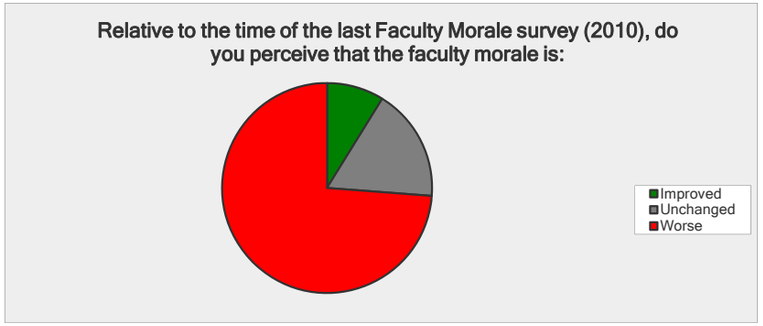
Faculty Survey 2012 (Question 1)

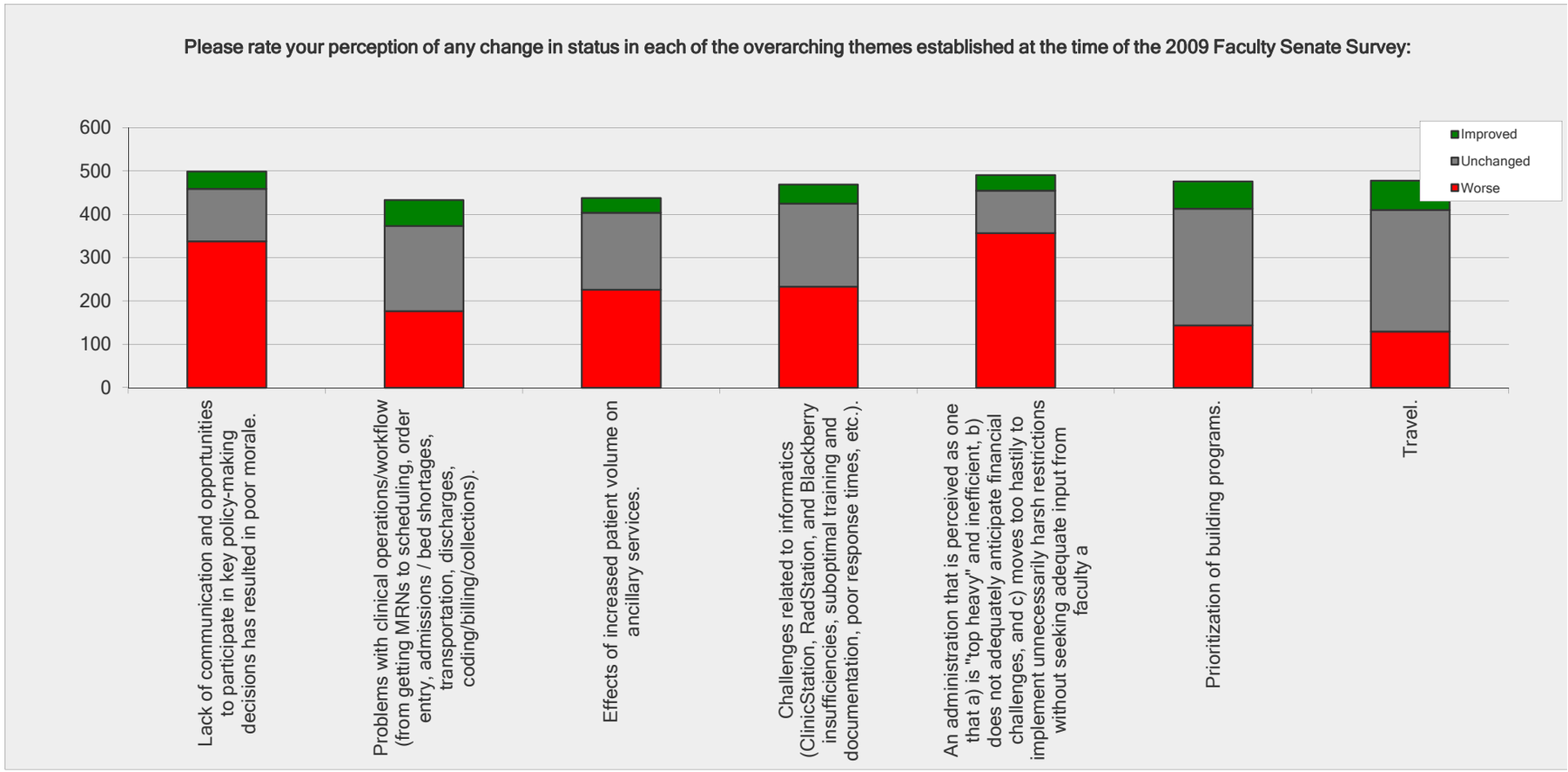
Relative to the time of the last Faculty Morale survey (2010), do you perceive that the faculty morale is:		
Answer Options	**Response Percent**	**Response Count**
Improved	8.8%	44
Unchanged	17.4%	87
Worse	73.8%	369
	answered question	**500**
	skipped question	**14**



Faculty Survey 2012 (Question 2)

Please rate your perception of any change in status in each of the overarching themes established at the time of the 2009 Faculty Senate Survey:

Answer Options	Improved	Unchanged	Worse	Response Count
Lack of communication and opportunities to participate in	40	121	338	499
Problems with clinical operations/workflow (from getting	60	196	177	433
Effects of increased patient volume on ancillary services.	34	178	226	438
Challenges related to informatics (ClinicStation,	44	192	233	469
An administration that is perceived as one that a) is "top	36	98	357	491
Prioritization of building programs.	63	269	144	476
Travel.	68	280	130	478
			answered question	499
			skipped question	15



Faculty Survey 2012 (Question 3)

If you perceive that the faculty morale is unchanged or worse relative to 2010, please list up to three issues that have led to this state:

Answer Options	Answer Options	Response Percent	Response Count
1.	1.	100.0%	370
2.	2.	93.2%	345
3.	3.	75.9%	281
	answered question	*370*	
	skipped question	*144*	

Number	Response Date	1.	Categories	2.	Categories	3.	Categories
1	Oct 20, 2012 2:21 AM	continued poor informatics, and lack of input from clinicians - instead still relying on non-clinical management to make decisions (like radiologists!)		Difficult in getting travel expenses approved is cumbersome			
2	Oct 19, 2012 10:40 PM	Excessive pressure by administration to do more clinical work to increase revenue		Inadequate infrastructure/personnel to handle #1		Insufficient time to do our own research due to #1	
3	Oct 19, 2012 2:23 AM	Recent rash of firing of high level faculty without explanation		Requirement for increased clinical productivity without increase in resources or input from clinicians		No attention paid to faculty concerns	
4	Oct 18, 2012 10:46 PM	Uncertainty about future		No transparency		The number of high profile individuals who are leaving or who have been asked to step down from their posts	
5	Oct 18, 2012 10:04 PM	overwork		feeling of powerlessness to affect chance			
6	Oct 18, 2012 10:04 PM	Over-reaching administrative burdens (trainings, etc)		Unrealistic work expectations		No time for innovative research	
7	Oct 18, 2012 9:39 PM	increasing nonsense we must contend with		new administration creating very bad press for institution			
8	Oct 18, 2012 9:07 PM	The perception that top leadership can do whatever they want with impunity.		Leadership cares about its own priorities that do not seem to involve the rank and file other than to ask it to perform at increasingly higher levels of productivity.		Buildings are more important that people - new administration building for example.	
9	Oct 18, 2012 8:01 PM	Requirement for increased clinical productivity In the face of "higher bar" for promotion and tenure		Priority of research over clinical efforts institutionally		Increasing regulatory burden	
10	Oct 18, 2012 7:24 PM	Ethical concerns with administration CPRIT/Stocks		Ethical concerns with patient effect moonshot, risking reputation of MDACC		Feel that clinicians 80 clinical/20research are underappreciated and asked to do more and more-beyond a reasonable amount	
11	Oct 18, 2012 6:51 PM	Problems with informatics		Lack of input from clinical faculty to administration		Bureaucracy	
12	Oct 18, 2012 5:49 PM	new chair who does not respect the faculty		new chair who does not tale faculty feedback			
13	Oct 18, 2012 5:38 PM	harsh restrictions without seeking input from faculty		micro management style			
14	Oct 18, 2012 5:05 PM	Top-down decision making without faculty input					
15	Oct 18, 2012 5:00 PM	increase of 30% for the margin		disregard of conflict of interest by admin		circumventing the rules by the president	
16	Oct 18, 2012 4:25 PM	no faculty input on decision that affect us		additional bureaucratic demands reducing time with patient		lack of transparency	
17	Oct 18, 2012 4:24 PM	Pressure		Fear		Stress	
18	Oct 18, 2012 3:55 PM	Dramatic increase in clinical budgets/targets		Poor infrastructure (IT and other staff) to support clinical increases		Feeling that clinical faculty are here to support bigger research initiatives	
19	Oct 18, 2012 3:45 PM	leadership has no idea what it means to take care of patients		It's impossible to hire a new PA but then 5 depts get millions of dollars for research - who is paying for that?		So tired of having to answer questions from other Houstonians about why MD Anderson is going downhill/ always in the Chronicle	
20	Oct 18, 2012 2:46 PM	people are afraid to speak up		too many chairmen were fired or forced to leave and this increases the level of unsafety among faculty on all levels		strategic plan for moonshot programs is clear but there is lack of info about the plans for research of other types of cancer	
21	Oct 18, 2012 2:21 PM	removal of faculty senate from advisory committee		"efficient communication" seems more one way than two			
22	Oct 18, 2012 2:18 PM	Growth for the sake of growth.		More work with the same amount of resources.			
23	Oct 18, 2012 1:57 PM	Bureaucratic hierarchy is essentially unchanged.		Too many bosses who do little real work.			
24	Oct 18, 2012 1:56 PM	Institutional Leadership Style		Mandates from top down, solutions expected bottom up.			

