Leading the MD Anderson Way

Stories about Leaders and Leadership

Developed by
Heritage Services, the Historical Resources Center, Research Medical Library

with support from
The Department of Faculty and Academic Development
In the 1940s when the institution was created, cancer was a death sentence.... It was a terrible, terrible ravaging disease. And the treatments that we had were quite primitive compared to now. Massive radical surgeries that left people extraordinarily disfigured. Caustic agents. Radiation that was very poorly controlled and delivered to lots of unnecessary structures in the body. So the morbidity and the mortality from the treatments was severe. And people were extremely afraid of the disease and afraid to talk about it.

The people who committed to those kinds of careers were dealing with a very, very difficult disease. And MD Anderson was a place where people came who really had a mission and believed in that mission. Many of them spent their entire lives here, and some of them died from the exposure to the agents that they were trying to develop for use to make them safer for people....

Those are the stories that we wanted to save and promote. And help contribute to our shared sense of mission...

Stephen P. Tomasovic, PhD
Senior Vice President, Academic Affairs (2006 - 2011)
The stories in this collection were originally shared in lively conversations recorded for The Making Cancer History Voices Oral History Project. The transcriptions intentionally preserve their conversational quality and the personality of each speaker.

We hope that these stories provide an intimate portrait of MD Anderson’s leaders and their strategies for meeting the challenge of leadership.ii

The transition to a leadership role constitutes an identity change which can be uncomfortable and personally challenging.

Janis Apted Yadiny
VP Faculty and Academic Development
The Oaks, an estate donated by the Baker family of Houston. The first location of MD Anderson.

Construction of the first clinic areas in the stables of The Oaks.

Groundbreaking and construction of the first permanent hospital.
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Introduction

The idea behind MD Anderson was born in 1941 from the actions of a visionary state legislature and the generosity of philanthropist Monroe Dunaway Anderson and the Anderson Foundation.

In 1942, it found a first home at “The Oaks,” the estate of Captain James Baker, a prominent Houston attorney.

Next, it evolved into 234-bed hospital referred to as “The Pink Palace of Healing.”

After decades of developing a culture of care and a commitment the bold mission of “eliminating cancer in Texas, the nation, and the world,” MD Anderson is the number one cancer hospital in the United States, with an expanding reach around the globe.
Leading the MD Anderson Way provides an introduction to the institution and its heritage through stories about its leaders and leadership.

During in-depth conversations, faculty and executive leaders recount how this institution was created—and continues to evolve—because of the efforts of dynamic individuals who each bring a unique history, vision, and skills to the challenge of building an institution.

What emerges is a picture of an institution with a continuing sense of its own culture of care, excellence, and dedication to a mission.

These personal stories provide an intimate look at leaders and an institution devoted above all to patients at the institution and everywhere, and to the thousands of individuals who work at MD Anderson to serve them.

They also demonstrate that this kind of culture and achievement do not happen by accident.

Just think about an institution that is solely dedicated to one disease. You don’t birth babies, and you don’t fix broken ankles. I mean, every day, 20,000 people wake up and come to this institution with one common enemy, and that’s cancer. And one purpose, and that is to defeat this disease and to make life better for the patients and their families that come here. I mean, you can tell somebody your purpose in life very quickly in an elevator when you wake up and go to that kind of place to work every day.

Patrick Mulvey
VP Development
Four Presidents: Continuity of Leadership and Tradition

The institution has had relatively few leaders.... The MD Anderson was founded in 1941. Dr. Clark took over in [1946], and I believe that’s seventy some-odd years—most of them with three presidents, now with a fourth. So the tenure of people as leaders has been long, which gives you tremendous continuity in the institution ... That has been really important to the institution’s success.iv

Martin Raber, MD
Associate VP for Patient Care (1992 – 1994)

When you take over leadership of an organization this size, it takes a year or so to figure out what makes it special, and where to grow. And to enlist the trust and the vision and the counsel of the people here so that when you plan growth it’s not a top-down thing. It’s an institution planning its growth .... I don’t think it was planned that we’d only have three presidents in our first 70 years, but the institution was fortunate that each president had the energy and the ambition, had the teamwork of the people with whom they were working at MD Anderson, and could develop action plans that didn’t have to be executed in a few years. They could have a 5- and 10-year span.v

John Mendelsohn, MD
President of MD Anderson, 1996 - 2011
Over three quarters of a century, MD Anderson has maintained a tradition of physician leadership that has kept pace with advances in cancer research, evolving into leadership by physician-scientists.

Throughout, the leadership has upheld the institution’s culture and values: dedication to patient care, multi-disciplinary approaches to treatment, and research to advance cancer science and build the evidence base for patient care.

All of this drives a deep commitment to the institutional mission –eradicating cancer in Texas, the United States, and the world.

Everyone agrees that this aim is very bold. It has also captured the imagination of faculty, staff, and employees since the institution’s founding and fueled their energy and dedication.

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**A Sense of Mission**

The MD Anderson has an intense sense of mission. .... We’re eradicating—eliminating cancer.... Everybody who works here understands what the mission is...and each of us understands what we’re doing here to achieve that, and that’s true whether you are the professor of medicine or the woman who is cleaning the room after the patient has been discharged. That understanding of mission is missing in most medical institutions.... We actually believe that we deliver the world’s greatest cancer care, and our patients believe that. That’s why the patients are here.vi

Martin Raber
Former Physician in Chief

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**Attracted by Commitment**

I saw a place that was passionate about clinical care and .... I met enthusiastic, smart clinician scientists and lab scientists who were really looking for a leader and who I had the feeling would kill for this place .... Most of the people that I worked with for 15 years would fall on their sword for this place ...

John Mendelsohn, MD
Third president
R. Lee Clark served for 32 years as MD Anderson’ first full-time president. Those who knew him see a direct link between his vision for the institution and today’s MD Anderson. They cite the fact that Lee Clark envisioned the treatment possibilities in the budding fields of chemotherapy and radio therapy. They explain that he had the skill to support his vision with a compensation system that would foster collaboration between surgeons and these new clinical practitioners to forge the best treatments for all types of cancer. He had the charisma and interpersonal skills to inspire people to commit to his vision and to the institution’s purpose.

Most frequent descriptions:

- Larger than life. A Renaissance Man.

He brought a global perspective from the beginning.


Dr. Clark came to MD Anderson having already established a four-year medical school in Jackson, Mississippi. (It could be said that institution building was in his blood, as his parents moved the family around Texas as they established Christian schools.) However, for the sake of what MD Anderson would become, it may be even more important that he had experience working in the research division of Dupont after graduating from the University of South Carolina (with a dual major in chemical engineering and pre-medical studies).

