both sides retired, so that people that had been the glue and kind of worked through the issue list changed. I think that our partner, which was Orlando Regional Healthcare, was struggling in their market and was looking for an expansion strategy that would help them survive economically, and they saw the University of Florida as a better brand partner than MD Anderson from Houston. And so I think there were marketing and financial strategies that they saw as beneficial, so we chose to part ways. I think they learned a lot from us, I think we learned a lot from them, and I think a lot of great care got delivered over the twenty years of that relationship.

[01:08:09]

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***Tacey Ann Rosolowski, PhD***

[01:08:10]

What were the consequences of dissolving that for MD Anderson?

[01:08:13]

***Thomas Burke, MD***

[01:08:14]

Well, I think the consequences were certainly there's a financial relationship, obviously, that was not there. I think that there was a certain long-term—I mean, it was a twenty-year relationship, so I think a lot of the people in that area had come to associate MD Anderson with Orlando Regional, and so I think there's some—I don't know how I would describe it. Maybe as just a change in the credibility of both programs, that you chose to part ways. Business partners part ways all the time, so I think it kind of falls under that category. We were pushing them to make the investment to change into the model that we currently are using, and they decided it was better to pursue a different strategy, and so I think both said that it would be unacceptable to do either of those, so we chose to separate.

[01:09:15]

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## **Chapter 22**

### ***The MD Anderson Network: Building Partnerships Based on Shared Mission***

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

Codes

A: The Administrator;

B: Beyond the Institution;

B: Institutional Mission and Values;

B: The Business of MD Anderson;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

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

C: MD Anderson Impact;

C: Understanding the Institution;

C: The Institution and Finances;

C: Research, Care, and Education;

C: Education at MD Anderson;

C: Cancer and Disease;

D: Fiscal Realities in Healthcare;

D: The Healthcare Industry;

***Tacey Ann Rosolowski, PhD***

[01:09:15]

So that relationship [with MD Anderson Orlando] ended and now the MD Anderson Cancer Network is going to be developing this new array, so what—or strengthening the existing—

[01:09:30]

***Thomas Burke, MD***

[01:09:30]

Yeah, my assignment is to try to figure out how all of those could be linked.

[01:09:34]

***Tacey Ann Rosolowski, PhD***

[01:09:34]

Yeah. So tell me about that. (laughs)

[01:09:36]

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***Thomas Burke, MD***

[01:09:37]

Actually, it's a fun agenda. That was a large reason I chose to do this is, you know, I think that we need to reach as many people as we can in whatever ways we can touch them, and so all of the relationships I described are ways to reach people, and we need to do it with other people who think like we think, who want healthy communities, want to provide great service for people. People who get into healthcare want to do these things, you know. It's not like they're there to make a bunch of money and leave town and do other things. They're there to make their communities healthier. And so finding people with that kind of a mission and thinking is just a perfect scenario for us. And if you thought about the big things that we could leverage are the things that I've started to work on in the last three or four months. One is that we need to be driving a manpower agenda for cancer.

[01:10:44]

***Tacey Ann Rosolowski, PhD***

[01:10:45]

What does that mean?

[01:10:46]

***Thomas Burke, MD***

[01:10:46]

Who are the people that are going to take care of everybody? The best way to provide MD Anderson-level care is to have MD Anderson-trained people delivering it. So I'm trying to take the fellows that we graduate from our programs, take other people in health professions programs, we have pharmacy programs, and say, "Why wouldn't you want to work for an MD Anderson partner somewhere?" You could work at the main campus. You could work in Phoenix. You could work in Camden. You could work with one of the twelve certified members we have.

So thinking in a forward way of instead of letting people become our competitors and move it into practices, why wouldn't you want to work in our network? Because the people that come here, they kind of want an academic environment, they want a cancer focus, they want a way to train other people to do clinical trials, and I have a lot of work environments now where you could do that.

[01:11:43]

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***Tacey Ann Rosolowski, PhD***

[01:11:43]

What are your incentive models to help ensure that that happens?

[01:11:46]

***Thomas Burke, MD***

[01:11:47]

Well, a couple things. One is that we are paying for training slots with MD Anderson money to support people to do those things. So the giveback to our own departments are that we'll fund an extra training position in your program that's not based on Medicare money or some federal program, but we'll use MD Anderson money because we'd like those graduates to be working for us. So that's one.

[01:12:13]

***Tacey Ann Rosolowski, PhD***

[01:12:14]

And where does that money come from?

[01:12:15]

***Thomas Burke, MD***

[01:12:16]

It comes out of the margin of the institution.

[01:12:17]

***Tacey Ann Rosolowski, PhD***

[01:12:17]

Mm-hmm. Wow. So it's a real investment.