25	**Oct 18, 2012 1:51 PM**	Across the board demand to increase patient volume by 5% without any increase in the resources need to accomplish this goal		IT rolls out new programs prematurely and we are left to deal with the consequences (new blackberries, ePrescription)		exodus of excellent faculty	
26	**Oct 18, 2012 1:39 PM**	Health care environment		Need to increase clinical productivity		Poor communication	
27	**Oct 18, 2012 1:31 PM**	lack of communication		lack of collaboration		non-colleagial competition	
28	**Oct 18, 2012 1:29 PM**	quality of care to patients, heard lots of complains		poor effecious management on trvavel		negative news of leadership	
29	**Oct 18, 2012 1:20 PM**	Multiple policies for everything while nothing ever happens					
30	**Oct 18, 2012 12:55 PM**	top heavy inefficient system					
31	**Oct 18, 2012 3:38 AM**	Perceptions of ruthlessness		Lack of transparency		Suspicion of COI up to corruption	
32	**Oct 18, 2012 2:25 AM**	insensitive president and administration		perception of clinical faculty as just revenue generators		constantly increasing demands for increased clinical productivity	
33	**Oct 18, 2012 2:20 AM**	best example is recent nursing refusal to help with eprescriptions. dramatically decreasing efficiency and worsening clinic team functioning. faculty have no say. barbara summers hides behind policies. medicine is not about policies it is about taking care of pts		admistration has had minimal cutts while all new faculty are hired at 80percent. can't keep increasing taxes, need to cut the bloated unnecessary fluff		get at the real problems. need improve downstream servicies. I tell pts to get ports outside, patlan tells pts to get biopsies outside. adminstration hires more ir docs but problem is not docs problem is ir is not optimized. schedule goes unfilled, do not have enough nurses to run full rooms, docs are on research track but nost irs do no research. this place needs somebody to go around hold people accountable and fix the real problem. more new pt/consults is not it.	
34	**Oct 18, 2012 1:51 AM**	Inneficiency in clinical operations		Increased work load		Problems with recruitment and retention	
35	**Oct 18, 2012 1:19 AM**	Lack of support for all faculty		Faculty has very little voice in adminstrative issues for the whole institute		Constantly fighting with the adminstration about lab space	
36	**Oct 18, 2012 12:49 AM**	Administration does not listen		Administration does not value clinicians		Clinicians pay the price for administrative initiatives	
37	**Oct 18, 2012 12:43 AM**	lack of management value for clinical faculty		financial burden put on clinicians despite individual or departmental productivity		travel planning complexity	
38	**Oct 18, 2012 12:38 AM**	Failed, arrogant leadership		Inappropriate changes in leadership		Lack of faculty input in major decisions	
39	**Oct 18, 2012 12:28 AM**	Lack of mentoring of junior faculty		Lack of resources while expectations higher		Concerning behavior of the President & Wife	
40	**Oct 18, 2012 12:17 AM**	at least two people committed suicide in the last year		some of these senior faculty members abuse junior faculty, postdocs and staff		as long as the old guards are in power nothing will never change	
41	**Oct 17, 2012 11:59 PM**	Petulant new chair		new schedules that don"t work		everyone is stressed	
42	**Oct 17, 2012 11:09 PM**	Increased workload without additional faculty		Insufficient/inefficient support staff (i. e. LIS)		Lack of efficient transcriptiontion of dictated pathology report	
43	**Oct 17, 2012 11:06 PM**	President's elitism		President's habit of getting in the media for the wrong reasons: himself.		President's practice of nepotism and cronyism	
44	**Oct 17, 2012 11:02 PM**	lack of faith in new president		at dept level, lack of faith in chair			
45	**Oct 17, 2012 11:00 PM**	Increased implementation of new policies, programs, and initiatives with little to no foresight on the day to day effects of changes or safeguards for problems...ie, resource one					
46	**Oct 17, 2012 10:58 PM**	Poor communication within department regarding timelines for new projects, new equipment.		Delays in travel expense reimbursement.		Slow response from 4INFO, RIS group.	
47	**Oct 17, 2012 10:49 PM**	High patient volume without improvements in efficiency		More emphasis on bureaucracy than quality patient care		Exclusion of physicians from decision making.	
48	**Oct 17, 2012 10:46 PM**	administration no longer prioritizes clinical care except for revenue generation to support research		conflicts of interest at the highest levels			
49	**Oct 17, 2012 10:45 PM**	conflicts of interest		corruption			
50	**Oct 17, 2012 10:43 PM**	negative press about MDACC		change to Resource 1 without adequate preparation and training			
51	**Oct 17, 2012 10:41 PM**	no plan or efficient means to make changes					
52	**Oct 17, 2012 10:40 PM**	Proliferation of bureaucrats		Proliferation of senseless rules that detract from patient care		Unresponsive leadership with delusions of grandeur	
53	**Oct 17, 2012 10:38 PM**	Intergrity of the Administration					
54	**Oct 16, 2012 7:11 PM**	Numerous faculty leaving institution.		Too many changes at the chair level.		Bad MDACC publicity.	

55	Oct 15, 2012 10:21 PM	Services (IT, trainee and alumni affairs) are not providing adequate support to their clients (i.e. Faculty)		Administrators/leadership are not accountable (decisions are taken behind closed doors and there are no clear benchmarks to evaluate administrators)		Consequences of decisions are not paid by the decision makers (who came up with the encryption idea/pla, is not using computers)	
56	Oct 15, 2012 5:04 PM	the new president		The new president's wife		fear of retaliation	
57	Oct 15, 2012 4:21 PM	Conflict of interest issues in media		termination of two administrators--DuBoise and Pollock		unrealistic clinical expectations	
58	Oct 14, 2012 7:11 PM	lack of communication and faculty input					
59	Oct 14, 2012 4:35 PM	the management of financial issues that led to a downturn in the margin in 2012		a mandate to increase performance in clinical operations to make up te margin		change in the culture of the institution from an academic institution to focus on drug discovery and pipeline development	
60	Oct 12, 2012 9:35 PM	Rapid change in institutional culture		Financial pressures		lack of effective communication	
61	Oct 12, 2012 5:54 PM	more beaurecracy		more pressure on faculty		funding climate	
62	Oct 12, 2012 12:23 AM	need for less paperwork		committees hinder instead of facilitate		cumbersome clincial research finance	
63	Oct 11, 2012 8:45 PM	Too many sweeping changes with the change in leadership		Uncertainty as to the impact of the moon shots on other research projects		Perception of MD Anderson in the public eye as just a "money-making operation"	
64	Oct 11, 2012 8:44 PM	Conflict of interest		Nepotism		Heavy-handed leadership	
65	Oct 11, 2012 2:44 PM	Increasing productivity pressures		Management heavy. The people who make these decisions seem to have no idea how clinics are normally run.		President DePinho's issues in the press	
66	Oct 11, 2012 2:39 PM	continuing negative press about our president		perception that president and wife get special treatment			
67	Oct 11, 2012 1:41 PM	burdensome policies for clinicians: e-prescribe, new verbal order policy, etc.		extreme delays in process of hiring and credentialing new clinicians		patients struggle to make appts and navigate huge system	
68	Oct 10, 2012 10:25 PM	top heavy leadership		ethics "sniff test" not passed by president and spouse		increased binning of clinicians versus researchers with less ability to do both	
69	Oct 10, 2012 9:03 PM	institution is top-heavy, departments are also heavy with administrative personell		policies are made at divisional and department level without open input from faculty		cinuical managers are makign decisions that affect clinical faculty workflow and performance	
70	Oct 10, 2012 7:10 PM	pressure more pt vol w/ less support and resistence of directors to change inefficient status quo		electronic informatics bulky, inefficient and backward. very dysfunctional and time consuming. Won't IT "flip the calendar"? we are decades behind. Dysfunctional and lack of electronic support ie BB, EMR, computers all shiftd down to clinical faculty.		Our dept +Division is extremely punative, oppressive atmosphere, functions by "reporting" and criticizing, after a series of "tattle -telling" what someone perceived,, by the time it gets upstream, the issue is expanded, misinterpreted and causes a waste of time, energy and time. no one clarifies early or asks ,, very unprofessional all around. Leaders enable this behavior and encourage it. Dept leadrs set in status quo,resistent to change , inefficient, ignorant of possibilities and resources . Atmosphere oppressive. "kill the messenger". Pervasive throughout the division. Leaders out of touch. and do not exhibit behaviors that would help them keep in touch. Months go by without seeing or talking to them. Faculty "lie low". It is frustrating as there is such opportunity with a magnificient group of mid levels and Doctors all capable of working together to provide fantastic pt care, improving pt vol, pt staisfaction, and creating a dept of National if not international recognition.	
71	Oct 10, 2012 6:50 PM	Unfavorable press related to our new president.		The "stepping down" of multiple leaders who have built this institution to accomodate the agenda of the new leadership.		The new leadership breaking up any voice that could challenge the direction of the institution.	
72	Oct 10, 2012 5:49 PM	Increasing expectations to see more patients with out providing support ot do that.		Telling faculty they are not meeting numbers but then turning around an saying that we are making tons of money, who makes money for the institution other that clinical faculty?		Our "electronic" medical record is just a scanned in document....you cannot even look at active orders for an inpt. you have to pull up all of the orders and leaf through them...this is hardly electronic medical records.	
73	Oct 10, 2012 4:13 PM	average citizen has no voice		top heavy decision making		"insecure" feelings	
74	Oct 10, 2012 3:10 PM	Apathy		Non eqitable salary structure for faculty		Non appreciation for good job	
75	Oct 10, 2012 10:10 AM	Increased patient volume resulting in longer work days		Travel funds through PRS have not kept up with increased costs of airfare, hotel etc		Patient care not recognized relative to publishing in promotion of clinical faculty	

76	Oct 9, 2012 11:42 PM	Changes in the health care system that pressure the system		Expectation that clinical revenue will support more basic research			
77	Oct 9, 2012 11:23 PM	Frequent bad press in Houston Chronicle		Perception that faculty who have been here for a long time are viewed as less important than new hires		Expectations that we "produce" more and more i.e. see ever increasing numbers of patients per clinical faculty, which obviously is not sustainable	
78	Oct 9, 2012 10:34 PM	There is anxiety in this period of uncertainty with a transition in leadership, hand in hand with the excitement of certain increased opportunities for research and patient care. The anxiety part for a significant number of faculty has taken the upper hand, which has lowered morale.					
79	Oct 9, 2012 7:36 PM	impression that leadership is arrogant		impression that clinicians are here to generate margin		absence of face time with leadership	
80	Oct 9, 2012 6:40 PM	monopoly of research resources					
81	Oct 9, 2012 6:34 PM	more pressure on clinic productivity without physicians's control		lack of dialogues between top-down decisions		lack of control in daily work	
82	Oct 9, 2012 6:24 PM	New president		Resignation of provost		Faculty turnover	
83	Oct 9, 2012 6:12 PM	Administration does not respect current faculty		Administration is self-centered		Administration is turning MDACC into private company	
84	Oct 9, 2012 4:57 PM	Leadership's actions lack intergrity		No perceived faculty input into the direction of the institution		Abrupt changes in many key hospital roles without reason/warning	
85	Oct 9, 2012 4:31 PM	different rules for president and other employees		no 'due diligence' in chair searches		president repeatedly circumventing the system	
86	Oct 9, 2012 4:10 PM	lack of communication on why and how policy-making decisions are made.					
87	Oct 9, 2012 4:09 PM	Clinical WorkLoads		Increased paperwork for compliance acitivities		Less administrative support	
88	Oct 9, 2012 4:04 PM	Faculty's lack of confidence in new president re: Conflict of Interest problems (IRB, negative press); Moonshot (where is the money? Promising too much with too much fanfare?); key people leaving or removed from leadership positions		Clinical faculty's perception that Physician in Chief demand for higher volume trumps clinicians' concerns over safety/quality of care		Funding is tough - research faculty getting hit hard	
89	Oct 9, 2012 4:02 PM	De-valuing everyone who isn't part of a moonshot		Emphasis on quantity rather than quality (pt care, grants, everything)		MD Anderson's reputation has been damaged (perhaps irreperably) by CPRIT/COI issues	
90	Oct 9, 2012 2:10 PM	New president has tarnished reputation with his COI problems		Lack of focus moving forward over the past year.		Increased emphasis on surgeons bringing in money while the remainder of institution does research. Marginalization of surgeons academically.	
91	Oct 9, 2012 1:40 PM	Administarion "Top heay and inefficient"		No Transparency		Do not listen	
92	Oct 9, 2012 1:13 PM	I am being treated like a mushroom in the dark. No input to changing my templates, etc.		We have less staff per doctor than 2009.		I am embarassed by out president and do not trust him.	
93	Oct 9, 2012 11:13 AM	more paper-work		obstacles to clionical research		patient load limiting academic, mentoring time	
94	Oct 9, 2012 5:04 AM	failure to engender full faculty support for Moon Shot program initiatives		unreasonable demands for increasing faculty productivity far beyond historical track record			
95	Oct 9, 2012 12:48 AM	Long process to get any paperwork done		No option to move unspent money to a Comapny-3 account		Too much work and expectation	
96	Oct 8, 2012 11:11 PM	No respect to senior faculty by new faculty		Departmental Adiministrative people do not show any respect to old faculty members.		We feel that we have to treat more patients without any increase in MLP or dosimetrists.	
97	Oct 8, 2012 10:43 PM	Increased demands on patient time		perceived lack of concern regarding faculty concerns		IT is in a state of disarray	
98	Oct 8, 2012 10:08 PM	Women faculty continue to be in salary disadvantage over male faculty.		Department chair lack empathy or clear understanding of the true issues their faculty are facing.		Demand to bill more, see more patients but, concurrently, publish more, have only worsened.	
99	Oct 8, 2012 10:02 PM	Lack of mentoring		Lack of dept, division, institution leadership		poor communication from administration	
100	Oct 8, 2012 9:59 PM	clinical faculty are asked to do more and more with fewer resources in a clinical enterprise that is already functioning at near maximum capacity		the sudden departure of high-ranking faculty: dubois, pollock, kurzrock		there are more people telling me what to do and how to maintain compliance and achieve clinical productivity targets, that people actually helping me to be clinically productive	
101	Oct 8, 2012 9:40 PM	Poor leadership		More paperwork/regulation/rules		Departure of key faculty/staff	
102	Oct 8, 2012 9:29 PM	encryption		email on server		beaurocracy	
103	Oct 8, 2012 9:12 PM	Poor communication to basic science departments about future		Space reallocation in research without a communicated rationale		No clear avenue for discovery based science faculty to contribute to moonshots	