At Dupont, he said, “The care and feeding of researchers became part of my interest,” one that
persisted through his years at the Medical College of Virginia (MD in 1932), where he came to believe that solving the problem of cancer might reveal some of the “mysteries of life.” It continued in Europe, when he took a position as Chief Resident at the American Hospital in Paris and developed connections at the Curie Foundation and Pasteur Institute.

Dr. Clark set MD Anderson on a track to translational research and global collaborations decades before anyone imagined such possibilities. One of Dr. Clark’s first tasks was to move MD Anderson from the estate where it was housed to a 234-bed hospital. When the MD Anderson Hospital and Tumor Institute opened in 1954, it was referred to as "Dr. Clark's Pink Palace of Healing," named for the Georgia Etowa Pink marble used for the exterior. ix

Dr. Clark had a tremendous engineering background. You know the stone that clad the original building is that pink marble that you see still today. He used to hitchhike back and forth from medical school to home on the weekends and would have to get up real early on Monday morning in order to be sure and catch a ride and be back at medical school by the time classes started. He said as he would be standing on the highway, the sun would come up on this quarry, and the marble took on a rosy pink glow that to him indicated hope. He said, “If I ever have a hospital I’m going to have that marble at the hospital.” And so sure enough, R. Lee Clark had a hospital, and he used the pink marble. I understand that when the Anderson-Clayton Foundation gave the building, wanting to preserve the quality of the structure, they said that all additions should have that pink marble...
Memories of R. Lee Clark

Gabriel Hortobagyi, MD
Founding Chair, Department of Breast Medical Oncology
(1992 – 2012)

The joke used to be that Lee would go up to Austin when the legislature was meeting, and he would present the MD Anderson budget, and there would be dead silence. And then someone would timidly ask, "But Dr. Clark, are you sure that's all you need?" (laughs) So he had a great deal of influence in Austin, and he knew how to use that influence and how to use that power.

Just put yourself in the situation of Texas in 1941. This was a backwater town, and how people lived here without air conditioning and in a swamp that had endemic malaria and yellow fever in a very primitive state—we are ... light years ahead of what this was at that time. And he had to struggle nationally with the perception from the Brahmins from the northeast ... that he was going to develop a competitive, first-class cancer center in the middle of Texas. You have to have incredible vision and courage. Not only did he do that, but in a very short period of time he managed to put this institution on the map.

He made some extraordinarily good recruitments. He recruited a very strong first chairman for radiation oncology in Gil [Gilbert H.] Fletcher.....The first group of radiologists was outstanding. The first group of pathologists was outstanding....

Lee Clark had an incredible vision. ...[H]e built this institution from scratch....He also had the vision to develop incredible international relationships.... So MD Anderson was pretty well known around the world—perhaps even better than inside the US—by the time I came here.
A Man Ahead of His Time

[R. Lee Clark] was basically a man ahead of his time. And this was a new—really a radical idea that you would train a PhD microbiologist or a PhD biochemist or a PhD geneticist side-by-side with somebody doing clinical research, doing patient care. His thought ... was that this was the way you could train people not only to be very good scientists but to use the very best science to be involved in translating and improving human health.

That’s the big thing we’re doing right now, translational research ...and I don’t know of anybody else at that time that had the concept of a graduate school that would be part of a cancer center or a hospital ... He wanted it to be the best science possible done in an environment where the students and faculty would see the problems that their clinical colleagues have to deal with, have access to patient material so they could do experiments not only on mouse tissue but on human tissue—both normal and diseased tissue—and he thought that was important for progress.

George Stancel, PhD
Dean, Graduate School of Biomedical Sciences (1999–2013)

Establishing a Culture of Care

I remember when I first came ...I was here really late sometimes ... and when I would leave ... Dr. Clark would be down there, because they had benches built in around the wall that was a seating area, and people that had family members in the hospital would many times be asleep down there on those benches .... and he would be distributing blankets and pillows, and if there was an empty bed somewhere in the hospital that he could take them, he would carry them upstairs and put them to bed upstairs in the patient rooms ...

That kind of concern has never left the institution, even though we have increased in size. The care and the love of people, the Anderson spirit has been there, and I think it’s very unusual for an institution to move from a small place like that with that kind of feeling and caring from the leadership all the way down to the present time, and I think you still see that, people that are trying and concerned and helping other people .... I think that’s been something that we’ve been blessed with, and certainly has been nurtured by the administration of this institution.

Michael Ahearn, PhD
Department of Laboratory Medicine; Dean, School of Health Professions (1987 – 2011)
Charles Aubrey LeMaistre, MD  
Second President, 1978 – 1996

Most frequent descriptions

A southern gentleman.

Inspired loyalty and excellence.

A master of state and institutional politics.

An early champion of cancer prevention.

When R. Lee Clark decided to step down as President of MD Anderson, Dr. LeMaistre was serving as Chancellor of the University of Texas System (1971 – 1979). He had helped develop the first broad spectrum antibiotics to treat tuberculosis, built clinical programs, and made his name in cancer control through his work on the first Surgeon General’s report on smoking and cancer (1964). Dr. LeMaistre believed that research could have an impact on individual patients. He acknowledges, “I was doing Administrative Medicine but creating institutions that had an impact on the problem. That was my motivating factor to do administration.” He also confides that he was a reluctant administrator, and without that sense of impact,

“I don’t think I would ever have done it.... I detested being away from patients. It’s very difficult when you take responsibility for a patient not to miss it when you get away from it.”

Dr. LeMaistre established the first Division of Cancer Prevention in the world. He helped convince the Texas Legislature to approve regulations allowing patients to refer themselves to MD Anderson. Through his influence, MD Anderson became a leader in outpatient cancer care, with the nation’s largest ambulatory treatment and ambulatory cancer surgery programs.
Charles LeMaistre talks about his vision

On Research and Faculty Support

[W]e expanded the support for the basic scientists here, which was very important, because at that time, they had salaries that were not really compatible with their talent and with competition elsewhere. The doctors in the clinic and in the hospital who earned the compensation for their services shared those in a pool called Physicians Referral Service that was able to ... encourage the basic scientists here and attract new ones.... The clinicians were the heroes, because they had earned the money but were willing to put it into a pool rather than to keep it in departments.