[01:12:19]

***Thomas Burke, MD***

[01:12:20]

So we've put some money into doing that. Those are people who are going to drive our clinical trials, they are people who are going to already have MD Anderson networks, so the people-to-people interactions will already be built, and they'll recruit other people to come with them.

The other side of that equation is we have great partners who are training people, so if you have someone who's done a general medicine or a surgery program who wants cancer training, I'd like to take those people into our fellowship programs, and in three years send them back to New Jersey or back to Phoenix, where they live, grew up, have families, and went into practice, but

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we built the specialty component of their practice. So I think that's a two-way opportunity for training.

If you think about our population is aging and the number of people that are going to need cancer services in the next twenty years, it's just enormous. There's no way it can be managed with the people we're currently training, so unless I start to build those people, we're not going to have them.

[01:13:33]

***Tacey Ann Rosolowski, PhD***

[01:13:34]

Right. Wasn't the literature—I know Dr. Hortobagyi [Oral History Interview] was involved in a study that said a 30 percent shortage by 2020.

[01:13:42]

***Thomas Burke, MD***

[01:13:42]

Oh, it's going to be even bigger than that.

[01:13:43]

***Tacey Ann Rosolowski, PhD***

[01:13:43]

It's going to be bigger than that.

[01:13:44]

***Thomas Burke, MD***

[01:13:44]

You know, if you just look at the wave of—

[01:13:46]

***Tacey Ann Rosolowski, PhD***

[01:13:46]

Wow.

[01:13:46]

***Thomas Burke, MD***

[01:13:48]

You know, we don't die of infections and heart disease and other things, so we live long enough to get cancer, so there's going to be a large group. The prevention strategies we talked about earlier are aimed at kids that are ten and twenty now. You're not going to see them for fifty

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years. So the people that we have in our population today are going to be huge consumers of cancer services. So part of what our network should do is to help provide the people that are going to do that work. So that's one unifying feature.

A second is around the issue of integrating clinical trials. I mean, one of the hallmarks of MD Anderson is it brings trials and research opportunities directly to people. The same clinical trials that I do in Houston or with our partners or with other members, they're really the same, and so why shouldn't that be an umbrella that covers all of those sites. So we've got a group that's working on what are the clinical trials that would be appropriate to do across a large network. You're not going to do things that are really intense, that require special equipment and expertise. You're going to do the stuff that is kind of frontline things, and we should be doing those things in suburban Houston and New Jersey and wherever else, and it doesn't really matter. So having arbitrary separations of the components of the network don't make sense from the trials perspective.

And I think the other big piece of this is that we really want to be able to provide access to people. And as I mentioned earlier, you won't be able to do that if you don't have a large reach of relationships. So I think the strategy for us is we'd like to identify a great partner in a large geography area that cares for a group of people, and we'd like to help provide the cancer services within that system, and it doesn't have to be we're trying to move those people to Houston or we're trying to do everything there that we do here. Maybe some people will come here for very specialized things, but the vast majority are going to be taken care of at home where they are.  
[01:16:19]

***Tacey Ann Rosolowski, PhD***

[01:16:20]

So what are you looking at to identify a good partner?

[01:16:24]

***Thomas Burke, MD***

[01:16:26]

Well, I think the main things are we want to be in places that have a partner who has access to the population, so we're looking at health systems that are recognized as high quality, that have a good market share in the places that they're at, know the population well, because every population in our country is different, and think like we think, you know. They want to be on the front end; they want to be delivering great care; they want to have a research connection; they want to train the next generation. So you know, you start to sift through the list, and we send teams back and forth to evaluate partners, and when the people I've sent out to do the evaluation come back and say these are people that think like we think, they really would be good, they're investing in the same kinds of things, they have the same agenda, and so those are good matches.

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[01:17:27]

***Tacey Ann Rosolowski, PhD***

[01:17:28]

Now, so this initiative to kind of bring all these external connections under one umbrella, that's new this year, basically.

[01:17:39]

***Thomas Burke, MD***

[01:17:39]

Yes.

[01:17:39]

***Tacey Ann Rosolowski, PhD***

[01:17:40]

And so what are some of the macro issues you're thinking about in making this shift? Because, I mean, that's a big shift. (laughs)

[01:17:50]

***Thomas Burke, MD***

[01:17:51]

So I think part of it is to internally communicate to the rest of MD Anderson what we're trying to accomplish.

[01:17:57]

***Tacey Ann Rosolowski, PhD***

[01:17:58]

Mm-hmm. And how are you going about doing that?

[01:17:59]

***Thomas Burke, MD***

[01:17:59]

So we have a whole bunch of stuff we're working on that. So I've tried to really greatly broaden the number of people that participate in all of these activities, so we have teams working on all of these areas. We have relationship teams for every partner that go back and forth, so that there's a couple hundred people who can sort of tell the story inside of what we're doing outside from a first-hand perspective.