104	**Oct 8, 2012 9:03 PM**	not adequate input from the clinical faculty in decision making		Not adequate support of mid career faculty.		too much control with administration, not enough power with clincal faculty even in small matters such as clinic structure,	
105	**Oct 8, 2012 9:00 PM**	Lack of transparency from departmental leadership		Lack of transparency from section leadership		Dismissive tone in departmental leadership in response to concerns	
106	**Oct 8, 2012 8:56 PM**	It seems to all boil down to communication		Faculty does not appear to have much of a say on many important issues			
107	**Oct 8, 2012 8:50 PM**	Increasing corporatist environment with attendant worsening conformism (or pressure towards it) at all levels		MDACC has developed (or appears to have) into a huge marketing machine trying to sell a product with all the exaggerations that are inherent to this process. It is often times impossible to satisfy expectations that are forced on clinical staff by patients who come here for treatment.		Ever worsening bureaucratic and administrative workload. The increasing paperwork for just about anything (among other issues) has turned this job into a daily exercise of attrition.	
108	**Oct 8, 2012 8:45 PM**	Poor EMR and CPOE, particularly with increasing volume		Failure to maintain ancillary staff (e.g., failing to replace retiring nurses)		Poor IT in general- extremely difficult to obtain data in timely fashion, slow ClinicStation, slow ePrescription	
109	**Oct 8, 2012 8:43 PM**	We are being asked to do more with less.		Administrative burdens in compliance, regulations are worse.		Inconsistent and hypocritical application of institutional polices.	
110	**Oct 8, 2012 8:42 PM**	Drop in NIH funding hampers Research Faculty					
111	**Oct 8, 2012 8:39 PM**	Other sections in the department of Radiology compared to Body imaging get paid more even though they have less RVUs		decisions are made without consulting the entire faculty -- specifically hiring people		Its stil a hierarchy--junior faculty have no power and no say in decision making	
112	**Oct 8, 2012 8:36 PM**	Poor strategic moves by upper management to increase patient volume without regards to impact upon faculty		Incessant hiring of more and more "chiefs" without enough "indians"		Narrow view of clinical activity (sole clinical metric is NP/consult volume) and constant demands to increase NP/consult volume without limit	
113	**Oct 8, 2012 8:35 PM**	Conflict with new President		Conflict with new President's wife		President and wife's conflict of interest	
114	**Oct 8, 2012 7:45 PM**	financials and clinical push		moonshots			
115	**Oct 8, 2012 7:42 PM**	Unclear reasons for th ecurrent "crisis".		Too many vice-presidents and bureaucracy			
116	**Oct 8, 2012 7:42 PM**	top heavy more so		more pressure on faculty to get funding		more rules regarding computers etc	
117	**Oct 8, 2012 7:36 PM**	Funding cutbacks nationally		Faculty leaving for equivalent positions elsewhere		Cannot attract star faculty at a faster pace	
118	**Oct 8, 2012 7:34 PM**	No one cares about the faculty		All our administration care about is compliance (paperwork)			
119	**Oct 8, 2012 7:29 PM**	Lack of involvement of faculty in any major decisions		Lack of standardization of clinical effort			
120	**Oct 8, 2012 7:22 PM**	Loss of faculty and personnel		"Direction" of new leadership at multiple levels		Emphasis on finances rather than patient care	
121	**Oct 8, 2012 7:19 PM**	poor communication		top heavy		disorganization	
122	**Oct 8, 2012 7:11 PM**	lack of transparency		lack of communication		asked to do more with less	
123	**Oct 8, 2012 6:23 PM**	conflict between generating clinical revenue and research productivity		cumbersome research infrastructure (regulatory, ordering system, etc) detracts from actual effort on research		financial constraints at the departmental level	
124	**Oct 8, 2012 6:17 PM**	Autocratic, often abusive behavior by administrators		Loss of key faculty, poor retention of key personnel		Unrealistic, dysfunctional travel restrictions	
125	**Oct 8, 2012 5:58 PM**	Upper Administration					
126	**Oct 8, 2012 5:34 PM**	Uncertainty of administration plans		Deepening inequality of clinical and research faculty		Insecurity for research support/progress	
127	**Oct 8, 2012 5:28 PM**	poor communication		demands to provide more work without additional resources			
128	**Oct 8, 2012 5:13 PM**	Lack of clear communication.		Too much administrators that work has a road block		Not enought emphasis on research per see. Too much on the clinics	
129	**Oct 8, 2012 5:05 PM**	Clinical load + increasing administrative burdens (MedAptus, Rx, Online orders) for clinicians		Archaic informatic systems and support			
130	**Oct 8, 2012 4:59 PM**	Increased patient load without proper support		Restrictions on faculty travel and reimbursement		Metrics that do not accurately measure clinical efficiency	
131	**Oct 8, 2012 4:52 PM**	leadership unresponsive to needs of rank and file		unrealistic goals by administration on department budgets		No imput by faculty on key decision making	
132	**Oct 8, 2012 4:51 PM**	Exclusion of faculty from important decisions		Transparency		Administrative priorities differ from faculty's	
133	**Oct 8, 2012 4:48 PM**	increasing clinical volume pressure without change of expectations for other duties		increasing shift of administrative work to MD- eprescription, electronic CSR, medaptus		decisions being made by people far removed from clinical care	
134	**Oct 8, 2012 4:42 PM**	salary structure		promotion			
135	**Oct 8, 2012 4:41 PM**	unstable administration		increased workload with no benefit			

136	**Oct 8, 2012 4:37 PM**	Crushing burden of an overly proliferative bureaucracy out of touch with the institutional mission and not accountable to faculty		Rapid move away from hard won clinical 'research' and knowledge in lieu of the glitz and glam of peer review research		Aggravating the lack of time and opportunity with a massive infrastructure expansion and no people or internal funding to support it.	
137	**Oct 8, 2012 4:33 PM**	N/A		N/A		N/A	
138	**Oct 8, 2012 4:25 PM**	New administration is converting a research institute into a drug company for himself and his wife		Conflict of interest with the goals of MDACC and the president and his wife		IACS personnel do not have to write grants and papers or bring in 40% of their salary on grants, yet they are paid more than the faculty	
139	**Oct 8, 2012 4:24 PM**	Leadership in the news - Chronicle, Cancer Letter		COI problems among the new leadership		Unattainable budget projections without room for discussion	
140	**Oct 8, 2012 4:22 PM**	Decreased represenation of faculty at exec committees		2 out of 3 internal candidates for the president's position have now been removed from their administrative posts (DuBois and Pollock)			
141	**Oct 8, 2012 4:18 PM**	Being asked to see more and more patients		and do more and more administrative work (e.g.MedAptus!)		with less resources (overwhelmed ancillary staff)	
142	**Oct 8, 2012 4:15 PM**	Increased clinical volume		Impact on downstream services		Inability to focus on clinical research	
143	**Oct 8, 2012 4:09 PM**	Increased clinical load and pressures.		Increased difficulties obtaining extramural funding.		Uncertainty regarding new President and his actions.	
144	**Oct 8, 2012 4:08 PM**	shrinking role of faculty in making decisions		loss of appreciation of the faculty efforts to overcome challanges		increasing distractions via administrative roles	
145	**Oct 8, 2012 4:08 PM**	No transparency on decision making		The distribution of the resource are extremely political. The sources always go to the limited powrful people.			
146	**Oct 8, 2012 4:07 PM**	promotion/tenure		space		interaction	
147	**Oct 8, 2012 4:07 PM**	extreme focus on moonshots with no added funding		irrational behavior/failure to be responsible - encryption		failure to engage faculty in any decisions/directions and to tolerate differences in opinion	
148	**Oct 8, 2012 4:05 PM**	too much paperwork		too many stupid rules		too many regulatory/unprofessional people	
149	**Oct 8, 2012 4:03 PM**	Lack of Departmental Leadership		Uneven work distribution among the faculty			
150	**Oct 8, 2012 4:02 PM**	excessive regulatory demands		Lack of clarity for where research faculty should spend time, moon shots or peer reviewed research		lack of federal funding for research	
151	**Oct 8, 2012 4:02 PM**	More involvement of clinical faculty in institutional decisions.		Unchanged inefficiencies in clincial operations. Instead increased expectations in faculty productivity.		Inefficient and in part incompetent, overblown administration (3:1 ratio of administrators:clinical faculty).	
152	**Oct 8, 2012 4:00 PM**	Encryption		Encryption		Encryption	
153	**Oct 8, 2012 3:59 PM**	administration heavy		lack of transparency and clinical faculty input on policy		increase in requirements of clinical productivity despite lack of infrastructure to support	
154	**Oct 8, 2012 3:59 PM**	No recognition for patient care		No financial or resources support for research		Excessive emphasis on physician scientists	
155	**Oct 8, 2012 3:57 PM**	resource distribution		nepotism			
156	**Oct 8, 2012 3:24 PM**	Autocratic decisions by leaders without faculty input		Research heavy priorities ignoring clinical care/programs		Extremely poor reward for hard work	
157	**Oct 8, 2012 3:19 PM**	new administration with lack of communication to faculty		loss of faculty representation on key committees		exaggerated new goals for gross billing and producivity wo explanations	
158	**Oct 8, 2012 3:04 PM**	autocratic decision making		faculty input not considered		bloated, unresponsive administration	
159	**Oct 8, 2012 2:48 PM**	The attitude of the new leadership		Conflicts of interest with the new leadership		A "one size fits all" attitude to IT issues	
160	**Oct 8, 2012 2:36 PM**	Lack of faculty representation on key committees		Refocusing largely on new president's goals		New president's unfavorable publicity	
161	**Oct 8, 2012 2:31 PM**	Concerns about the priorities of the current leadership		Fielding impressions from non-MDACC colleagues that we are "having problems"		Unexplained changes in mid-level leadership	
162	**Oct 8, 2012 2:30 PM**	Fear of becoming irrelevant leading to job loss due to changing demands		Sudden loss of top leaders		Failure of top leadership to appreciate concerns of lower level faculty (i.e.: not chairs and division heads)	
163	**Oct 8, 2012 1:53 PM**	Clinical faculty and our issues do not seem to be priority		Clinical faculty and excellence in patient cae seem not to be of interest		Too many resources being placed in non-essential areas	
164	**Oct 8, 2012 7:48 AM**	mandatory wastes of time		retention of high-quality research faculty			
165	**Oct 8, 2012 3:35 AM**	Too much increase in work load		increase in salary requirement and penalty if not meeting the minimum		Very little social or leaizure activities are provided to faculty	
166	**Oct 8, 2012 2:41 AM**	Administration		Integrity		Communication	
167	**Oct 8, 2012 2:09 AM**	Problematic policy making		We often do not know who is behind and responsible for decisions		Institution seems to be run by lawyers and committees rather than health professionals	
168	**Oct 8, 2012 1:20 AM**	Increased bureaucracy in clinical reseaerch		Increased bureaucacy in the clinic		Increased patient load	
169	**Oct 8, 2012 12:48 AM**	Molecular profile testing		High institutional costs for running clinical trials		Institutional barriers cause long delays to open clinical trials	