The faculty ... measures the ability of someone ready to build a career here and create their international reputations here.... Most of all, they have to meet the task of putting the patient first here, and if they can’t do that, we really don’t want them to stay.xii

Charles LeMaistre

Patient Care

[There] was a very dramatic shift in the type of care we rendered here. .... Working with our great pharmacy here, I was able to see that the patient could take their chemotherapy at home by providing pumps. When I came here [they] weighed fourteen pounds. The pharmacy miniaturized them to weigh just a few ounces. We would ship the chemotherapy to the refrigerator of the patient’s home to teach someone in the family how to administer it. Dr. Fred Conrad was the chief engineer in revolutionizing this to expand our patient care so that all of our patients didn’t have to be admitted ... They could come and go, and that’s why we have such a large outpatient department now. It was seeing a problem and then trying to find the right person to do it and follow through on it.
Steve Stuyck, MPH  
Former Vice President of Public Affairs

I reported directly to him for fifteen years….I learned so much from him about how you treat other people….He was so encouraging that it was like, my God, this guy is really counting on me. I can’t let him down.

We had the governor come here one time to make an official visit. His press secretary told me to interrupt him at a certain time to take questions from the media that were assembled, and new governor said, “Hell, no! I’m not going to answer any God damned questions! Get out of my way, you fool.” Right in front of all these people. That night Dr. LeMaistre called me at home. “You know, Steve, it’s my job to get along with the governor. It’s your job to get along with the media, and don’t you worry about this at all.” And that was the kind of thing he did a lot for the people who worked for him.

I was at a luncheon and he was sitting up at the head table at the podium getting ready to give a talk…. He got up from the podium and walked around the room … to where I was seated at the back and bent down and asked me some question … And the guy sitting next to me said, “You know, my boss would never do that with me. He would never get up and leave the podium to come talk to some lowly staff person.” But I have many memories like that …. And I was just blessed to have that kind of relationship. It was really pretty amazing.
Charles LeMaistre worked on the first Surgeon General’s report on smoking and cancer. Under his leadership, MD Anderson became a smoke-free cancer center in 1989.

One of the portable chemotherapy pumps developed under Charles LeMaistre, and which contributed to MD Anderson’s leadership in outpatient care.
I’m a yellow tablet guy. I made arrangements to meet with each of the departments the first 100 days. I go into a room, sometimes with 50 or 100 people in it, and I’d sit down in a chair in front of them and say, “I have 1 question for you. If you had my job, what would you do differently so your job would work out better and you’d be able to achieve your goals?” They just poured it out, and I took notes and assimilated it.\[^{xiv}\]

“I’ve been very good at selecting presidents who were the right ones for their time,” observes Stephen Tomasovic (former VP Academic Affairs).\[^{xv}\] When Charles LeMaistre was ready to step down as president, the institution was serving more patients than ever and a foundation had been set to further develop the institution’s research culture.

Dr. Mendelsohn had the experience to meet this challenge. He had realized his dream of becoming a physician-scientist before the term existed.
Working with Gordon Sato, he had produced monoclonal antibody 225 (Cetuximab or Erbitux), completing the translation of knowledge from bench to bedside. He had gained experience in complex institution building in his role as founding director of the University of California San Diego’s NCI-designated cancer center. He refined his approach to building research while serving as Chair of the Department of Medicine at Sloan-Kettering and co-heading the Program in Molecular Pharmacology and Therapeutics (1985 to 1996).

At MD Anderson, Dr. Mendelsohn became a ferocious institution builder. Under his leadership, the size of the institution doubled, fund raising increased five-fold, and MD Anderson developed the capacity to conduct research on a new scale and with the capacities of team science to leverage new knowledge bases, new technology, and big data.

We knew where cancer was going. We knew about the exciting developments that were occurring. We knew that this couldn’t be led and pioneered in an average hospital.

It had to be pioneered in a place that had the kind of assets that MD Anderson had, a large faculty with protected time to do research and a total commitment to the very best standard of care.... We decided to ignore these consultants and to take advantage of the demand for our services and to grow, and we didn’t stop. xvi

We had committees to do the vision statement. It was bold. “We shall be the premier cancer center.” We talked a lot about that. We were number two. “Do you want to put that in writing?” “Yes.” “Based on the excellence of our people, our research-driven patient care, and our science.”

.... We had committees for the values .... The committee chairman presented me with “caring, integrity, and discovery” and it worked. Those values are important. All of our personnel evaluations are pegged to those values, for example. Every business person knows you’ve got to have your vision statement and your values to create your culture. xvii

John Mendelsohn on his vision for MD Anderson

In 1996, ironically, there was a downsizing going on .... To me and to the faculty, this didn’t make sense.
Robert Bast, MD
VP Office of Translational Research

John Mendelsohn is one of my heroes. I think that he really is a superb leader. Over the fifteen or so years that he was president, John grew MD Anderson into the footprint that exists today. He accomplished that in some pretty turbulent times. About five years after he arrived at MD Anderson, as you recall, the Enron crisis occurred. I think you know that he was genuinely innocent of any wrongdoing in that, but he had served on their Board and survived as head of MD Anderson. Over the years, John and Ann were able to bring together the Houston community and had exceptional rapport with the Board of Visitors. He had a vision for actually growing the institution in size, and growing MD Anderson out of whatever dangers we faced financially.

John was not only a champion for research, he had deep respect for patient care and realized that our clinical enterprise must be strong. He understood the importance of surgery as an important front door for the institution. He recruited strong clinicians and expanded translational research.

Lorenzo Cohen, PhD
Director, Program in Integrative Medicine

John, he was probably my most important mentor here. He had an open-door policy, although most people didn’t necessarily have the courage necessarily to walk through that door. But I met with him regularly …. on big career decisions ….. What John said ultimately is, Don’t get overly caught up in that concept of ego and needing … are you paid fairly and are you able to do what you need to do ...

Steve Stuyck, MPH
Former VP Public Affairs

One of our secret weapons …was Dr. Mendelsohn. He loves intellectual give and take. He never loses his cool…. Media love him. He conveyed that scientist kind of honesty that others don’t always do. And we took him all over the world to meet with media …. We made media tours to Washington, D.C., and to New York City several times with him, and they would be briefing sessions: ‘Here’s what’s going on in cancer today. And by the way, when you think about cancer for your publication think MD Anderson. We’re here to help you.’ He was really good at that.
John Mendelsohn with the Bush Family at the 50\textsuperscript{th} Anniversary celebration (above), and with the Zayed Family (below), celebrating the gift that would fund the Zayed Institute for Personalized Cancer Therapy. Dr. Mendelsohn developed a vision for the “Cancer Care Cycle” (upper right) that would integrate MD Anderson’s research initiatives. The Zayed Institute completed the vision.
Ronald DePinho, MD  
Fourth president, 2011 – the present

Most frequent descriptions

The new R. Lee Clark

Has the common touch

Inspiring, challenging, raises the bar for research

A physician-scientist for today’s MD Anderson

Gabriel Hortobagyi notes that, “Most of us who have made some progress have .... stood on the shoulders of giants, as the old saying says.”