The other side of that is that our partners want frontline people that are doing MD Anderson work, you know. They don't want me as an administrator or they don't want somebody we've

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hired to be a network person. They want MD Anderson people to be their interfaces. And so those relationships teams need to be doctors and nurses and pharmacists and administrators who are working every day at MD Anderson and this is part of their assignment. And so then we build the people connections between those places that actually make them work. It doesn't work on paper. (laughs) It works with people. And so we need to train their people. We need to decide who needs to come here, who needs to go there, how could we help them get better, what are areas they're having trouble with. Those relationship teams float that stuff up, and then we get strategies for how to address those specific issues.

The goal is to make them better at whatever they do, and so I think that's actually a good message. I mean, that's one that resonates pretty well, and it's entirely consistent with what we're trying to accomplish. So a much broader base of people is where I'm headed, and then also to leverage what we're doing. So if you think about we have a network in Houston, we're trying to do the same thing in Phoenix, we're trying to do the same thing in Camden, so why wouldn't I use some of our Houston teams to be supporting those other relationships? Why would we arbitrarily say, "Well, that's a partnership team"? Or if we try to go and do some international work, that's not any different than what we're trying—so how would you leverage the experiences and the knowledge base of the people that have built these programs across a broader area?

So that means that we're going to need more people to do that as the number of relationships grows, and for MD Anderson it means that we will greatly expand the reach of the trials operation, we can greatly expand the discovery resources that come back, and I think that it'll also help us—each of these is also a financial relationship.

[01:20:50]

***Tacey Ann Rosolowski, PhD***

[01:20:50]

Yeah, I was going to ask about that piece. What's the expectation there?

[01:20:53]

***Thomas Burke, MD***

[01:20:53]

So we usually do these as a business arrangement that has fees attached to it, so our partners pay for those relationships and the services and the training and the back and forth, and those represent sources of revenue back to MD Anderson that allow us to pay for research and training and main campus agendas that we can't fund off of other things. NIH and NCI are restricting. All of our resources are tightening. These are ways for us to invest in our mission.

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You know, it ought to be a renewable cycle, so if I take money that I make from the relationships and I invest it in training the next generation of people, those are people that are going to work for the network. So I should be able to—you know, the money we invest in the research infrastructure—data managers, computer systems, research nurses—is going to be the way that we sustain the clinical trials that our partners want to use. So it should build into a self-sustaining relationship that adds value everywhere. The value to our partner is that we're training your people. We're putting a lot of resources on the ground that have special expertise. We're bringing clinical trials to your patient population that's appropriate for them, and that's what you get back in return for investment in the program, but it also increases your value in your community because you're bringing things that other people are not. And so I think when we get to that level, then it becomes a self-sustaining proposition for both.

[01:22:38]

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## **Chapter 23**

### ***Building the MD Anderson Cancer Network***

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

Story Codes

A: The Administrator;

B: The Business of MD Anderson;

B: MD Anderson Culture;

B: Education; D: On Education;

B: Research;

B: Care; D: On Care;

B: Beyond the Institution;

B: Institutional Mission and Values;

***Tacey Ann Rosolowski, PhD***

[01:22:39]

Now, what are some kind of key points of challenge that you have seen or identified as, you know, you've gotten into this area and started to examine the territory?

[01:22:53]

***Thomas Burke, MD***

[01:22:53]

The biggest one is, like everything, is everybody has a territory that they're comfortable with, and so I think in all the time I've worked, the hardest thing is to get people to move beyond their immediate sphere of view and influence and to really think strategically.

[01:23:13]

***Tacey Ann Rosolowski, PhD***

[01:23:14]

Can you give me an example of how that plays out, how that limitation plays out?

[01:23:18]

***Thomas Burke, MD***

[01:23:18]

Well, I'm really comfortable managing what's happening in Houston, and I never really thought about I should be sending my people to Phoenix or I should be sending my people to Camden. They work and, you know, it's a Houston team. The reality is what we're trying to do here is the same as what we're trying to do there and elsewhere. And if you're really strategic, you think about how can I project what are the basics to a much broader play.

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The other piece is people look at, you know—people think about their own budgets and their own revenue and they lose sight of the institution's budgets and revenue. So one of the advantages of me taking over the network is I have a financial view that's much broader. So we might choose to make one component of the network pay more on the expense side, knowing it's going to generate revenue on somebody else's side, and all we really need to worry about is what's the bottom line to the institution. We don't have to worry about your bottom line being carved up a little bit in the process. I'm investing in the training positions. We're paying for that. In the end, those are the frontline people that are going to deliver care and bring in all of the revenue from the patient care side of the equation. So I invested a couple of million dollars in those people and their training time, and we're going to expect them to bring in 100 million, and it might be for our partner. So you've got to be able to not get bogged down in the details of meeting my budget.