170	**Oct 7, 2012 10:05 PM**	Concerns regarding leadership		Concerns regarding image of our institution after issues covered by the cancer letter			
171	**Oct 7, 2012 2:02 PM**	Firing of CRC chairs		Circus around DePinho/Chen/Aveo		Firing of Dr. Pollack	
172	**Oct 7, 2012 3:57 AM**	No transparency in administration, financial operation, and in policy-making decisions of the institution.		No clarity in allocation/distribution of institutional funds.		Increased workload with no compensation/reward recognition	
173	**Oct 7, 2012 3:41 AM**	disregarde by the President and Executive Leadership for clinical operation challenges		2-tiered faculty/investigator where salaries are skewed to the individuals brought in by the President		fear of retaliation and dismissal if voice disagreement with the President, his wife or the policies	
174	**Oct 7, 2012 3:33 AM**	Uncertainties due to change in leadership		Uncertainties due to changes in healthcare system		Unrealistic demands for budget increases	
175	**Oct 6, 2012 8:48 PM**	Perception of nepotism, conflict of interest from the executive team		Firing of people who speak out, ineffective leaders "yes sir's" still holding office		Bullying by Division Head's pervasive. We do a lot of work arounds to look good on paper. Leadership doesnt care for faculty needs	
176	**Oct 6, 2012 8:18 PM**	Implementation of ResourceOne		Rapid turnover in leadership		Increased regulatory and procedural burden of clinical trials	
177	**Oct 6, 2012 6:23 PM**	Making physicians into data entry clerks		IT systems waste time, hard to use, not supported		Too many patients & too many regulations	
178	**Oct 6, 2012 4:50 PM**	The Internal Medicine Center cath is very negative and it is making the clinics very inefficient and the staff very depressed		Too many administrators who do not have a clue on cancer disease telling the health providers how to treat it		No opportunities to modify admonistration	
179	**Oct 6, 2012 3:02 PM**	workload is much higher		Changing programs with out training on how to use them		more documentation	
180	**Oct 6, 2012 1:11 AM**	uncertainty re new leadership		PR missteps of new leadership		abrupt departure of several chairs/provost	
181	**Oct 5, 2012 11:56 PM**	comittees without faculty membership		lack of recognition of key clinical programs necessary to care for patients		directives to see more patients with insufficient resources including space and time and insufficient time for academic work for clinicians	
182	**Oct 5, 2012 11:12 PM**	too much bureaucracy and politics		performance and reward are not correlated			
183	**Oct 5, 2012 11:10 PM**	DePinho		Chin		the lack of administration to recognize our needs	
184	**Oct 5, 2012 9:56 PM**	Faculty are left out of decision-making		Key leaders are ignoring severe problems in their areas		Good people keep leaving - what is wrong?	
185	**Oct 5, 2012 9:56 PM**	Lack of leadership understanding of patient care issues		See more patient - make more money - no help to do it.		Harder - no more beds, no more OR space,...	
186	**Oct 5, 2012 9:44 PM**	Lack of transparency; oppressive senior leadership		Increased bureaucracy		Inefficient administrative offices	
187	**Oct 5, 2012 9:37 PM**	New Leadership		Hypocrytical policies (faculty held to standards that President is not)		Heavey Handed Approaches	
188	**Oct 5, 2012 9:21 PM**	increased workload		email, email email			
189	**Oct 5, 2012 8:28 PM**	top down administrative approach		administration is in general dismissive of faculty		fear of retaliation	
190	**Oct 5, 2012 8:24 PM**	a lot of change quickly without people being prepared		IT has not kept up with industry standards			
191	**Oct 5, 2012 8:23 PM**	increased bureaucracy		increased clinical load		decreased input from faculty	
192	**Oct 5, 2012 8:03 PM**	abrut dismissal of key personel		more risk if you speaking up on issues		less input on direction of MDACC and less importance of clinical programs	
193	**Oct 5, 2012 8:02 PM**	worsening national funding environment		unnecessary, 1 size-fits-all encryption		continuing increases in slow red tape	
194	**Oct 5, 2012 7:35 PM**	continued lack of staff/faculty		increased workload		increased pressure for research productivity	
195	**Oct 5, 2012 7:19 PM**	Job security		Fear		coruption	
196	**Oct 5, 2012 6:45 PM**	lack of shared governance		lack of proper communication on institutional changes		decisions taken w/t consideration of faculty well being	
197	**Oct 5, 2012 6:32 PM**	Inadequate communication w/faculty & no participation in decision-making		lack of appropriate concern from top leadership about faculty development or support- especially clinical faculty		ethical questions about top leaders that diminishes MDACC reputation and our ability to recruit/retain	
198	**Oct 5, 2012 6:06 PM**	Production pressure that is out of sync with the resources provided		A verbal committment to patient quality and safety that is not born out with resources			
199	**Oct 5, 2012 5:42 PM**	poor administration/ leadership		lack of a willingness to LISTEN to faculty concerns		support staff that does not actually assist faculty	
200	**Oct 5, 2012 5:41 PM**	poor communication					
201	**Oct 5, 2012 5:23 PM**	lack of participation in institutional goal setting		budgetary rat race for clinical faculty to generate more revenue		continued weakness in coordination of services	
202	**Oct 5, 2012 5:19 PM**	Lack of scheduled faculty meetings		Failure to provide timely notice when there will be a meeting		Open door policy that really isn't	
203	**Oct 5, 2012 5:12 PM**	Inadequate input from faculty regarding budgeting		too much bureaucracy		no individual value, i.e. we are replaceable	
204	**Oct 5, 2012 4:56 PM**	Don't see what has been done since 2010 to improve the morale!					

205	**Oct 5, 2012 4:48 PM**	Changes in leadership and faculty attrition		Increased focus on Discovery and less on Caring and Integrity		Negative publicity for the institution	
206	**Oct 5, 2012 4:41 PM**	administration busy all day firing and hiring		although performing well, claims that we are not			
207	**Oct 5, 2012 4:35 PM**	scandals in the news		top heavy decision making		shady behavior	
208	**Oct 5, 2012 4:19 PM**	less transparency from administration		top-down decision making		no or very little involvement of those "in the trenches" in decision making	
209	**Oct 5, 2012 4:18 PM**	Pet projects at the same or slightly higher		Clinical care is slower and there are more obstructions to flow:clinicstation is worse (slower and more cumbersome)		Work load in clinics worse. People were burnt out 2 years ago and the work loads are worse	
210	**Oct 5, 2012 3:59 PM**	leadership change		politics			
211	**Oct 5, 2012 3:53 PM**	New leadership will always create uncertainty		Hard to see improvement in the midst of change		This may stabilize and true change will be observed	
212	**Oct 5, 2012 3:35 PM**	Recent changes in CRC procedures and ability to do clinical research		Too much emphasis on administration's pet projects			
213	**Oct 5, 2012 3:32 PM**	Reduced access to administration - faculty representation seems to be a token		Negative press re: CPRIT, etc - reflects poorly on entire institution			
214	**Oct 5, 2012 3:31 PM**	change in administration		constant increase in clinical productivity expectatation		overall economic environment both internal and external	
215	**Oct 5, 2012 3:19 PM**	Increase % salary on grant when funding is getting worse		Loss of lab space from rapid influx of new research personnel		Inadequate access to institutional research funds for investigator-initiated proposals	
216	**Oct 5, 2012 3:19 PM**	Nepotism, favoritism and corruption disguised as "conflict of interest approved by UT System"		Lack of input by the Faculty Senate in any decision making		Poorly disguised contempt for Faculty now described as "workforce members", and lumped with classified staff.	
217	**Oct 5, 2012 3:16 PM**	still asking for higher volumes of new patients without providing resources					
218	**Oct 5, 2012 3:13 PM**	cannot comment, did not participate in 2010 survey					
219	**Oct 5, 2012 3:02 PM**	Too many administrators		Too many physicians becoming administrators		Too many physicians doing too little clinical work	
220	**Oct 5, 2012 2:59 PM**	lack of transparency from leadership		perception that new leadership does not value the clinicians as anyting more than cogs to generate revenue for the moonshots		continued bad publicity for the institution in the lay press related to COI, CIPRIT	
221	**Oct 5, 2012 2:51 PM**	delay in getting timely feedback					
222	**Oct 5, 2012 2:49 PM**	Lack of demonstrating professionalism from the President's office.		Sacrificing core Departmental Resources such as space to try to drive the Moonshot programs			
223	**Oct 5, 2012 2:45 PM**	increased burden of requirements/paperwork/non-medical responsibilities		increased work load		less time for academic work	
224	**Oct 5, 2012 2:44 PM**	arrogant leadership		Poor communications		No input from department chairs	
225	**Oct 5, 2012 2:42 PM**	increased clinical demands					
226	**Oct 5, 2012 2:40 PM**	untrustworthy leadership		dictatorial leadership approach		intimidation strategies by senior leadership	
227	**Oct 5, 2012 2:36 PM**	DISCONNECT between frontline faculty who deliver patient care and decision makers...Leadership within the hospital and departments do not know, understand or appreciate issues with clinical operation		Problems continute to persist or worsen due to weak leadership and lack of care			
228	**Oct 5, 2012 2:34 PM**	the president seems oblivious to the importance of the clinical faculty					
229	**Oct 5, 2012 2:31 PM**	Shift away from Basic Research as a priority		Lack of financial support for faculty in tough economy			
230	**Oct 5, 2012 2:28 PM**	Corrupt leadership		Hiring of division heads by people not in the department itself		Physician salaries not competitive with community	
231	**Oct 5, 2012 2:25 PM**	development of a "second-class faculty" environment		excessive bureaucracy - overexpansion of administration		greater exclusion of faculty from critical decision-making	
232	**Oct 5, 2012 2:20 PM**	Poor communication by upper administration		Marginalization of faculty voice at institutional level		Uncertainty from new initiatives without communication of how this will integrate into existing structure	
233	**Oct 5, 2012 2:13 PM**	controversy associated with new leadership, conflicts of interest		attitude of new leadership "get on board or get left behind"		lack of desire aamong new leadership to understand the nature and importance of cancer prevention research (that I do)	
234	**Oct 5, 2012 1:53 PM**	Ethical concerns with new president		New president being perceived as a dictator		Change in the balance between scientific and clinical operations	