Ronald DePinho arrived at MD Anderson prepared to take the institution into a new phase of evolution thanks to the labors of Drs. LeMaistre and Mendelsohn. The patient population had grown; multi-disciplinary care had been formally adopted as the MD Anderson strategy of patient care; the research capacity of the institution had grown both in terms of space, faculty; and funding and support for team science had evolved.

I think the distinguishing feature of an entrepreneur is to try to understand how best to reduce something to practice ... that could impact the human condition. An entrepreneur has to be able to bring together business development strategies, scientific — as well as clinical — development strategies, financing of those opportunities, multidisciplinary teams from different sectors – all into an engine that can effectively support --financially, operationally, and conceptually-- the ability to go from idea to a practical product.
Dr. DePinho brought the intellectual commitments of a physician-scientist coupled with the sensibilities and skills of an entrepreneur.

During his years at Harvard, he conducted research on the relation of cancer and aging using an integrated genomics and biological systems approach, developed mouse models of human cancers, and developed novel cancer therapies. He founded the Belfer Institute for Applied Cancer Science to fast-channel research results into drug development by breaking down the barriers that have traditionally isolated academia, industry, and pharma in distinct siloes. He worked with practical challenges as well as the cultural challenges to shift academic medicine’s traditional focus on individual researchers into team focus.

At MD Anderson, Dr. DePinho has set about engaging the potential of a premier academic medical center with non-traditional partners and industry-based workflows and strategies, all to leverage the potential to capitalize on the latest technology and intellectual advances in every relevant field.

Ronald DePinho
on his vision for MD Anderson

....I thought about where the field was in terms of its conceptual maturity ... knowledge of how the immune system works, and other major advances in the technology of genome sequencing, cognitive computing, the ability to manipulate genes at will, genetically engineered models that have matured — all of those things were converging at a time when the institution was poised to seize the moment and apply that knowledge more vigorously.

I recognized that MD Anderson was a unique institution, in that it already had this culture of collaboration and collegiality. It had a critical mass of both basic translational, as well as clinical science. It had a global reach, so that if things were discovered, it would be easier to facilitate the exporting of that knowledge to other institutions around the world, other parts of the world.

That's one of the things that inspired me about this place. I recognized the tremendous potential that it held to be the leader in taking all of this amazing knowledge and converting it into new drugs, new diagnostics, new standards of care for patients, as well as prevention and early detection strategies.
Ron will use the Moon Shots as a pulpit to change the approach to cancer prevention, detection and treatment nationally and internationally. That’s an audacious vision, but I think it’s very important that somebody have an audacious vision.

The Moon Shots have been controversial, but I think that that’s one of the most important things that’s happened at MD Anderson in the last twenty years. This is Ron’s signature experiment and .... Ron’s unique personality and vision set the challenge to find things that can be done in the next five years that are going to change the status of practice. And to challenge us to do the Moon Shots was a very important thing to do.....

I think [innovation] is the dynamics of the future. … I’m constantly challenging myself on what’s next? What’s the future hold? I think that mentality, as well, is starting to get more ingrained in MD Anderson as an institution. And I attribute that back to Dr. DePinho again. ‘Innovation ‘was a word that—I think it may define his presidency. It may define what he leaves as his legacy.

All of us have gotten not only passionate about that, but are constantly trying to find the best angle .... It’s the key to solving the cure. It’s the key to really making impact across a global healthcare crisis in a time when we are, ourselves, financially, in a healthcare crisis. It’s almost as if we’re entering into the perfect storm. You know, we have all these incredible advances happening. We have all of this technology at our fingertips. Yet healthcare finance is a mess, and the status of academic organizations is being questioned. And funding for research is drying up. And most new drugs can’t make it even through the pharma pipeline without being cut. So we have all of these inhibitors, but at the same time we’re at the cusp of greatness around immunology and genetic testing.
I wanted to say goodbye to Dr. DePinho. He has been amazing for me.... And so I called: “What’s the next two days like? Is the big man in or not?”.... I went up there ... and ... he talked about my legacy, and I just -- I wept. And then when it was time to go, I stood up and I put my hand out to shake his hand, and he grabbed me and gave me this big hug. And before I could say it, he said, “I love you.” Yeah. Big deal. Big deal. So, can’t get better than that. Can’t get better than that. xxiv

Now we have this Moon Shots vision under Dr. DePinho. And it’s our business to go about developing that strategic vision of his, in a philanthropic manner, to be able to go out and secure the funds that are needed for that vision.... He’s right there in the middle of it, too.... And he’s worked very closely with us to hone our business plan... and he gives us a significant amount of his time, too, to go out all over this country to see those individuals that need to be seen, to hear his vision, and then to share their resources with us.... [W]e’ve learned from him, absolutely, to be bold and to set out your strategic vision, and then to make sure that we put the resources that are necessary there to accomplish that, absolutely. xxvi
Each president has left—and is leaving—a signature mark.

But without the faculty, the four presidents could never have turned their bold visions into a reality.

The presidents have known this, recruited accordingly, and provided necessary support and freedom.

The faculty has always provided a reservoir of energy, vision, creativity, and dedication that has shaped the institution at all levels.

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**Bold Visions**

You know, Anderson is not what it is today because of somebody not having those type of bold visions. There was one under Dr. LeMaistre. There was one under Dr. Mendelsohn. And now we have this Moon Shots vision under Dr. DePinho....And so, I think he is very closely following in the footsteps of his predecessors in setting a tone for this institution that’s going to take it to its next level.

Patrick Mulvey
VP Development Office
These stories show the range of ways in which faculty members bring a bold vision to their on-the-ground work.

They demonstrate how inspired leadership can have a wide impact on research, on disciplines, and on the structure and workflow essential to the institution’s operations.

**Leading within Systems**

You cannot just make good speeches. You have to know systems in order to manage well, to lead well.

Alma Rodriguez, MD  
VP Medical Affairs

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**Leading Beyond the Rules**

You have to let a little bit of that rowdy, crazy side of you say, “I know what the rules are, but I am going to think a little bit outside the rules for a moment”....By definition, existing knowledge is limited. So in order to go beyond that limit, you have to think differently. Otherwise, you always come up with the existing limitation—the wall within which your knowledge exists.

Gabriel Hortobagyi, MD  
Founding Chair, Breast Medical Oncology
Colonizing the Surgical Oncology Conference

I became chair in November of ’93 … One of the things that I thought would be very important was to figure out what are the fast tracks to bring visibility to this group of relatively young people.