And the other part is that the network is, just because of where it is and what's happening, much more entrepreneurial than the rest of the organization. The sort of traditional MD Anderson is a big academic behemoth that kind of rumbles on (laughs) and has a whole lot of stuff stuck to it, and the network is a lot more freewheeling and a lot more evolutionary. So having people that can work in that environment is really critical, people that can understand changes in direction and adjustments. And that's not sort of the traditional way that MD Anderson has worked. So I think that's a plus, actually.

[01:25:48]

***Tacey Ann Rosolowski, PhD***

[01:25:48]

Hmm. Now, have you—in order to help bolster that entrepreneurial character of the network, have you done internal recruiting for the people you're partnering with? Are there additional hires? I mean, how's that all working? Because this is a new kind of take.

[01:26:05]

***Thomas Burke, MD***

[01:26:06]

So a lot of it is internal people. A lot of it is young people we're training that we're bringing into the network. Part of the goal of broadening the participation is to identify early career faculty and administrative people who would want to see this as their institutional service niche, so giving people a lot of opportunities for sort of tryout positions. I can do something 5 or 10 percent of my time, and if I really like it, those may become the people that lead a partnership team or do something big for us.

[01:26:44]

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***Tacey Ann Rosolowski, PhD***

[01:26:44]

Right. Hmm. What are—you know, when you say “entrepreneurial” and, you know, that model of taking MD Anderson fellows or paying people from sister institutions to come here and take training in that reciprocal relationship, what are some other innovative ways that you’re thinking about creating those bonds which are basically going to help spread some portion of MD Anderson culture?

[01:27:16]

***Thomas Burke, MD***

[01:27:17]

So I think the really important piece is to know what things resonate with what relationship. So one aspect of this is we want to profile the patient populations, the cancer patient populations that our partners care for. I only want to open the trials that are appropriate to those patients. It makes no sense—you know, I have a thousand trials on the main campus. I’m going to open a dozen in Camden. And the reality, the other interesting reality is Camden is a minority city, and so the patient population and the cancer population in Camden look a lot more like what happens at LBJ in Houston than what happens in suburban Katy.

[01:28:09]

***Tacey Ann Rosolowski, PhD***

[01:28:09]

Now, when you say “profile,” what would be the profile of the Camden population and how would you tailor trials [unclear]?

[01:28:17]

***Thomas Burke, MD***

[01:28:17]

So a lot of the disease, the cancer diseases in African Americans, which is the big base of population in Camden, is going to be lung cancer, prostate cancer, colon cancer. We’re going to kind of aim at those areas. They’ve come back to us. This is another great—they have a huge smoking population, so they would be very interested in cancer control programs and preventive strategies for tobacco, which MD Anderson is getting ready to launch a big initiative on. So that’s a perfect fit for that group that maybe our other partners don’t have that focus or that emphasis.

And Cooper has recruited the County Health Department and the State Department of Health to help fund some of those activities. So that would be a terrific value for them to provide in their community. It matches perfectly with the program we would love to export, and we’re going to be training their people how to do that. We’re going to have some interchange of how to get it

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off the ground, but they could run with that.

[01:29:19]

***Tacey Ann Rosolowski, PhD***

[01:29:20]

It sounds like it would also leverage other connections within their community.

[01:29:23]

***Thomas Burke, MD***

[01:29:23]

Sure, sure, for funding.

[01:29:24]

***Tacey Ann Rosolowski, PhD***

[01:29:25]

Yeah, yeah, and for future programs [unclear].

[01:29:28]

***Thomas Burke, MD***

[01:29:29]

So this is how do you fund the prevention and the front-end strategies. You're not usually going to do that from a treatment center; you're going to do that from a County Health Department or a state program. So I think that's a great opportunity for what a—you know, I could see as a network projection that you might not otherwise pick up. Who would make the connections? So we've already made the connections between those teams, they're meeting to discuss what programs, so that's a nice benefit of bringing that part together.

[01:30:02]

***Tacey Ann Rosolowski, PhD***

[01:30:03]

What's another center that there are conversations with right now that might be a bit different in terms of patient population?

[01:30:12]

***Thomas Burke, MD***

[01:30:13]

So I probably can't say those right now. So until we sign, we're talking to three or four other people now. Our goal is to have, obviously, a geographic distribution across the United States, so we wouldn't be looking at New Jersey or Arizona, but other places. I'd like to see us have three, four, five of those areas.