235	Oct 5, 2012 1:51 PM	Pressure on clinical faculty to increase productivity without adequate resources		It is twice as difficult to get NIH grants funded, but for research faculty, % salary on grants has been raised to 40% with many rumors that it will soon be 70%		It is clear that to get resources for moonshots, everything else will be squeezed	
236	Oct 5, 2012 1:49 PM	The new leadership has consolidated power and listens less to faculty than the previous leadership		Despite asking for increased new patients and consults the leadership has not addressed the resources which limit our ability to see patients (labs, radiology, nursing, etc)		The Moonshot program has disrupted our community of collaboration as a whole, for the sake of forcing collaboration in limited areas. Now that 5 are chosen, the feeling of "what about our work?" is bringing down morale.	
237	Oct 5, 2012 1:36 PM	lack of support		underappreciation		too much clinical work load	
238	Oct 5, 2012 1:31 PM	increased patient numbers without concomitant increase in staff		reliance on patient care revenues to pay for all institution's programs			
239	Oct 5, 2012 1:13 PM	dubious ethical choices by president and resulting degradation of institutional reputation		lack of transparency in institutional decision making			
240	Oct 5, 2012 1:05 PM	Communication		Faculty participation in decision making			
241	Oct 5, 2012 12:46 PM	dishonesty in the highest admin. levels		nepotism in the highest admin. levels		decreased interest in quality of care by senior admin.	
242	Oct 5, 2012 12:33 PM	Media continually bashing UTMDACC		Media has targeted Dr DePinho, dragging us all down w/him		Dr DePinho has excluded Faculty Senate participation from top level committees	
243	Oct 5, 2012 11:56 AM	Lack of leadership concern		Ethics violations by leadership		job threatening attitude of leadership	
244	Oct 5, 2012 11:33 AM	COI perception issues of the President and Dr. Chin.		Moon Shots		IAC establishment	
245	Oct 5, 2012 11:29 AM	Unstable leadership. Frequent personnel changes.		Increased inefficiency of operating rooms.		Unrealistic budget goals without changes in infrastructure or processes.	
246	Oct 5, 2012 4:27 AM	Disengaged President who puts personal agenda before everything else					
247	Oct 5, 2012 3:57 AM	the leadership is even less inclined to include faculty in the process of decision making.		MD adnerson reputation suffers because of the presidents conflicts of interest.		the divide and animosity between faculty and administration has deepened	
248	Oct 5, 2012 3:22 AM	Recent upheaval in leadership of many departments and divisions at MDACC		Controversy about conflicts of interest involving MD Anderson leadership			
249	Oct 5, 2012 3:11 AM	lack of trust		lack of input		lack of support	
250	Oct 5, 2012 2:59 AM	more clinical work required		firing of the Surgery Division Chief		wholesale raiding of faculty research space	
251	Oct 5, 2012 2:54 AM	Leadership perceives problems of poor morale as a personality disorder rather than an issue that should be addressed		Growing disconnect between the faculty and the leadership		Increasing work load	
252	Oct 5, 2012 2:49 AM	Poor direct communication between MDs		Clinic support staff that lack polish and self-sufficiency		Constant culture of fear	
253	Oct 5, 2012 2:05 AM	IT infrastructure is lacking - lack of computerized order entry - so that PSCs have to go behind and re-enter orders in CARE, painfully slow MedAptus, not enough money/resources to build integrated clinical research databases		Clinical+Administrative demands keep rising leading to less protected time and clinical time for same position/rank very between departments, yet we are judged similarly for promotion		because of demands, personal/family time is squeezed leading to increased stress	
254	Oct 5, 2012 1:51 AM	IT problems. Nothing works well.		Not enough physical plant resources		Division head prioritizes nursing	
255	Oct 5, 2012 1:31 AM	electronic prescribing system		poor documentation quality due to structured notes		slow computer access and short auto timeout	
256	Oct 5, 2012 1:27 AM	uncertainty and change of top administration		negative media exposure of president and MDACC			
257	Oct 5, 2012 12:30 AM	Increased volume of patient care.		Increased overhead costs.		Increased regulatory burden.	
258	Oct 5, 2012 12:22 AM	restriction with travel		top heavy managment style		total inefficient operation	
259	Oct 5, 2012 12:18 AM	Perception of more top down than before		Lack of transparency		Overworked with fewer resources	
260	Oct 4, 2012 11:57 PM	even more top-down leadership, less communication than before		ever increasing demands in spite of scarcer resources		ever increasing corporatization	
261	Oct 4, 2012 11:54 PM	increased paperwork and requirements		increased patient load		no change in the "old guard" that advises the president	
262	Oct 4, 2012 11:39 PM	Questionable ethics and nepotism of our leader(s)		Suddern and unexplained firing of Dr Pollock as DoS chair		Unrealistic budgets without commensurare infrastructure to support them	
263	Oct 4, 2012 11:34 PM	pressure on the clinical faculty to meet higher clinical metrics without consideration to their academic goals		problems with clinical operations/workflow		administration does not listen to faculty input regarding clinical metrics and productivity	
264	Oct 4, 2012 11:22 PM	The appearance of COI and nepotism in Presidents office		Total inability of Physician in Chief office to update EMR		Moon Shot vs. IPCT Right hand vs Left hand	
265	Oct 4, 2012 11:21 PM	Clinical faculty (I am not one) under great production pressure					

266	**Oct 4, 2012 11:16 PM**	Less faculty integration in key decision making committees		Productivity increases which disproportionately penalize those who are already performing at top capability			
267	**Oct 4, 2012 11:14 PM**	The lack of function of search committees		The lack of faculty ability for faculty input		The evidence that the institution in being run by one man	
268	**Oct 4, 2012 11:05 PM**	Uncertainty regarding leadership and instability.		New person seems to be being stepping down each week.		Unreasonable demands for increasing clinical activity	
269	**Oct 4, 2012 11:00 PM**	Credibility of leadership		Ethical standards of leadership		Excessive focus on moonshots	
270	**Oct 4, 2012 10:58 PM**	department chairs have no leaderships; only focus on their own interests		division heads ignored faculty members' perception; only communicate with chairs			
271	**Oct 4, 2012 10:55 PM**	Continuous request to see more patiets to increase revenue		More and more mandatory work (now e-prescriptions)			
272	**Oct 4, 2012 10:53 PM**	Dr. Ronald Depinho		Dr. Lynda Chin		Their minions	
273	**Oct 4, 2012 10:49 PM**	Dictatorial leadership that is out of touch with clinical realities		MedAptus, CPOE, eprescribing, nurses not allowed to initiate chemotherapy orders, inadequate support personnel in the clinics		Outrageous salaries for top administration while they nickel and dime the faculty	
274	**Oct 4, 2012 10:41 PM**	too much power to chairs		too much power concentrated in the division		too much power concentrated in presidents office	
275	**Oct 4, 2012 10:40 PM**	Unrealistic clinical expectations		Unwillingness to improve ancillary services capacity		Top heavy and heavy handed administration	
276	**Oct 4, 2012 10:39 PM**	clinic load expectations		poor funding climate		perception that the president's primary interests are not MDACC	
277	**Oct 4, 2012 10:37 PM**	physicians pressured to see more and more to generate revenue		increasing burden of management		shortages of resources at the department level with low budgets	
278	**Oct 4, 2012 10:32 PM**	Lack of communication		Lack of focus on faculty needs		Increased workload	
279	**Oct 4, 2012 10:31 PM**	Increasing target goals for new patient volumes		Cutthroat funding climate leads to frenzied grant submission processes			
280	**Oct 4, 2012 10:31 PM**	The Administration pays themselves large bonuses, while clinicians generate the revenue and are not given same bonuses		MD Anderson reputation is being torn down by media (Chronicle)		Work hours have increased due to bureaucratic work while cost of living and tax increases eclipse salary increases	
281	**Oct 4, 2012 10:29 PM**	very poor management by chairman		Non transparent favoritism demonstrated by chairman		salary level not comminsurate with subspecialty training	
282	**Oct 4, 2012 10:29 PM**	change in leadership which led to slide in trust and transparency		bogus goals of the new administration, money grab by the president; his conflicts of interest; his wife's new building renovation		increased chokehold of bureaucracy on everything, starting with HR, sensless trainings, red tape everywhere	
283	**Oct 4, 2012 10:27 PM**	IT leadership and prioritization					
284	**Oct 4, 2012 10:27 PM**	MDs are being asked to do more with less support from clinic staff		not having RNs be able to give refill authorizations through E prescriptions is LUDICROUS and is taking up more of the clinician's time		we work hard to meet financial goals and then are asked to increase this each year--at some point, there is so much an individual can do	
285	**Oct 4, 2012 10:27 PM**	Inefficient promotion system		Extreme favoritism (favorites are usually promoted, even when their accomplishments are less than faculty members who are not promoted.		Lack of "true" mentoring.	
286	**Oct 4, 2012 10:24 PM**	Faculty have a global mistrust of nearly all administrators, including dept chairmen, division heads, VPs, and President		My chairman and my division head do not have a good working knowledge of the strengths of individual faculty in my dept and division		President has not adequately addressed the very serious issues regarding CPRIT and COI. He has been dismissive of these issues, which makes faculty not only distrust him, but any administrators under him.	
287	**Oct 4, 2012 10:22 PM**	Lack of transparency from leadership		Increased work volume to meet budget		Lots of unreasonable regulations/changes without faculty input	
288	**Oct 4, 2012 10:17 PM**	poor communication		no or limited input on decision making		recruitment searches that go on too long	
289	**Oct 4, 2012 10:10 PM**	INCREASED BUREAUCRACY		INCREASED BUREAUCRACY		INCREASED BUREAUCRACY	
290	**Oct 4, 2012 10:08 PM**	Autocratic/corporatist leadership		Increased compliance burden			
291	**Oct 4, 2012 10:07 PM**	Prioritization of building programs		"Top heavy" administration		Lack of communication and opportunities to participate in key policy-making decisions	
292	**Oct 4, 2012 10:06 PM**	Lack of interest in basic science		Lack of information on new recruitment		Lack of cohesive interaction between moonshot and other research activity	
293	**Oct 4, 2012 10:04 PM**	Increasing demands with decreasing resources		Decreasing quality fo life for faculty		Increased regulatory demands	
294	**Oct 4, 2012 10:04 PM**	Top-down management style		Heavy-handed leadership changes		Poor communication regarding institutional direction	
295	**Oct 4, 2012 10:02 PM**	Lack of a faculty voice		Increased meaningless responsibilities		Damage to our institution's reputation	