The major academic surgical oncology organization is called the Society of Surgical Oncology, and at that time, their annual meeting was limited to forty-two podium paper presentations …. The abstracts that were judged and ranked in order for someone to get onto the podium were viewed in a blinded fashion, which was a real advantage.

So I brought the department together, and I said, “Listen, let’s work on colonizing this meeting….Let’s make a commitment to each other that we’re going to try to bring our very best work to this Society of Surgical Oncology meeting and we’ll help each other with the abstract-writing processes and we’ll see if that strategy can bring us more visibility.” Because, up to that point, ….the vast majority were from Sloan-Kettering.

So we did that. [W]e met as a department and went through the abstracts we were going to put together. People gave very, very selflessly. We stayed down here until 11:00, 12:00, 1:00, 2:00 in the morning. There were people who were taking the abstracts down to the downtown post office just before the deadline and sending them out FedEx. We bought pizzas for everyone. People were moving from one office to the others. People who were very good at statistics were crunching the numbers. These abstracts, they give you a teeny-tiny box, so it’s almost like writing a Japanese haiku poem. There were others who were very, very good at fitting ideas into very small spaces, others who were very good at generating hypotheses and would be critical: ‘You say this, but that’s just descriptive; it’s not a real hypothesis.’ We worked together as a unit. Everyone saw everyone’s abstract, so it was like a huge internal peer review mechanism.

We went from three to twenty-seven of the podium presentations in two years. And we so dominated that meeting for two to three years that they finally said, “We can no longer review the abstracts blinded.” But by then we’d made the reputation that Anderson was a very, very strong academic program.
There was a big contract with the NCI called the Cancer Information Service...It was the very first NCI-funded public education programs about cancer. There was a toll-free WATS line—an 800 number that served the state of Texas where people could call you with their questions about cancer, and there were some educational programs targeted for minority and underserved audiences. And this was brand new, and I cannot convey to you how controversial it was at the time.

This was 1975 when most communication about cancer was between doctors and patients. And the notion that trained lay people could answer the phone and answer a technical question about cancer was preposterous to many people, especially to doctors....One MD Anderson doctor said to me, “I hope you screw up early before you do some real damage.” Nobody wanted to touch it. And I know that sounds so foolish nowadays....but it was just a different era.

[I]t was very pioneering ....Hell, I’m thirty years old, and I’m thinking this sounds like a great idea to me. So I volunteered to Dr. Clark ...Thirty years old with a bachelor’s degree at that time and they make me the principal investigator on the most—not the director but the PI-- on a very innovative and controversial contract, thinking this would probably go nowhere at any time.

And it worked out fine (laughs) ....[W]e ran that contract for thirty years .... We had to get all the resources, find space, hire people—all that sort of thing. We had to set up the 800 number, develop training programs and quality assurance programs for the people who answered the phones, develop liaisons in the community with African American and Latino populations, create media materials and get them approved by doctors. We were taking—well, near the end of it, it was 100,000 a year or so. This was a national network of about fifteen or so contracts all around the country.

.... CIS helped open the doors .... It was a national and worldwide movement—the educational movement in health care and disease prevention—and we were just part of it.
Our first female leader at the executive level, Dr. Margaret Kripke, was appointed to the President’s Commission on Cancer and became aware of the issue of cancer survivors…. She shared it with Dr. Mendelsohn, and shortly after, the Institute of Medicine report was published [From Cancer Patient to Cancer Survivor: Lost in Transition (2005)]…Dr. Mendelsohn felt that it was important to integrate cancer survivorship into our care delivery…. We held focus groups, and what we heard both the providers and the patients tell us was, the patients were accepting of the idea that maybe their focus—the focus of their care was no longer going to be necessarily the cancer itself. And in fact, many of them welcomed that it would now be more wellness and prevention. But they did not want to separate from their clinics. They wanted to feel that… the community of oncologists who were expert in their disease were still linked to that survivor care.

.... And being that we have multi-disciplinary disease-specific clinics, and that the patients felt most comfortable in that closeness to their primary clinic, we built the survivor clinics for each disease group for patients with certain categories of disease within that same group. So in gynecology, for example, we built a gynecology survivor clinic in the Gynecology Center.

....And to be survivors? We didn’t say, ‘Immediately upon completing chemotherapy you must transition them to survivor.’ We said, ‘At what point do you, the clinicians, consider it safe to transition to survivorship?’ The doctors’ opinions were, ‘OK oncologic care does not end until the patient has reached a point at which the risk of relapse is fairly minimal to nil. That’s when it’s safe for me to say, “You’re a survivor.”’

.... [W]e delegated that responsibility and accountability for determining the time point of transition to the primary providers. And to do that, they built what we call algorithms of transition… So there’s all of these disease-specific knowledge that we built into these models of care. So the providers feel comfortable: ‘I’m not just sending these patients to a clinic where somebody’s going to say, “Eat vegetables.”’ ‘That’s not it. They’re going to have, you know, a delivery of care that is aligned with these concerns that need to be addressed downstream.
Envisioning a Comprehensive Neuro-Oncology Service

This was the vision that I believe I brought to this program—not only to have the best neurosurgical service, but it had to be comprehensive.... [B]ehind you on the wall, there is a tree... that is the basis of the establishment of this department. To make an impact, you cannot piecemeal it. You have to bring the whole thing together.

This includes the ability for the surgeons to do high-level surgery. That means technology. It includes infrastructure, such as a tissue bank for research, such as a database to collect the information prospectively, and therefore eventually be able to analyze and understand, what’s the impact of the work we’re doing? It includes education and training, because there were very, very few neurosurgeons trained in the modern ways of treating brain tumor patients. Neurosurgical management of pain is a major component of our efforts here, because cancer patients can be debilitated with pain, intractable pain. And they will take all these drugs—morphine or whatever—and they would be zombies, so quality of life....I]t shows you that neurosurgical oncology is not only brain tumors, okay?

As I tell my faculty, “This is a partnership....We wouldn’t be as strong if we didn’t have the MD Anderson backing.” And MD Anderson wouldn’t be as strong if they didn’t have our neuro program. We all benefit from each other.
Since about 1983, I have been co-organizing a scientific meeting in Paris.... [David] asked me to join him as the co-president of the meeting, and we have been doing that ever since every year.

