

Alma Rodriguez, MD tells a story of Leadership Challenges

Alma Rodriguez has served as MD Anderson's Vice President of Medical Affairs since 2005. In an interview conducted in 2015, she talks about a major initiative creating the institution's practice algorithms and shares what she learned from the process.



Establishing Practice Algorithms and Lessons about the Art and Science of Medicine

When I was assigned to this role [Medical Affairs], I realized that on a national scale, we also were beginning to talk about algorithms of care, actually they were called “guidelines,” guidelines of care. We chose to call our maps of care “algorithms,” because essentially “if this, then that, if that, then this.” We said we will have institution-wide clinical algorithms for all the major cancers that we see. You can’t have an algorithm for everything; there are some malignancies that are so rare that there is no known best strategy for treating them. But for all the more common and more widely-seen malignancies, we have developed algorithms for cancer care. We have over 100 now, 147 algorithms. And within those maps of care, there were unique focus areas, particularly all the domains that had to do with the delivery of chemotherapy.

[T]he effect of the algorithms is in—number one, it brings to awareness, to people’s awareness, that there are indeed best practice processes. In a way, it’s an intellectual discipline process, it’s a process of doing a very rational and thoughtful analysis of where should we be? Then it usually piques the interest of people in saying, well, where are we? I would say, the best outcomes have been that some departments have become interested in looking at themselves again, a self-inquiry, looking at ourselves and saying, “Gee, are we really doing this?” And, “Is this what we want to keep doing?” Some of them have questioned, just because we have done X, Y or Z forever, it doesn’t mean that it’s the best strategy. What does the data say? And this is where Stephanie Fulton and her [Research Medical Library] group come in, because they support us in doing professional intensive literature searches. They then can give us the objective information that says, well, you know, that’s changed. Other people think that this is better, or they might say, you know, the needle hasn’t moved, it’s still the same, in which case, it might also initiate a different conversation, which is, “Gee, should we start to try something different?” (laughter)

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So, for some departments, this has been a process of self-inquiry, of self-assessment, of updating, renewing, refreshing information on what's appropriate and relevant to their practice. In others, in many of the supportive care algorithms, for example, the management of deep vein thrombosis, it has initiated major conversations about who are the appropriate patients who should be placed on these prophylaxis modalities of treatment, are we doing it? It generated a whole deep analysis into practices by various groups. And we surfaced, who are the people who really do it, the people who don't do it, and we fed that data back to them. And they're like, "Ooh, that's us, we can't believe it!" So it again has brought—one department that said, "our patients are really high-risk, we're seeing this as a complication often." Why is that? So they initiated a research protocol for that. So it can have very positive consequences, depending on the attitude of the individuals who are participating in the process. And again, we don't expect humans to be uniform. So it's a good thing.

First of all, I've learned that the overwhelming majority of the physicians who practice here care deeply about doing the right thing, and taking the best care of their patients. That's been incredibly rewarding for me, to say as a profession, I think we are an outstanding group of people. I'm very proud to work with them and for them, actually, because I work for them. The other thing that I've learned is that there is always a potential risk in medicine. I mean, this has been true for centuries; we are a profession that is very, for lack of a better word, dogmatic, and that you have to be vigilant to the risk of being purely dogmatic versus quality and safety-motivated, when you say, no, look, this is the best way to do this. It's not OK to do X, Y or Z, just because you like to do things that way, right? I mean, the physician is the artist. Everyone says that medicine is both an art and a science. Well, one has to guard a bit against the over-artistic aspects, as well as the over-scientific aspects, because being at both extremes may not be the most optimal for the patient. There's a harmony to both the art and the science. Patients are very conscious of this. They truly do want the treatment that, according to the scientific evidence is the best, or would be the best. But at the same time, they want the treatment that would be most suited to them as individuals. So I think that's the most valuable professional skill to have, to have the appropriate judgment to determine the harmony of the science versus the humanity of the decision.

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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