296	**Oct 4, 2012 9:58 PM**	there is still too little extramural funding, which is not MDACC fault but is still significant. How will MDACC respond to faculty who can't get funding?		moonshots will redistribute funds to a select few		rumors that president doesn't care for faculty that arent at his calibur	
297	**Oct 4, 2012 9:55 PM**	Public mIssteps by the President		IT problems related to encryption and other system changes (Concur, Resource 1) that were poorly planned and executed		Decreased funding for patient care and reseach from almost all funding sources while administration continues to grow exponentially	
298	**Oct 4, 2012 9:52 PM**	Emphasis on money generation rather than quality or academic interests					
299	**Oct 4, 2012 9:49 PM**	Financial conditions		Leadership changes			
300	**Oct 4, 2012 9:49 PM**	inequity between new staff in new research institute and long standing staff (in favor of new staff)		representation with upper management		poor public relations stories/conflict of interest	
301	**Oct 4, 2012 9:47 PM**	Moonshots & public embarrassment about COI		Increased administrative burden on faculty		Too much bureaucracy and required approvals	
302	**Oct 4, 2012 9:45 PM**	Encryption problems		ResourceOne problems		Administration problems	
303	**Oct 4, 2012 9:45 PM**	the CPRIT issue		more vp are being hired		too many non sense surveys (eee) for basic Sc	
304	**Oct 4, 2012 9:44 PM**	Poorly executed Faculty Clinical Incentive Award		Unaccountable and marginally functioning admin staff		Emasculated faculty leadership	
305	**Oct 4, 2012 9:43 PM**	dept chair has too much power					
306	**Oct 4, 2012 9:42 PM**	Basic Science-Low NIH payline		Clinical-"need to work 24-7-365"		Too much top-down manegement	
307	**Oct 4, 2012 9:41 PM**	leadership transition		worries re: budget benchmarks		building growth outstripsclinical growth	
308	**Oct 4, 2012 9:36 PM**	Major changes in administration		Decreases in federal funding		Productivity increases requested by administration	
309	**Oct 4, 2012 9:35 PM**	poor leadership		nepotism		complacency	
310	**Oct 4, 2012 9:35 PM**	increased administration size and their expense (salaries)		increased focus on high productivity		flawed productivity measures	
311	**Oct 4, 2012 9:35 PM**	Overall clinical operations issues are slow to improve		Increased stress on quantitative metrics for reward, not quality measures			
312	**Oct 4, 2012 9:32 PM**	No interest at all in research faculty.		The compay motto is "we eat our young."		Promotion is based on popularity.	
313	**Oct 4, 2012 9:29 PM**	many unexplained changes in personnel		frequency and magnitude of negative press		budgetary pressures	
314	**Oct 4, 2012 9:29 PM**	too much administrative work to be done		too many surveys/training courses that seems to be useless			
315	**Oct 4, 2012 9:27 PM**	leaders with conflict of interest		no input of faculty		resources hoarded by the top	
316	**Oct 4, 2012 9:27 PM**	Lack of leadership accountability		Unrealistic expectations of faculty clinical workload		Grossly inadequate EMR	
317	**Oct 4, 2012 9:27 PM**	Too much administration		Too many regulations		Too many restrictions	
318	**Oct 4, 2012 9:26 PM**	Changes in leadership leading to uncertainty		Continually increasing clinical productivity requirements		Increasing regulatory requirements for new clinical trials	
319	**Oct 4, 2012 9:26 PM**	infrastructure has decayed physically and updating of process is ignored		leadership is not attentive to patient or employee needs		perception that some new faculty do not have to adhere to MDACC standards	
320	**Oct 4, 2012 9:26 PM**	admin issues get increasingly complex, inaccessible and time consuming		basic science appears less and less valued		increased pressure to obtain NIH (not donor, funds) grants	
321	**Oct 4, 2012 9:25 PM**	Short-sighted Policy decisions that generate buzz in the media with minimal chances of making any major changes in cancer Care, all without consulting the the clinical faculty who alongwith clinical workers drive this institution		Too much administrative and legal interference in clinical and resaerch operations		Unnecessary restrictions on travel with a lot more red tape and bureaucracy without improving the efficiency	
322	**Oct 4, 2012 9:25 PM**	ethical challenges at top of administration		perceived lack of confidence in research quality of current MDA faculty		I am concerned on the research side that we are becoming a "cancer relevance-ocracy" instead of a meritocracy	
323	**Oct 4, 2012 9:24 PM**	the mass exodus of faculty		disenfranchisement of basic research		Disrespect with which our clinical faculty are treated by the administration	
324	**Oct 4, 2012 9:24 PM**	Actions of Dr. DePinho, bullying and retaliation for speaking out		conflicts of interests of Dr. DePinho and Dr. Chin		nepotism with respect to Dr. Chin	
325	**Oct 4, 2012 9:23 PM**	Poor communication		Top-down decision making		increased administrative burden	
326	**Oct 4, 2012 9:23 PM**	pushing computer encryption		shuttle route changes; no direct shuttle from the main campus to SCRB1/2		further limits on using ProCards, & expenditures on PRS funds	
327	**Oct 4, 2012 9:20 PM**	Salary contribution is now 40% from grants		Less funding available		Red tapes	
328	**Oct 4, 2012 9:20 PM**	Shared governance dispute - removal of senate representatives from institutional committees		Controversy surrounding CPRIT commericalization grant led by Dr. Chin		Dr. DePhino's request to the Board of Regents for a conflict of interest waiver	

329	**Oct 4, 2012 9:20 PM**	Each faculty is expected to see more patients each year than the year before. I felt overwhelm with my clinic volumes last FY but now am being asked to see even more. This has a huge impact on faculty morale but importantly increases the risk of errors.		Being asked to do more with less (see more patients but no added resources to assist the faculty)			
330	**Oct 4, 2012 9:20 PM**	lack of communication and participation in decision making		worry that grandiose undertakings (moonshot) will simply suck up all the money that currently is used to support Department infrastructure, renovation of equipment, IBS Centers, etc		worry that there is no room for the common researcher to participate in the moonshot you are just out of luck	
331	**Oct 4, 2012 9:19 PM**	Continued focus on research with less attention to the clinical care provided					
332	**Oct 4, 2012 9:16 PM**	patient volume and demands		unreasonable patient expectations		no support for faculty stress and overwork	
333	**Oct 4, 2012 9:16 PM**	New president who apparently has no moral compass		Nepotism vis a vis the president's wife		Exodus of top people who are well-respected	
334	**Oct 4, 2012 9:15 PM**	increased salary on grants during poor funding climate		increased demand to see patients for clinical faculty who are already maxed out			
335	**Oct 4, 2012 9:15 PM**	Major changes in percent effort for tenure track faculty		Fears over cuts in salary incentive		Seems like we are being discouraged from seeking funding that does not have high indirect costs, e.g., CPRIT's 8% vs NCI 58%.	
336	**Oct 4, 2012 9:15 PM**	loss of non-chair faculty input on key decision-making committees		tremendous turnover in high-level faculty positions (Provost, Surgery chair, etc)		perception that new programs are duplicating and replacing existing efforts	
337	**Oct 4, 2012 9:13 PM**	fear of change with Dr. Mensohn's leaving		Perception that clinical excellence is no longer important		Perception that resources are kept for our Boston new colleagues	
338	**Oct 4, 2012 9:13 PM**	Feeling that new administration does not value existing MD Anderson faculty		leadership does not appear open to input/ frank discussions		concerns about job security	
339	**Oct 4, 2012 9:13 PM**	perception that there is one set of ethical rules for top level administration and another for the rest of us		marginalization of rank-and-file faculty and exclusion from decision making processes			
340	**Oct 4, 2012 9:12 PM**	Gigantic adminstration system, with numerous rules and regulations		Some underachieving chairs and division heads who have been around for ever, some for more than 10 years		What is the outcome of the BIG SURVEY? It costs money and time, and nobody really knows if there is any result were based on the BIG SURVEY.	
341	**Oct 4, 2012 9:12 PM**	Increased uncertainty about the future.		Decreased respect for the institution in light of leadership miscues.			
342	**Oct 4, 2012 9:11 PM**	Arrogant leadership		Lack of focus on clinical staff and mission		Poor publicity about MD Anderson in the press	
343	**Oct 4, 2012 9:10 PM**	decisions mad without input of faculty		dictatorial		promises being made that can't be met (Moonshot)	
344	**Oct 4, 2012 9:10 PM**	increased clinical workload		increased bureaucracy		bullying by chairman	
345	**Oct 4, 2012 9:10 PM**	Administrative mandates to increase revenue by faculty who are already high-performers within department		Inefficient clinical procedures (e.g. ePrescriptions system and not allowing RNs to place an ePrescription on behalf of providers)		distrust of the President's motives	
346	**Oct 4, 2012 9:10 PM**	Disconnected Executive committee from faculty and faculty leaders		Focus on research and away from patient care		Firing a division head who stood up for his faculty	
347	**Oct 4, 2012 9:07 PM**	Bureaucracy has increased		No independent thinking allowed - all yes people		Open competition among ourselves - moonshot - NEVER has been part of our culture	
348	**Oct 4, 2012 9:07 PM**	lack of vision		lack of leadership and blatant nepotism		imperious President	
349	**Oct 4, 2012 9:07 PM**	Lack of appreciation of the work of faculty members		Lack of objective assessment of clinical needs		Unacceptable payment despite of harder work compared to administrators' salary	
350	**Oct 4, 2012 9:06 PM**	An Imperial presidency		An Imperial presidency protecting an out of control wife		Endless proliferation of vice presidents	
351	**Oct 4, 2012 9:06 PM**	Poor communication		Constant and unrealistic pressure to increase clinical revenue		Lack of opportunities for career advancement	
352	**Oct 4, 2012 9:06 PM**	top heavy		lack of participation in key decision making by faculty		a lot of bad publicity in media from our administrators	
353	**Oct 4, 2012 9:05 PM**	Lack of communication		Top heavy administration		Clinical work flow	
354	**Oct 4, 2012 9:05 PM**	Unethical conduct of the president (COI; waivers, support of his own companies, running clinical trials here in which he has ownership interest)		Lack of respect for the existing faculty and what they bring to the table		Removal of key personal that oppose the president, unreasonable clinical demands (i.e 9% increase in productivity to fuel his agenda)	
355	**Oct 4, 2012 9:05 PM**	MDACC represented poorly in the news		Economy		Healthcare bill (uncertainty)	
356	**Oct 4, 2012 9:04 PM**	More "quality" initiatives that do not improve quality		I am happy, but I hear that many of the med oncs feel overworked and overburdened and we've had several on our team leave for other jobs			

357	**Oct 4, 2012 9:04 PM**	top-down managerial approach without transparency		upper management without any experience in trenches		erosion of customary advantage of academia by instituting non-trivial monetary rewards based on revenue generation or clincial productivity	
358	**Oct 4, 2012 9:03 PM**	Poor leadership		No strategy		Awful IS	
359	**Oct 4, 2012 9:03 PM**	Workplace bullying		Ineffectual Leadership - Chairpersons		Lack of accountability	
360	**Oct 4, 2012 9:03 PM**	Poor Transparency and increased presidential nepatism		Poor oversight of information technology		Lack of vision and increased arrogance	
361	**Oct 4, 2012 9:03 PM**	Disinterest or dismissal of faculty participation from the upper leadership		rapid change without buy-in		perception of nepotism and hiring of 'Yes" men; not many women	
362	**Oct 4, 2012 9:02 PM**	Lack of consensus on financial targets		Lack of knowledge to estimate financial targets			
363	**Oct 4, 2012 9:02 PM**	lack of interest in patient care		lack of interest in clinical faculty			
364	**Oct 4, 2012 9:02 PM**	Unfair bonus distribution		Increased patient load with no incentive to work harder		Inequitable salary	
365	**Oct 4, 2012 9:01 PM**	Loss of faculty representation in the executive committee		Repeated conflict of interest of senior administration		Increased demand for productivity from faculty	
366	**Oct 4, 2012 9:01 PM**	change in leadership		change in health care practices in usa		schizophrenic message of academic and financial profit	
367	**Oct 4, 2012 9:01 PM**	conflict of interest		unfair wages		moon shots	
368	**Oct 4, 2012 9:00 PM**	leadership that does not appear to care about faculty		poor ethics of leadership			
369	**Oct 4, 2012 9:00 PM**	1a. Leadership; 1b. No clear transparency		"resignations" of key personnel		Unacheivable budget increases with all $$ perceived to go to funding moonshots	
370	**Sep 20, 2012 4:20 AM**	less resources		focused on revenue and not truly patient			