....So one day we are sitting in at an ASCO meeting at a coffee shop or a bar or something like that. We were thinking of what can we do to make an impact for the millennium with our meeting.... and we just started to free associate. So we said, “Well, you know, why don’t we ask whether we can rent the Cathedral of Notre Dame for a concert.” So the other guy laughs, saying, “That’s a crazy idea. There’s no way we can pull that off.” So the other one says or I did—I don’t know who—this is just the two of us throwing crazy ideas. “Maybe we could ask the mayor of Paris to throw a cocktail party for all of our speakers.” “Yeah.” “Well, maybe we could then ask the president of France to give a reception in the presidential palace.” “Yeah. That sounds great.” “Well, maybe we could organize a reception dinner at the Versailles Palace—the palace of Louis XIV.” And this went on and on.... If someone more reasonable than us had been listening to us, they would probably have called the men with the white coats. But we got all excited about this.

We had all of these things written down on a napkin, and we said, “Oh, my goodness....it’s a great idea.” So we thought about it for a couple of days. Again we met, and I said, “You know this not such a crazy idea. I think we can pull this off.”

Then we said, “Well, this is all fluff. So why don’t we put some really high-powered science behind it to justify the fluff?” I said, “Okay. So why don’t we organize a world summit on cancer research? And let’s invite a number of very high-profile investigators.” Eventually we put together a list of about forty, forty-five Nobel Prize winners..... To make a long story short, about half of them accepted to come and speak. So we put together this incredible program with the top biomedical investigators of the latter part of the twentieth century.
Then we said, “Well, we have our meeting, .... What are we going to do with these people?” So then we asked for City Hall in Paris to be lent to us. We were able to infect with enthusiasm the mayor, who later became President Chirac. He said, “Let’s do that. We have a wonderful large conference area. You can take that for a one-day conference for the world summit, and I put the City Hall’s resources to your disposal. And that evening I’ll organize a reception.”

…. So then we said, “Okay, well, check one off. Now let’s go to the president’s palace and see if we can play the two against each other.” We managed to get an appointment with one of the secretaries of the president and explained our plan. And I said, “You know, it would be a shame if all of these personalities came and the leadership of the country is nowhere. So we would also propose that we write a charter.” And by then we had written like a ten-point rights of cancer patients ... the Charter of Paris. To entice the president and his entourage, we said, “We can bring all of these personalities, plus we can invite a bunch of heads of state or their delegates to come and sign this in the French president’s palace.” So then he got all excited about it. He said, “Okay. So I’ll offer a signing ceremony here followed by a reception at the Palais de l’Élysée.” So check number two, and then we did something similar with the Versailles Palace.

Eventually, not only did we get the Museum of History to give us for free for one night the Versailles Palace, but we convinced two of the top chefs in Paris to provide food for free. For 700 of our closest friends.

You can’t do this unless you let that crazy side of yourself think big and think way beyond where our traditional thinking would restrict us. Had we been rational we would have said from day one, “This is not possible. Let’s not even try it. We are just going to waste a lot of time being frustrated, and at the end of it won’t have anything.” Instead we kept feeding each other’s craziness.

Originally it was called ... International Congress of Neoadjuvant Therapy ... Then the International Congress of Anti-Cancer Therapy [ICACT].... [F]or the signing of the Charter of Paris, we got something like fifty or sixty nations to send us either president, prime minister, or head of health to sign this charter. I invited Dr. Mendelsohn, who is also one of the signers of this document. He was there at the Élysée Palace and City Hall and at Versailles. He got a copy—which is exhibited somewhere in the Rose Building—of this beautiful charter which has the rights of the cancer patient and the signatures of several hundred people who signed on then. Then we put that up on the web and by now we have I don’t know how many tens of thousands of signatures from around the world.
Beyond a Traditional Leadership Model

Up until recent years, the traditional model of who became a Chair was this eruditious, best-known, highly-glorified individual…. with the thickest CV. But the irony is that once you step into that role, you have to let go of that ego persona, because the job of the Chair really is not to continue to aggrandize your own identity, but rather to bring forth the future leaders of the field, and to ensure that the people who are reporting to you themselves have the opportunities to become great people, great leaders in the future. xxxiii

Alma Rodriguez  
VP Medical Affairs

Clinicians and researchers traditionally complete their formal education without receiving any training in leadership or management, despite the fact that they will inevitably have responsibility for programs and for managing other professionals and staff.

This has been true for ambitious MD Anderson faculty, who have come to the institution eager to make a mark in their fields, to innovate programs, and to contribute to building the institution.

For many years, they learned on the job.
Then, in 1999, MD Anderson addressed the pressing need to prepare faculty for leadership by establishing a Department of Faculty Development headed by Janis Apted [Yadiny].

A team created a leadership development curriculum and held the first leadership retreat in The Woodlands in 2001. Ms. Yadiny recalls, “the faculty complained like mad that they had to miss a weekend, be away from their families, drive all that way up there,” but “it was fabulous because they came out saying, on Sunday morning, ‘I didn’t know any of this stuff, this is exactly what I need to know, to be able to manage myself and my team.’”

Today’s Faculty Leadership Academy draws on that curriculum: self-awareness and emotional intelligence; leading self, leading others, leading managers; identifying goals and vision. Here the faculty talk about filling the gap in their training. Some are Faculty Leadership Academy alumni. Others built their skills before this resource existed.

The Limits of a Title

I learned from [JoAnn Duffy] about how to use the various types of power and authority that you have … to achieve good, I guess, for lack of a better word. I learned about the fact that there’s legitimate authority that comes from your title and your position, but that really is a very limited type of power and authority. Yes, you can boss people around and make them do things because you’re the boss. “You do this because I tell you you have to do it.” But that’s really a weak type of leadership, and if you have to resort to that, then you probably need to be brushing up your CV and getting ready to go someplace else.

Barbara Summers, PhD
Chief Nursing Officer,
Head, Division of Nursing
(2003 – 2015)
I have a younger brother who had gone through the Harvard MBA program. I called Benji up and said, “Benji, I know in business school they teach leadership. Can you send me the syllabus from the course you took at Harvard?” … One of the books that I read which has made a tremendous impression on me through the years is a book called Servant Leadership by a man named Robert Greenleaf.…

One of the quotations that he harps on in his book and comes back to is from St. Francis. And I’m Jewish, so I can quote St. Francis with impunity. St. Francis says, “Seek ye to listen, rather than to be listened to.”

I think that’s the most powerful concept about leadership. As soon as you make a commitment to listen to someone, that automatically means your ears are open, your mouth is shut … and it forces you to be able to empathize with someone else. You have to be able to put yourself in someone else’s shoes, and then, looking through their eyes, ... see what the horizon looks like to them and what they see are the issues in the way of getting to that nirvana-point out there, their aspiration. … It doesn’t mean that you’re necessarily absolved from personal productivity demands, but your personal demands cannot be at the expenses of the needs of the other people around you. So do the walk-around research, go into other people’s offices, learn about what they are trying to accomplish, what are the important things for them, work with them to figure out what resources they need, help them secure those resources, and get the heck out of the way ... as they try to use those resources.