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And if you think about, you know, Phoenix is largely a retired population, a large component of it, it's largely Caucasian, and so it's very much like Katy or The Woodlands and very different than Camden, and so we'd have a different clinical trials portfolio in Phoenix than we would in Camden. We might offer different preventive programs. We might be looking at things that are related to breast cancer screening more in the other locations. So all of those, I think, give great insight to what can be accomplished, and those are things that would be—it's ways for our partner to be successful in delivering on their mission, so when we're all aligned in the same—  
[01:31:31]

***Tacey Ann Rosolowski, PhD***

[01:31:31]

Yeah.

[01:31:33]

***Thomas Burke, MD***

[01:31:33]

So finding those alignments, I think, are really keys to being successful. I think the other key to being successful is picking the right partner at the beginning, because no matter how either of you have conceived how it's going to go, it won't go that way. And so there will be bumps, there's going to be stuff that works great, there's going to be stuff that exceeds what we thought would happen, and there's going to be stuff that, what the hell were we thinking? So you've got to have people that are committed to the long run, who are willing to work through whatever those bumps might be.

[01:32:11]

***Tacey Ann Rosolowski, PhD***

[01:32:16]

What are the particular leadership skills or interactive skills that you are either using or evolving right now in this new role?

[01:32:29]

***Thomas Burke, MD***

[01:32:30]

I think the biggest assignment I have is to build the connections to the main campus so those are solid. As I said earlier, what we want to deliver is MD Anderson people thinking care strategies, and you can't do that if you're not using MD Anderson people. So that has to be a critical part. I have a long history here and a lot of connections, and so that allows that to happen.

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I'm trying to figure out a way for payback, okay, so if I take people's time or use people as resources or, in the worst case, steal them, you know, to do an assignment, we have to be willing to back-fund those positions. So it might be new positions, new faculty, investment in specific departments and programs, so the Network has to pay back some of that. So part of it is the training positions are a give-back. If I build the clinical trials infrastructure and I fund that through the Network budget, then that's a give-back that the department doesn't have to pay for. So we're looking for ways to not have all of the work go one way without a return for people spending their time. And there are going to be some people who say, "You know, I really like doing this, and that's what I want to do as a career direction."

[01:33:59]

***Tacey Ann Rosolowski, PhD***

[01:33:59]

Mm-hmm. What are the financial projections for the MD Anderson Cancer Network?

[01:34:05]

***Thomas Burke, MD***

[01:34:06]

I think they're uncertain. Last year, all of the components that we currently categorize under the Network had a margin that was in the 60- to 80-million-dollar range, which was a pretty significant contribution to the institution's margin. That got reinvested in all of the kind of main campus activities that we have, as well as some of the programs I've talked about that are Network programs.

I think that obviously the size of the Network, because of the fees that partners bring in, grows with the number of partners that there are, and then at some level we share in the margin of our partners once we exceed financial targets. So the incentive is for both of us to grow the program, and to grow it there. So I think that's an important distinction. The strategy is not to bring a bunch of people from other locations to Houston; the strategy is to grow those programs there and develop expertise and bring together specialty teams in those places. Houston has six million people.

[01:35:33]

***Tacey Ann Rosolowski, PhD***

[01:35:37]

Is that piece a slight shift in thinking after—I mean, I'm wondering if there have been some philosophical shifts, I mean, now that the MD Anderson Network is in existence as an umbrella. Is that part of what it means to bring these things together?

[01:35:54]

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***Thomas Burke, MD***

[01:35:55]

I think everybody had a different view, and so it depends who you talk to. My view is that this should be an umbrella of everything we do off the main campus, and the activities are the same as what we do on the main campus. We want a huge play in patient care, we want some dimension of training in education, and we want to bring research to places that don't normally do a lot of research, because that'll enhance what they're able to do.

So if you think about it, those are really just extensions of the institution's mission played out in a little different way. So it'll be probably with lower intensity and sometimes in different strategy. You know, a lot of these partners, they don't have subspecialty surgical capability. They don't have radiation centers that are being quality-controlled for every treatment plan. They don't have expert pathology access. They don't have subspecialty medical oncology. So just some of the basic things that we consider part of our model are huge upgrades in those areas, and they're going to grow over time. You know, a community of six million people here supports a center like ours in a distributed Houston area. Phoenix is going to be six million people. Southern New Jersey is four million people. I mean, we should be able to grow those programs to pretty good size over time if we deliver on quality and value and the other things that are part of that.

[01:37:33]

***Tacey Ann Rosolowski, PhD***

[01:37:35]

Is there anything kind of outside of what we've talked about so far that is one of your goals for the Network? What's kind of the full range of what you foresee?

[01:37:48]

***Thomas Burke, MD***

[01:37:49]

Well, it would go back to where I was at the beginning, is I would like us to be able to touch a large segment of the U.S. population through whatever portfolio of relationships works, and to be able to move discoveries and changes in standard of care quickly, and I think those are the endgames. So the larger I reach and the more—you know, the reality is if you touch something like 10 or 15 percent of the people, the others are going to catch on. You know, everybody will up their game, and so that will—so you don't even have to do it all yourself. You know, just the fact that you're out there and doing it and talking about it, and our partners advertise and they talk about what's happening and at local meetings discuss what's there, I mean, that just forces other people to get better at what they do. That's great.