Faculty Survey 2012 (Question 4)

What recommended change(s) would you suggest to address each issue identified above?			
Answer Options	**Answer Options**	**Response Percent**	**Response Count**
1.	1.	99.7%	317
2.	2.	85.8%	273
3.	3.	62.3%	198
answered question		*318*	**318**
skipped question		*196*	**196**

Number	Response Date	1.	Categories	2.	Categories	3.	Categories
1	Oct 20, 2012 2:21 AM	Have those actually knowledgeable and experienced with IT development and clinicians make IT choices and hiring rather than those who are self-proclaimed IT professionals.		Remove limits on travel expenses - if you have the funds, use as needed rather than having to nit-pick what is and is not approved.			
2	Oct 19, 2012 10:40 PM	Develop realistic estimates for clinical productivity that ensures patient safety and quality outcomes		Don't expect clinical faculty to exceed what the infrastructure can manage		Allow faculty sufficient time to perform their research, i.e., that is why they came to MDACC	
3	Oct 19, 2012 2:23 AM	Allow low level faculty input into or understanding of decision making		Decrease administrative layers		More focus on accomplishments and needs of clinical efforts	
4	Oct 18, 2012 10:46 PM	Transparency		Respect for our clinical realities and challenges			
5	Oct 18, 2012 10:04 PM	Decrease administrative burdens		Reasonable work load		Encourage innovative research that makes MDA special	
6	Oct 18, 2012 9:39 PM	let us work		avoid conflicts			
7	Oct 18, 2012 9:07 PM	We should all be subject to the same rules regardless and to the same extent - ie conflict of interest for an example.		Leadership's job is to enable the rest of us to do our job and not to put up beaurocratic roadblocks and withold monies that would help us do better patient care - ie providing outdated or unwanted equipment and preventing getting the materiel that we need and want.		Invest more in people and programs and less in the buildings - I think we have enough buildings.	
8	Oct 18, 2012 8:01 PM	Face the clinical vs research productivity of clinical faculty more realistically		Faculty can't trust DePinho on whether clinical income will pay for moon shots		Increase support staff and other support for clinical faculty	
9	Oct 18, 2012 6:51 PM	Consider how to best assist faculty with changes in informatic system					
10	Oct 18, 2012 5:49 PM	not sure					
11	Oct 18, 2012 5:38 PM	have top administrators tell dept chairs to seek input from faculty		encourage a restpectful attitude from all employees			
12	Oct 18, 2012 4:25 PM	increase faculty input		reduce bureaucracy		increase transparency	
13	Oct 18, 2012 3:55 PM	More explanation of why sudden increase in budget targets		Better education of IT staff and more qualified staff to support initiatives such as encryption		What is the benefit for clinical faculty to increase productivity if left out of incentives	
14	Oct 18, 2012 3:45 PM	DePinho should come to a faculty meeting in each dept and hear us out (not senate - that was not helpful at all)		EASIER MEANS to get funding for clinical positions (PA's, NPs etc)		Please don't hire anymore higher level admin/ institute directos/research leadershipetc etc people - they cost money and actually do not contribute to our getting better research done here; a research nurse would be a way better use of funds!	
15	Oct 18, 2012 2:46 PM	opened and honest explanation the reasons for firing high-ranked investigators/clinicians		announcement of development plans for all res. centers and divisions		develop some protection programs for people that have to leave their job due to the lack of funding or other reasons on all levels	
16	Oct 18, 2012 2:21 PM	Listen to the people "on the ground" before implementing changes		continue towards true tranparency about decisions			
17	Oct 18, 2012 2:18 PM	Reign in growth, or grow where it is needed.		Make sure that the resources are there to get the work done quickly and efficiently.			
18	Oct 18, 2012 1:57 PM	More anonymous surveys,		Everyone evaluated not only by boss, but peers, subordinates.		Each manager's clinical workload is at least 80% of his/her immediate subordinates	
19	Oct 18, 2012 1:56 PM	Burke, Colman, Leach to be re-assigned.					
20	Oct 18, 2012 1:51 PM	Administration should have a dialogue with the faculty, not dictate to us.					
21	Oct 18, 2012 1:39 PM	Improved communication will alleviate only 1 of the 3 problems.		Health care reform which is out of our control.			
22	Oct 18, 2012 1:31 PM	consider faculty morale and capability to work as a team member as an important factor (rather than academic achievements) when hiring					

23	Oct 18, 2012 1:29 PM	need to balance the numbers and quality		please provide a reasonable approach for managing faculty trvaeling			
24	Oct 18, 2012 12:55 PM	fix the IT problems		reduce silos by focusing on patient care not process		reduce the number of people involved in every decision	
25	Oct 18, 2012 2:25 AM	get a new president that knows how to communicate with faculty		set caps on limits for clinical productivity demands			
26	Oct 18, 2012 2:20 AM	our administration is a bunch of yes men/women. need to hold people accountable and fix the real problems		department head and division head have no real power to make any meaningful clinical input		pharmds are controlled by pharmacy, should be controlled by department they are in	
27	Oct 18, 2012 1:51 AM	Task force		Common sense		Both	
28	Oct 18, 2012 12:49 AM	Frequent faculty/administrative meetings		More value		Cut back on initiatives and allow for clinicians to research	
29	Oct 18, 2012 12:43 AM	allow staff to buy own travel outside of MDACC agency					
30	Oct 18, 2012 12:38 AM	Real change in leadership		Include faculty in all major decisions that impact clinical care			
31	Oct 18, 2012 12:28 AM	Stricter rules must be applied to the president and his wife and more oversight on the president's office		Clinical resources & revenue need to be protected		Senior staff should also be told about mentoring; not just junior staff	
32	Oct 18, 2012 12:17 AM	make everyone re-apply for position. keep the playing field level		Objectivity across the board		Complete Transparency	
33	Oct 17, 2012 11:59 PM	return to previous operations		get rid of new chair		more communication w current staff	
34	Oct 17, 2012 11:09 PM	Hire more facuty in high clinical load		Hire and keep qualified informatics (LIS) technical staff		Adoption of Voice recognition system	
35	Oct 17, 2012 11:02 PM	more "enterprise opportunity" at faculty level		change leadership			
36	Oct 17, 2012 10:49 PM	Acquire and deploy an efficient Electronic Medical Record system		Provide assistance with billing, scheduling, etc		Incorporate physicians at all levels of administration. This is a hospital. Administrators should be led by physicians, not the other way around.	
37	Oct 17, 2012 10:46 PM	??		immediately eliminate all possible/perceived conflicts of interest at the highest levels			
38	Oct 17, 2012 10:45 PM	(fear)					
39	Oct 17, 2012 10:43 PM	more transparancy		adequate training of personnel before introduction of new systems			
40	Oct 17, 2012 10:41 PM	Need to think outside of the system of how to improve clinical workflow and paperwork which is burdensome on busy clinician		Need an efficient and severely improved medical record (Clinic Station changes are not the answer)		Administration needs to step down to the level of the clinician and find real answers	
41	Oct 17, 2012 10:40 PM	Reduce the number of administrators		Listen to the medical staff		Limit grandiosity	
42	Oct 16, 2012 7:11 PM	Retain and recruit good faculty.		Miminimize the number of senior faculty/chair changes.		Improve MDACC outside exposure and openly inform faculty about state of affairs.	
43	Oct 15, 2012 10:21 PM	Putservices such as IT, TAA, under faculty supervision (i.e., their clients)		make administrators accountable for their decisions...the criteria to evaluate their performance should be clear		Involve the final users before blanket policies are dropped on them	
44	Oct 15, 2012 4:21 PM	Start over with new President and complete exec council		reinstate Pollock			
45	Oct 14, 2012 7:11 PM	Feedback from faculty senate or similar committee to the upper administration					
46	Oct 14, 2012 4:35 PM	An increased participation by all faculty in the moonshot programs rather than for those invited to be a part of the individual mooshots		streamlining of the upper administrative structure to make up for deficits rather than leaning on already overworked clinicians		increased two-way communication between administration and faculty	
47	Oct 12, 2012 9:35 PM	Clinical faculty to be involoved more in strategic decisions regarding the future of institution		Scrutinize buiolding projects, curtail unessary bureacracy		Reward effectiveleader who communicate well, give opportunity to a new generation of leaders that value collegiality, and communication	
48	Oct 12, 2012 5:54 PM	improve efficiencies		stop asking more and more of faculty		provide more funding support	
49	Oct 12, 2012 12:23 AM	electronic order entry- help !		Fire Buzdar		Fire Mary Veazy	
50	Oct 11, 2012 8:45 PM	Changes should have been gradual. Not sure if anything can be done.		Need to have a better system for identifying groups that have promising research results but are short on grant funding. Seems like the "moon shot" cancers already have deep resources.		Need to concentrate on patient care. That's what the public will remember.	
51	Oct 11, 2012 8:44 PM	Make the President divest or leave		Remove Linda Chin to Rice or UH or Baylor or her own institute		Listen to faculty concerns and involve faculty in decisions	
52	Oct 11, 2012 2:44 PM	More physician input		Cut administration by 1/2		Serious ethics review of the president and his wife	
53	Oct 11, 2012 1:41 PM	decentralize clinical policy-making to divisions/depts. one size does not fit all		put resources into improving the experience of the patient; customer service is very poor (delays, phone system, etc.)		avoid unnecessary additional burdens to clinician such as revoking verbal orders to RNs for scripts	
54	Oct 10, 2012 10:25 PM	transparency at the top		clear definition of the role of the president's spouse		clarify whether clinicians are welcome to do research under the new regime	
55	Oct 10, 2012 9:03 PM	streamline administrative support within departments/divisions		more transparency in decision making		encourage clinical operations managers to listen and suspport the clinical facutly	