Also, never take credit for their successes, and celebrate their victories in public and their defeats in private…
Letting Go of Alienating Approaches

I learned how to accomplish some goals without ... a zero-sum proposition, where someone had to lose for someone else to win....

For example, there were two faculty members in the department who were both working in the same disease site and were very critical of each other. They would make rounds on all of the patients that had the specific type of disease, including the patients of the other person, and then, in front of the fellows, they would criticize the management, which was very destructive.

I handled that by pulling them both in my office and saying, “This is going to stop immediately or else there will be repercussions. These are the tools that are at my beck and call: your salary, your tenure, and your employment. What about that don’t you understand?”

It accomplished the purpose, but .... it would have been much more constructive to have spoken to them individually and demonstrated how destructive their actions were and how much consternation it was causing the trainees because they felt like they had to pick sides in this process. It was unfair to them and detrimental to their education. It would have been much more constructive to tell them I really had higher expectations because I knew that they could do better. Yes, I was going to have to monitor it now that this had come forward, but please, let’s make this the last time that we have to talk about this. That has a very different feel.

A Way of Listening

I learned more about ... public listening. You may be the Chair, but that doesn’t mean you have to come up with the answer right then and there. It’s a very effective thing to say, “You know, I hadn’t thought about it from that point of view. I’m not totally sure I agree with you on this yet. I’m going to take 48 hours and chew on this and think about it.” Then I’m going to come back to the group or the individual and say, “I’ll tell you what I think so we can pick up the thread of the dialog.”

That’s very different than feeling that somehow you are being challenged ... and feeling like you have to respond immediately with a show of force. “Listen, buddy, I’m the top dog here. No, you’re not going to pee in my swimming pool. This is not your call. This is my call.” That type of behavior is like posturing in response to posturing. I think that I was pretty effective in putting that aside and learning how to build cohesion and consensus.
Once you move into that level of administration it’s like the white water rafting analogy. You get in, and you start paddling because you can’t do anything else. You have no time to think about what it is that you’re doing, and so it’s extremely important to lead from principles because it forces consistency. It enables transparency, and it gives you guideposts for decision making.

One of [the principles] was a mandate from Dr. Mendelsohn, and that is to support excellence. If you have a choice to make, and you have to decide who gets resources, you support excellence.

One of my favorite principles is to reward the behavior that you want. I really tried to stick with that. It’s easy to do things for people who are pounding on your desk, and screaming, and being the loudest. I always tried not to reward bad behavior and to make part of the institutional awards include an element of being a role model in the institution. So reward the behavior that you want is an important one of mine.

Another principle is to always tell the truth. It’s amazing how many people don’t do that. Always tell the same story. I know people in leadership positions that will say one thing in one context and say something somewhat different depending on who the audience is. That never works. It’s a disaster. Some people never take responsibility for decisions and for actions. You should always be ready to stand up and take responsibility for what it is that you’re doing.

It’s amazing how often those are not followed. I have seen previous leaders who were very secretive about who got resources and how things worked, I suppose as a protective mechanism.
Linda Elting, PhD, MPH  
on  
*Developing Leadership*

I think it’s a bigger package of skills than most people perceive. I think it involves presentation skills, short elevator talk skills, formal professional presentations, how to tell your story on the telephone. How to raise money. How to sell your idea to a for-profit company. All of those things I think are very important.

... I work with younger women to ensure that they don’t end up being the workhorse of the institution who is never on the podium. That’s a real danger for a really competent person. And it’s even worse for someone who isn’t assertive and outgoing, because they gravitate to those kinds of jobs.

...And it’s such a silly thing to have a career damaged over. But those sorts of things, or sounding when you talk like you’re a hick, the way you pronounce words, the way you express yourself, your diction, all of those things unfortunately can really sink your career.

Janet Bruner, MD  
*Preparing for Administrative Leadership*

[Dr. Batsakis’] suggested that I needed to change my attitude and think more globally and not so much about my own career or neuropathology. I needed to think about the entire department, how things affected it, how it functioned, and how the department affected the institution.

My mentor back in Ohio said, “I think if you are a good mentor and a good leader, you have to be willing to have the people that you’re leading grow to be bigger than you are. If you can’t do that, you’re never going to be as good as you could be. You can’t be afraid that they’re going to be greater than you” .... I think that’s the issue with being the chair... [I]f they grow to be greater than you—more famous, bigger in national institutions, have more publications, do better research—then you have to want that. .... The larger they grow the better that is for everybody.
Barbara Summers, PhD

on

*Project Leadership*

…I learned … about the process of developing plans for achieving improvement, if you will, and not only setting the objectives and the timelines, but also being very clear in your mind what is the evidence going to be that will demonstrate that I’ve achieved the goal, you know, causing you to have to be concrete enough to be able to say, “Okay, here’s the evidence that I’ve gotten to this place,” or that this staff has moved to this place…. [I]t was just great.

Oliver Bogler, PhD

talks about

*Creativity*

I’ve always had a creative side to me. I’ve never been a pure scientist, a pure analytical person. … I’ve always sort of enjoyed art and creativity and so on. Obviously science is also a creative activity … and certainly in my administrative role also I feel the analytical is combined with some different ways of looking at things and just moving things into new areas, particularly trying to bring actually some scientific thinking into some of my administrative roles and some data-driven approaches … That’s definitely been something that’s kept me interested and engaged, because, some of what you do in an administrative role, some of it is fairly transactional. So I think for me to be happy, I need to blend some of those things.
Physicians are fiercely independent—and especially physicians in certain specialties—and I point first at the surgeons. Even within that surgical group of very accomplished and highly skilled surgeons, there were no two who did the same thing. And each of them felt that they knew better than the other two or three how to treat breast cancer. And therefore to question why was—to question their integrity—to question their skills. And in retrospect, perhaps some of that is because they couldn’t tell me why they did it differently than the next person, why they cut here as opposed to here. But that is just my theory.

It takes a process until you are comfortable enough in your skin to say, “Okay, so this person from a different specialty is asking me something that goes to the fundament of what I think is my knowledge about my specialty. How dare he?” And as opposed to, “Well, he is asking me either because he doesn’t understand, and I haven’t explained it well enough or because there might be another option that I should consider.” But that takes taking a step back and looking at the bigger picture. And I think that ability to step back is what helped me tremendously over the next several decades to bring our group together and make it a more productive and more interactive group.

