

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 that because palliative care falls outside of the main thrust of the institution, he had to build a clinically and academically successful department without up-front institutional support.



Building a Department in Anticipation of Support

So, we were not one of the departments that were lucky enough to get upfront support. We knew that—and I knew that from every aspect of where I've been, it's always very hard to grow a program that is not right in the main highway of what an institution does. So if an institution is in the area of heart care, like the Texas Heart Institute, you know that what will give you a lot of work, prestige and resources, is to be a cardiologist or a cardiothoracic surgeon. So, we knew that we were not going to ever be given resources in anticipation of growth. It was always going to have to be the opposite procedure. That is, you first grow, you show the growth, then you ask for the resources to cover. Unless the clinical care, the patients are safe, then it gets hard to build the other part [the research program]. But of course, you're always at the edge of burnout, because you're having big demands. So what we did is we, every year consorted ourselves and said are we able to grow the business? Yes. Okay, how many positions do we ask for? One more or two more? That's what we did, and we continuously started asking for that growth.

So I was able to build some preliminary data and I did it in a way that was kind of unusual. So some of my establishment package was used to pay some doctors, because I had no positions. Then, I did that preliminary data with international centers.... so I got people from Denmark, Australia, and some other centers in Canada, and we established an international kind of research group. ... We passed a couple of protocols through the IRB and we started collecting data. That data was very, very useful because that data was what allowed us to write our first R01s with the NIH, because we were doing a lot of clinical work.... That data was what we really used for two of our three R01s, of the three R01s I got, and I used that data as the pillar, the preliminary data was used for the application.

So as we were growing clinically,... -we had saturated the clinical practice to the point of exceeding ourselves by one full position. Then we got one more, and then we got another more, and then we got another more. But of course each growth was very painful for us. It meant that first we had to grow the clinical activity to the point that would justify one more faculty position, then ask for the faculty position, then wait until the faculty position was hired. And at that point the burden came down a little bit and then that job started again.

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As the decompression started to happen for weekends and vacation and so on, then writing became a little bit easier, because now we had more time. Even if it was weekend time, we had more time to allocate to the nonclinical part of the operation.... So we knew that we had to basically pay our way into other academic activities, but we developed a strategy within our team, to support each other and to basically help each other be productive. We were, I think, fortunate in the sense that the team, the members that were arriving, were willing to put a little bit of time --because we didn't have an awful lot of time-- but a little bit of time into writing, into doing papers. My job was to provide them with the infrastructure, to get the research nurses, the statisticians, the people who would make their life easy, so that our clinically busy faculty would not have to be running around trying to get money. The money was my job, and they got to work on the ideas and the projects, and write them and so on, and that helped us. Over the years, we have been one, I think by far, of the most productive academic teams in palliative care in the United States.

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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Photos and archival material: Javier Garza, MSIS, jjgarza@mdanderson.org