[01:38:53]

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***Tacey Ann Rosolowski, PhD***

[01:38:54]

In what ways has your background as a clinician who's been also deeply involved in research, what has that brought to—how has that enhanced your ability to do this particular administrative job?

[01:39:10]

***Thomas Burke, MD***

[01:39:11]

I think it lets me communicate to partners what the core elements are because I still practice them, and that's that you have to work in true multidisciplinary teams. So we're able to call our partners up. Well, we sort of meet in this room, and the surgeons don't come unless they have a case. That's not a multidisciplinary care. Everybody works in the same building. Everybody brings their cases to the conference. Pathology gets shown to everybody. So you're able to kind of call to question on people who are trying to, you know, sneak out and leak out the sides.

And the other is, you know, you've got to bring research opportunities to those patients. Otherwise, you're the same as everybody else in town. You're doing sort of your current community's standard of care. You're not doing where the cutting edge today needs to be. So you need to be on the front end of that and you need to be willing to do that. We'll help you put the infrastructure in place while manage the dataflow, but if you don't do that, you're not any different than anybody else who you're trying to be better than. So I think it helps to have practiced that way for a long time.

And I think the other piece is to understand what truly expert clinical people bring. Somebody who's done a three-year fellowship in breast surgery as well as a general surgery residency and has five years of experience is not the same as having your operation done by a general surgeon who also does gall bladders and colon resections and lymph node biopsies. So, understanding the distinction of those very special experts and insisting that you want to grow them. So we've had to talk our partners, "You need to get these people."

[01:41:14]

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***Tacey Ann Rosolowski, PhD***

[01:41:15]

There's an interesting piece of strategic thinking there, too, you know, that appealing to individuals to become involved in a partnership program of this kind, I mean, for the benefit of patients, certainly for the benefit of institutions, and also for the benefit of the careers of the individuals, I mean, that this is providing a new context in which their careers can develop slightly differently than they would have otherwise.

[01:41:38]

***Thomas Burke, MD***

[01:41:39]

Yeah, and if it works, it works for everybody, you know. I mean, you're more challenged if you're the practitioner. Your patients get better options and better care. Your hospital makes more money because it's recognized as an expert. I mean, it all flows. And so if you really are committed to doing it and you make it work, it works for all the players.

[01:41:59]

***Tacey Ann Rosolowski, PhD***

[01:41:59]

Yeah. We have about fifteen minutes left today. Is there anything more you'd like to say about the Cancer Network?

[01:42:08]

***Thomas Burke, MD***

[01:42:09]

No, I think we got the hotspots of my—

[01:42:11]

***Tacey Ann Rosolowski, PhD***

[01:42:11]

Yeah. Well, it's sort of a story to be continued. (laughs)

[01:42:14]

***Thomas Burke, MD***

[01:42:14]

Yes, it's a good start.

[01:42:17]

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## **Chapter 24**

### ***Significant Research Initiatives***

#### **A: The Researcher;**

Story Codes

A: The Researcher;

C: Discovery, Creativity and Innovation;

D: On Research and Researchers;

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

A: Career and Accomplishments;

***Tacey Ann Rosolowski, PhD***

[01:42:17]

Yeah, yeah. It's exciting.

In these last minutes, as I mentioned before we turned on the recorder, we didn't really talk about some of the major research that you've done after coming to MD Anderson, and I wondered if you wanted to just give me some examples of what you felt were some of the most important contributions.

[01:42:47]

***Thomas Burke, MD***

[01:42:47]

I think I haven't been an active player in the research side for probably a decade, but, you know, when I can, it was not the very beginning but close to the beginning of chemotherapy, a lot of the initial drugs and a lot of the studies were done in the late seventies and early eighties, and so it was really the beginning of a big play for medical oncology. GYN oncology was a very different—we talked, I think, way back in our session about had always done surgery and chemotherapy and was—

[01:43:34]

***Tacey Ann Rosolowski, PhD***

[01:43:35]

Yeah, multidisciplinary from the word go.

[01:43:36]

***Thomas Burke, MD***

[01:43:36]

—importantly a player in radiation. And so a lot of the early work I did was to try to define the

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role of chemotherapy in the treatment of women with uterine cancers. And there's a controversy that's continued for the entire time of my career about whether the better strategy was to look at radiation or to use chemotherapeutic agents in women with endometrial cancers, and so a lot of our early projects were we were trying to define those two.

