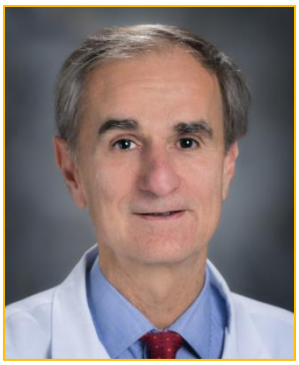
Eduardo Bruera, MD tells a story of Leadership Challenges

Medical Oncologist, Eduardo Bruera, MD, has served as Chair of MD Anderson's Department of Palliative, Rehabilitation, and Integrative Medicine since 1999. Here he explains key strategies for building consensus while implementing changes in service delivery.



Implementing Change by Building Consensus and Trust

All those changes in the way we operate took first to observe, then to decide what could we do different, then try to get consensus by all the players: 'this is not the way we've been doing it, but I am willing to give it a try and see what happens…. And then say well, okay, let's try it for two months and then we'll come back.

Putting music in our center, in our Palliative Care Unit, was regarded as really bad by our own faculty and some of our nurses. They said, my goodness, we're going to make mistakes here, we're going to get distracted, we're going to write the wrong orders, and the patients might not like it, and the families might not like it. So we basically had to do it again three months later --an anonymous survey. I always emphasize anonymity because it's not easy for an assistant professor to vote against Bruera, because I happen to be the professor, I'm the chief…. Although there were very, very heated arguments against, when we asked patients and families and staff members, the negativity went down from about 60 to 70 percent to about 9 percent in the anonymous. Everybody loved the music and then we kept the music.

Abolishing the waiting room was another thing that we wanted to do. The waiting room to us is not good …. In palliative care, having a lot of people who are suffering sitting in front of each other, they don't look good. It required us to reengineer the patient floor. A lot of our doctors said and our nurses said, 'my goodness, this is going to be crazy, because I'm going to have all my rooms full, and how am I going to flow the patients, and how are we going to keep the appointments and how are we going to keep those rooms open?' We had to put big boards with all the names of the patients and the rooms … to see which room was open and which room was not open. Again, it took thinking, can we do it differently? Yes. Okay, well, convincing some people, being reluctant, and then ask them, and they overwhelmingly loved it. So we've introduced over time, a lot of changes. But we require building consensus, and then evaluating. Some of them were failures. We embedded a doctor into the Thoracic Medical Oncology Clinic, to do palliative care there, to get the patients and then move them later on, to the Supportive Care Center; it was a failure. It did not have the resources, it did not have the numbers of patients, and so on. We did that for three or four months, five months, and then we went back and said, it didn't work, let's move back. And I think when people know that it's going to be for a time period and then if it doesn't work we go back, they have a tendency to say, let's give it a try.

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About This Content

This interview clip was taken from an in-depth interview conducted for the Making Cancer History Voices Oral History Project. This ongoing project currently contains almost 500 interview hours with MD Anderson institution builders.

The transcript has been edited from the original.

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Interview link: https://mdanderson.libguides.com/BrueraE

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