But it means sometimes—and I am not exactly a humble person—but it sometimes means swallowing your pride and swallowing your tongue and just becoming a better listener and sometimes just serving as the lightning rod for other people to vent and do their thing until they realize that I am not trying to threaten them or take anything away from them.
ENDNOTES

References to Oral History Interviews

1 Stephen Tomasovic: Session One, Chapter One: [007:43]
2 This collection is a production of Heritage Services, a section of the Historical Resources Center in the Research Medical Library. All the interviews cited were conducted by Tacey A. Rosolowski, PhD for the oral history project. She also compiled this collection and provided the supplementary text. Javier Garza, Archivist and head of the Historical Resources Center, provided the photography.
3 Mulvey, P_02_05_Dedicated_to_One_Disease
4 Martin Raber, 0:25:49.3
5 John Mendelsohn, Session One, Chapter One: 0:09:51.2
6 Martin Raber, clip # Raber, M_04_21_An_Intense_Sense_of_Mission
7 1907-1994
8 Don Macon interview with R. Lee Clark, MD, President of the University of Texas Cancer Center, videotaped on November 30, 1973 for the series, History Makers of the Texas Medical Center.
9 Picture below taken from “The First Twenty Years.” Photo caption: “Dr. Clark discusses a plastic model of the proposed building with The University of Texas Regents, Mrs. Margaret Tobin and Judge Dudley K. Woodward Jr in 1952.”
10 QB-Ahearn, M_01_02_R_Lee_Clark’s_Pink_Marble_and_Hope
11 Charles Aubrey LeMaistre, Session 01, 05-24-2012, 0:31:46.9
12 Charles Aubrey LeMaistre, Session 01, Segment 12: 0:12:09.5
13 QB-Stuyck, S_01_02_Lessons_from_Charles_Lemaistre
14 John Mendelsohn, Session 01, Chapter 07: [1:34:25.4]
15 Stephen Tomasovic, [00:15:10]
16 John Mendelsohn, Session 01, Chapter 01: 0:03:54.2
17 John Mendelsohn, Session 01, Chapter 01: 1:55:42.7
18 Robert Bast, Session 03, Chapter 21: [00:46:08]
19 Lorenzo Cohen, Session 02: 1:20:37.6
20 Steve Stuyck, Session 01, Chapter 06: 00:11:24
21 Gabriel Hortobagyi, Session 02, Chapter 08: [0:00:46.0]
22 Ronald DePinho, Session 01, Chapter 06: [00:58:29]
23 Robert Bast, Session 03, Chapter 22: [00:46:08]
24 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
25 William Boyd Baun, Session 03: [1:23:34.6]
26 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
27 QB-Ahearn, M_01_02_R_Lee_Clark’s_Pink_Marble_and_Hope
28 Dr. Ian Suk prepared the illustration of the Neurosurgical Oncology tree, based on Dr. Sawaya’s concept. This image is reprinted by permission; the original hangs in Dr. Sawaya’s office.
29 Ronald DePinho, Session 01, Chapter 06: [00:58:29]
30 Robert Bast, Session 03, Chapter 22: [00:46:08]
31 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
32 William Boyd Baun, Session 03: [1:23:34.6]
33 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
34 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
35 Alma Rodriguez. Session 04: [01:11:40]
36 Sawaya, R_01_02_A_Vision_of_a_Comprehensive_Neuro-Service
37 Dr. Ian Suk prepared the illustration of the Neurosurgical Oncology tree, based on Dr. Sawaya’s concept. This image is reprinted by permission; the original hangs in Dr. Sawaya’s office.
38 Alma Rodriguez. Session 04: [01:11:40]
39 Robert Bast, Session 03, Chapter 22: [00:46:08]
40 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
41 William Boyd Baun, Session 03: [1:23:34.6]
42 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
43 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
44 Alma Rodriguez. Session 04: [01:11:40]
45 Robert Bast, Session 03, Chapter 22: [00:46:08]
46 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
47 William Boyd Baun, Session 03: [1:23:34.6]
48 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
49 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
50 Alma Rodriguez. Session 04: [01:11:40]
51 Robert Bast, Session 03, Chapter 22: [00:46:08]
52 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
53 William Boyd Baun, Session 03: [1:23:34.6]
54 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
55 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
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57 Robert Bast, Session 03, Chapter 22: [00:46:08]
58 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
59 William Boyd Baun, Session 03: [1:23:34.6]
60 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
61 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
62 Alma Rodriguez. Session 04: [01:11:40]
63 Robert Bast, Session 03, Chapter 22: [00:46:08]
64 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
65 William Boyd Baun, Session 03: [1:23:34.6]
66 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
67 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
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69 Robert Bast, Session 03, Chapter 22: [00:46:08]
70 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
71 William Boyd Baun, Session 03: [1:23:34.6]
72 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
73 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
74 Alma Rodriguez. Session 04: [01:11:40]
75 Robert Bast, Session 03, Chapter 22: [00:46:08]
76 Amy Carpenter Hay, Session 02, Chapter 18: [01:32:11]
77 William Boyd Baun, Session 03: [1:23:34.6]
78 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
79 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
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81 Robert Bast, Session 03, Chapter 22: [00:46:08]
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84 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
85 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
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87 Robert Bast, Session 03, Chapter 22: [00:46:08]
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91 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
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97 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service
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101 William Boyd Baun, Session 03: [1:23:34.6]
102 Patrick Mulvey, Session 01, Chapter 04: [00:46:52], [00:46:52]
103 QB-Stuyck, S_01_03_The_First_Cancer_Information_Service

Cover photography. Front, Dr. Kelly Hunt in the operating room; photographer, F. Carter Smith.
Back, Siyuan Zhang, PhD with mentor Dihua Yu, MD, PhD; photographer, Wyatt McSpadden.
This version of *Leading the MD Anderson Way* was prepared for distribution for the 2016 holiday season.

In celebration, here are two photos from the Children’s Art Project (CAP). Run by innovative leaders since its founding in the seventies, CAP’s product sales have raised millions for pediatric programs.

Steve Stuyck, former VP of Public Affairs, appears with CAP Assistant Director, Karen Harrison, and First Lady, Lady Bird Johnson.

And to the left is “Gift Heart” by Ellen. This was the first Christopher Radko holiday ornament that CAP produced from a pediatric patient’s artwork in the early 2000s.

*All Good Wishes  
for the Holiday Season and for 2017.*
For information on the interview collection and to request content, audio clips, and historical images, please contact the Historical Resources Center.

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<tr>
<th>Name</th>
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