I think the end result is that radiation has become recognized as an appropriate strategy for sort of control of local cancers or the prevention of local recurrence, but the real value for systemic diseases is chemotherapy, and we had a lot of the initial work in that area, and the initial trials were all led out of here at the time. They were very hard to do on a national level because there was such a dichotomy between the radiation community and the chemotherapy group, so it became almost impossible to run a large-scale trial. It was frustrating to be involved in that.

[01:44:58]

***Tacey Ann Rosolowski, PhD***

[01:44:59]

What was—I mean, where did the gap come from?

[01:45:03]

***Thomas Burke, MD***

[01:45:04]

Well, I think if you believed in chemotherapy, you had to have a component of the trial that did not include radiation, and if you believed in radiation, then it had to be in both sides of the trial, even if you were going to give chemotherapy in one, and so we could never get to a consensus.

[01:45:22]

***Tacey Ann Rosolowski, PhD***

[01:45:23]

Interesting.

[01:45:23]

***Thomas Burke, MD***

[01:45:23]

And it frustrated a lot of the discovery around those areas. But a lot of the early work in chemotherapy we did here. And then a subset of uterine tumors that are called papillary serous cancers, it's only about maybe 5 percent of uterine cancers, but it was recognized as a distinct tumor in the eighties, and a lot of the work that separated out those tumors as different than the traditional kind was done here because it was a large referral center. So a lot of that work came out of our group as well.

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And then a lot of the definition of the surgical staging procedures for uterine cancer was part of our early work. What to biopsy, what lymph nodes were involved, where to do work in the operating room kind of came out of—a lot of uterine cancers were not well staged surgically, a lot were done in community settings, and so a lot of the decisions were made on less than optimal information. So a lot of the work in the eighties and then in the early nineties was around what's the right operation, you know, what are the supplemental biopsies that get done in the operating room came from that.

And then I trained a whole bunch of people that went on to develop robotics and laparoscopic surgery and other things. I don't do that myself, but the people that came through at the time modified the surgical procedures to take that forward. So most uterine cancers today are actually treated with robotic surgery or laparoscopic techniques.

The other place I did a lot of work was in vulvar cancers, which are extremely rare. It was a great niche assignment. I talked earlier about we were given niches to work in. The sixties and seventies were sort of the era of very radical surgery, and vulvar cancer was a skin cancer that spread to lymph nodes, and the treatment was a very radical operation that was pretty disfiguring and really led to some long-term debility for patients that got that procedure but who otherwise didn't have a curative choice. So Dr. Rutledge and some of the founders of our department and our institution had pioneered that surgery and other things.

And so one of the things I worked on earlier was trying to define more conservative approaches to surgery. So we separated—conceptually we separated the management of the primary cancer from the treatment of lymph node areas, and so instead of having to do a large resection, we were able to do two resections and really preserve a lot of function and tissue, and we got to tailored radiation to deal with areas of spread rather than large surgery.

Then we had seen some of the work with lymphatic mapping where they inject dye into cancers to identify lymph nodes that drained the cancer, and a lot of that work got done in melanoma originally. We were thinking about, well, melanoma's a skin cancer just like vulvar cancer; we should try the same techniques. So we did a lot of the early injections of tumors and we were able to define the lymph node drainage more accurately using that. And then we used the dye injections as part of the strategy for how to limit resection to the lymph node areas in addition to the primary tumor. It's now a strategy that's almost identical to what they do in breast cancer. The problem is vulvar cancer is really rare, so to prove the concept, you would never get enough.  
[01:49:36]

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***Tacey Ann Rosolowski, PhD***

[01:49:36]

Oh, how interesting.

[01:49:37]

***Thomas Burke, MD***

[01:49:37]

It took years and years and then a national study to prove the concepts, but melanomas and breast cancers are very common, so they were able to accumulate data very quickly. But a lot of things came out of that, I mean, the variability of lymphatic drainage patterns, how the pathologists looked at lymph nodes. You know, if you're looking at one lymph node that's picking up dye and you make 100 hundred slices, you find a lot of them have microscopic tumors. And before, if you just did one section or two sections, you'd miss all that. So a lot of side information came out of these early strategies to do it.

So I think probably the two areas I spent the most time in my academic career was around sort of systemic chemotherapy for uterine cancers and then a much more conservative tailored approach to women who had vulvar cancers.

[01:50:32]

***Tacey Ann Rosolowski, PhD***

[01:50:42]

Well, we have only a few minutes left, and I had just a couple other questions.

[01:50:46]

***Thomas Burke, MD***

[01:50:46]

Sure.

[01:50:47]

***Tacey Ann Rosolowski, PhD***

[01:50:47]

But I wanted to ask you if there was anything, any topic that you wanted to add in [unclear].

[01:50:52]

***Thomas Burke, MD***

[01:50:52]

Yeah, we've covered a lot of ground. (Rosolowski laughs.) I think I'll finish out with what you've got.

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[01:50:56]

***Tacey Ann Rosolowski, PhD***

[01:50:56]

All right. There has been a lot to cover. You could see I'm rubbing my hand. (laughs) I've been taking so many notes.

Well, I wanted to ask you, I mean, you obviously have taken on this new role, but looking back at what you've already—the contributions that you've already made to the institution, what are you most gratified to have done?

[01:51:19]

***Thomas Burke, MD***

[01:51:20]

You know, I like it all, and part of life is that you have to reinvent yourself, and it's good to do that. So transitioning here from a military career was a reinvention. Building kind of an academic research career was a reinvention. Switching to an administrative role was a reinvention. Changing to this role is a reinvention. I think those are good renewable things, and each one took advantage of something I had learned in a prior role. All of it kind of comes together. I love taking care of patients. I love training fellows. I like what I did as a hospital administrator. I'm going to love what I'm doing in the Network.

[01:52:06]

***Tacey Ann Rosolowski, PhD***

[01:52:07]

What legacy do you feel you're leaving?

***Thomas Burke, MD***

[01:52:12]

You know, I think anybody's—the truth is once you're gone, nobody remembers who you were, okay? (Rosolowski laughs.) So I don't have any issues with that. Your real legacy is the people that you trained and what they're able to accomplish, and I already see that in a lot of people, and that's a much broader reach than what you can do yourself. I have teams that conceived and designed and built and executed an unbelievable array of cancer facilities. If you think about the [unclear] Hospital, the Mays Clinic, the pavilion that's going up now, the Proton Center, what we're doing regionally, all of those kind of came together. And obviously we did it with lots of people, but it takes a lot of thought to conceive of the design of those and put together the services and then make them operational. So I'm proud of what people accomplished doing that. We built an entire hospital on top of another hospital while we were operating it. It's phenomenal that people can do that.

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[01:53:30]

***Tacey Ann Rosolowski, PhD***

[01:53:32]

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

[01:53:34]

***Thomas Burke, MD***

[01:53:35]

No, this has been fun. So big is the whole series? You're going to do how many people?

[01:53:41]

***Tacey Ann Rosolowski, PhD***

[01:53:41]

Well, let's see. I mean, we're funded year to year, so we're not quite sure, you know—

[01:53:48]

***Thomas Burke, MD***

[01:53:48]

How far you'll get.

[01:53:48]

***Tacey Ann Rosolowski, PhD***

[01:53:48]

How far we'll get. But let's see. I will have completed fifty-nine interviews this year.

[01:53:56]

***Thomas Burke, MD***

[01:53:56]

That's pretty good.

[01:53:57]

***Tacey Ann Rosolowski, PhD***

[01:53:57]

So, yeah.

[01:53:57]

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***Thomas Burke, MD***

[01:53:57]

That's a lot.

[01:53:58]

***Tacey Ann Rosolowski, PhD***

[01:53:58]

Yeah. And then there are some that were interviewed in the first pass when the project was started about twelve years ago.

[01:54:06]

***Thomas Burke, MD***

[01:54:06]

Oh, very cool.

[01:54:07]

***Tacey Ann Rosolowski, PhD***

[01:54:07]

So, yeah, it is, it's very cool and [unclear].

[01:54:09]

***Thomas Burke, MD***

[01:54:07]

That should be fun. These resources don't exist. I think it's a great, great concept, because you never—no matter what you read or what gets written down, you don't get sort of the inside as to why decisions were made.

[01:54:23]

***Tacey Ann Rosolowski, PhD***

[01:54:24]

The inside, yeah. And just the benefit of wisdom, you know. I mean, one of the things that I've been interested in hearing you talk is the perspective of the clinician who is a leader and someone who develops large programs and what that means to an institution, to have that skill set brought into, as you've described it, you know, now an entrepreneurial kind of area.

[01:54:47]

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***Thomas Burke, MD***

[01:54:47]

Yeah, it has to all come together.

[01:54:48]

***Tacey Ann Rosolowski, PhD***

[01:54:48]

Yeah, it's very interesting. So it's—

[01:54:51]

***Thomas Burke, MD***

[01:54:51]

Okay.

[01:54:51]

***Tacey Ann Rosolowski, PhD***

[01:54:51]

That's the value of capturing all these different perspectives.

[01:54:54]

***Thomas Burke, MD***

[01:54:54]

Thanks.

[01:54:55]

***Tacey Ann Rosolowski, PhD***

[01:54:55]

Well, thank you very much.

[01:54:56]

***Thomas Burke, MD***

[01:54:56]

Thanks. Appreciate it.

[01:54:56]

***Tacey Ann Rosolowski, PhD***

[01:54:57]

And I am turning off the recorder at 2:58.

[01:55:00] (End of Audio Session Three)