56	Oct 10, 2012 7:10 PM	MD's seeing pts generates $ $ $. Restructure entire clinic flow .. enhancing pt care and satisfaction, increasing communication between faculty of other departments. Decrease redundancy in clinical activity for each pt visit. after decreasing redundancy in each visit, I would look at other models and try to integrate efficient tactics that work with our system. Remember doctors generate $$$. All non $$ generating activity should be delegated to reliable support personell as much as possible, .		Technology exists to correct the outmoded informatics available at MDACC. The inefficient passe technology wastes time and $$$$		I haven't the foggiest idea of how to change the behavior of stale, doddering , vintage closed minded leaders. Thousands has been spent on consultants to improve cohesiveness and leadership, but change is difficult and unless the leaders want to change, they won't. There is a direct benefit of leaders who have been here 20 + years , never having seen or experienced any other system, at least they know the key players. I personally do not think the embedded narrow minded leaders are open to cahnge.. maybe a brain transplant with some of the thought leaders in "silicon valley" would help. Seriously how do you open a closed mind? How do you encourage a leader to learn more ? To think outside staid operations? To stop with demoralizing behaviors? To stop back stabbing? How do you encourage a dept and / or division leader to beome something that they are not? I do believe their behavior and inadequacies in navigating and nurturing a successful tam is not based in malice; but lack of knowledge and skills , along with the difficulty inherent in change. i find it sad.	
57	Oct 10, 2012 5:49 PM	get a true electronic medical record, such that we do not have to dictate and then go back and sign everything....takes too much time					
58	Oct 10, 2012 4:13 PM	change the approach to problem solving		allow true voices to be expressed by faculty			
59	Oct 10, 2012 3:10 PM	More participation by faculty in decision making		Equitable salary structure		Due recognition for good work done.	
60	Oct 10, 2012 10:10 AM	Increased faculty salaries		Increased PRS funds		For clinical faculty, less pressure to publish in order to gain promotion	
61	Oct 9, 2012 11:23 PM	Make the rules apply to everyone, no matter how highly placed		President should visit each dept to meet the faculty, as prior presidents have done when they assumed office		If higher patient flow is expected, then reduce the bureaucracy and systems inefficiencies to allow this to happen	
62	Oct 9, 2012 10:34 PM	Clear and well in advance communication cannot be overstated, that comes out of prior integration of faculty views and concerns.					
63	Oct 9, 2012 7:36 PM	inclusive rather than dictatorial		demonstrated appreciation for clinicians		get out and listen rather than direct	
64	Oct 9, 2012 6:40 PM	different policies, administration for clinician and researchers					
65	Oct 9, 2012 6:34 PM	physicians (practicing>80%clinical) have to be involved in decision makin		improving supportive clinical staffs		administrative accountability	
66	Oct 9, 2012 6:24 PM	Better communication					
67	Oct 9, 2012 6:12 PM	New administration					
68	Oct 9, 2012 4:57 PM	Decisions the leaders of the institution should not come under scrutiny of the Houston Chronicle.		In additional to better communication from leaders, leadership has to address the issues that are put forth from the faculty.q			
69	Oct 9, 2012 4:31 PM	replace the president		listen to people who actually work		practice humility	
70	Oct 9, 2012 4:10 PM	more communication, less do- it orders.					
71	Oct 9, 2012 4:09 PM	Realistic workload guidelines		increased assistance for non clinical responsibilities			
72	Oct 9, 2012 4:04 PM	address faculty concerns; be open to criticism/opposing views (eg humility)		addresss clinicians' concerns at the dept level		bridge funding esp for non-traditional research projects (eg hybrid projects)	
73	Oct 9, 2012 4:02 PM	Administration should listen instead of tell or argue - serious lack of open minds at the top		Re-evaluate what matters as an institution and apply those values to decision making		Admit mistakes publicly, divest, then move on	
74	Oct 9, 2012 2:10 PM	Increased involvement and attention to surgical services		Complete divestment of president of financial ties to companies which continue to pose a conflict of interest and a double standard for his coi requirements and that of the rest of the faculty		Scrap the ClinicStation and get a real EMR.	
75	Oct 9, 2012 1:40 PM	Doctors should decide on policy changes		More transparency		Please listen!	
76	Oct 9, 2012 1:13 PM	Don't keep so many secrets from the clinicians who see patients.		Allow for more hires for staff.		Get rid of president	
77	Oct 9, 2012 11:13 AM	eliminate all nonessential and/or redundant docomentation. limit who can initiate a n institutional initiative.		get rid of nitpicky changes to protocols at CRC and IRB		get a real estimate of the patient workloads that are appropriate and enforce the load on less busy individuals.	
78	Oct 9, 2012 12:48 AM	Less adminsstration		Less bureacracy			

79	Oct 8, 2012 11:11 PM	Instead of building new building, we need more support to take care of our patients.		Change administrative people's attitute. We do not work for them. We work for our patients.		We have to concentrate to improve patients care.	
80	Oct 8, 2012 10:43 PM	Less demand on faculty for revenue to support non clinical efforts		increase effective communication		I am at a lost of how to address this	
81	Oct 8, 2012 10:08 PM	Systematic investigation from HR yearly to investigate the reason behind salary differences between members of the same department.		Department chairs, including Dept of Emergency Medicine, should be required perform a minimum of hours actually seeing patients on the "field" (not just in writing).		Decide which faculty will be focusing more on clinical work, and have the department chair actually respect that, instead of pressuring faculty for research behind closed doors.	
82	Oct 8, 2012 9:59 PM	reduce administrators		replace with cheaper FTEs to directly assist clinicians: health information assistants, etc			
83	Oct 8, 2012 9:40 PM	New leadership		Less paperwork			
84	Oct 8, 2012 9:29 PM	no encryption unless patient data on machine		obey academic freedoms		do not run as corporation	
85	Oct 8, 2012 9:12 PM	Tell basic science faculty what the plan is for their departments		Establish an internal funding program to encourage discovery oriented (true) basic science		Move away from the micromanaging style in the Provost's office	
86	Oct 8, 2012 9:03 PM	decrease red tape					
87	Oct 8, 2012 9:00 PM	Increase transparency - share section/departmental clinical data		Clarity in expectations. Avoid favoritism among faculty. Increase professionalism.		Hire more faculty	
88	Oct 8, 2012 8:50 PM	There is no solution. MDACC is determined to develop further what it has become		see 1		see 1	
89	Oct 8, 2012 8:45 PM	Invest surplus not in buildings, but in technology and personnel		Either massively and quickly upgrade ClinicStation or move to alternate system		Maintain appropriate staffing to sustain high quality care.	
90	Oct 8, 2012 8:43 PM	Probably hopeless, due to the economic and demographic aspects of healthcare.		Probably hopeless due to external requirements and entrenched institutional bureacracy.		Survey of faculty to identify specific problems and creation of a Senate group to evaluate the circumstances.	
91	Oct 8, 2012 8:42 PM	More opportunities for Instructor and Asst Prog with Intra-instutional funding mechanisms					
92	Oct 8, 2012 8:39 PM	Need to hire appropriate peopel for the appropriate job		pay scale should be equalized in depending on rank and not one section getting paid 100K more than the people at the same rank			
93	Oct 8, 2012 7:42 PM	Better communication		Less expenses in research			
94	Oct 8, 2012 7:42 PM	more decision making by faculty		more funding for science, less admin		run like a university not a company	
95	Oct 8, 2012 7:36 PM	Should not increase demant of external funding on faculty		Improve faculty retention by more communication		This is tough since our insitutionsis going through incertainly at many levels	
96	Oct 8, 2012 7:34 PM	Less paperwork		Personal communication. Would someone listen to the Faculty?		There are too many layers and too many administrative hurdles in the way. There is no efficiency	
97	Oct 8, 2012 7:29 PM	Involve faculty in decisions and have open dialogue		Define clinical effort by type of position and rank			
98	Oct 8, 2012 7:22 PM	Communication		Enhanced interactions with faculty		Realistic financail planning	
99	Oct 8, 2012 7:19 PM	better communication between administrators & faculty		administrators listen & give feedback when faculty contacts them about issues		more organization/communication between faculty and leadership	
100	Oct 8, 2012 7:11 PM	engage the faculty in making decisions		ask faculty to me on important decision making committees		communicate more clearly	
101	Oct 8, 2012 6:23 PM	fostering an environment where the clinical and research contributions of faculty are recognized/protecting research time		increasing support for research administration to speed turnaround time/increase efficiency		need stronger financial support teams	
102	Oct 8, 2012 5:34 PM	Improve communications		Due recognition based on contributions		Ensure equal support that is not polarized	
103	Oct 8, 2012 5:28 PM	better shared communication from each admistrative level, dept chairs, division chiefs,, on up		more work requires more space and potentially more support personel however-until suboptimal care is documented over some great length of time-(i.e. documenting justification for additional support) administration denies need for new positions			
104	Oct 8, 2012 5:13 PM	Clear way the communicate and listen to Faculties		Remove the number of administrator per Dept. They are "Untouchable", Why? Should be evaluate by the Faculties who intereact with them everyday		Research should be a driving force in this Institution.	
105	Oct 8, 2012 5:05 PM	More information exchange between clinical IT systems		Searchable features/autopopulation features in clinic station			
106	Oct 8, 2012 4:59 PM	Faculty represented meeting and task force to include assistant, associate and profressors		Better anticipation of overall budget expenditure			

107	**Oct 8, 2012 4:52 PM**	much more power for day to day decision making in the hands of clinicians		involve each department in developing realistic budgets		leadership should listen to the faculty - more resources should be allocated to expanding the main OR, radiology, etc to improve patient through-put	
108	**Oct 8, 2012 4:51 PM**	Include faculty senate in important decisions		Open communication with faculty about issues that may affect them		Submit to faculty vote issues that would affect institution and faculty	
109	**Oct 8, 2012 4:48 PM**	representation by faculty with clinical duties- not purely rely on division heads		evaluation of cost effectiveness of impact of shift of administrative work to faculty		clear message to faculty about what the business plan is for the institution	
110	**Oct 8, 2012 4:41 PM**	stabilize the administration		management needs realistic expectations			
111	**Oct 8, 2012 4:37 PM**	Require administrators to properly assess the 'institutional impact' of their pet programs. This includes cost, staff, and, most importantly faculty time. It should be in concert with ALL other requirements, and not in isolation.		Get back into the business of using your faculty to develop the 'best cancer care in the nation' and stop sacrificing them like sheep to pay for 'press release research'. At least re-instate some balance here.		Seriously re-evaluate the people leading compliance efforts. The word 'Draconian' and 'knee-jerk' needs to be decoupled from any description of 'MDACC Policies and Procedures'	
112	**Oct 8, 2012 4:33 PM**	N/A		N/A		N/A	
113	**Oct 8, 2012 4:25 PM**			The MDACC president should divest his holdings and financial responsibilities in his companies			
114	**Oct 8, 2012 4:24 PM**	Transparency		Better communication and input from faculty about budget		Allow same breaks for COI that the president is allowed.	
115	**Oct 8, 2012 4:22 PM**	Have faculty representation at exec committees		New leaders should try to incorporate existing leaders with their institutional history in their plans			
116	**Oct 8, 2012 4:18 PM**	Limit patient numbers... I don't want $600, I want time to do academic work, which is why I am here		Get administrative people to do administrative work		Increase support staff	
117	**Oct 8, 2012 4:15 PM**	Set realistic volume goals with faculty input					
118	**Oct 8, 2012 4:09 PM**	More involvement of clinical faculty in financial decisions, goal setting, etc.		More effective support from grants office, research administration, support staff. Equitable distribution of resources in each department and division.		Better communication among administration, faculty, and staff.	
119	**Oct 8, 2012 4:08 PM**	Faculties need to be involved in decision making		More support to overcome increasing administrative burden		Effecient feedback system	
120	**Oct 8, 2012 4:08 PM**	Provide the information regarding how average faculty can get involved in big projects.		Decision making on the resource distribution including Moon Shot projects need to be more transparent. Most of faculty members haven't never been informed and invited to the meetings before Moon-shot programs are decided.			
121	**Oct 8, 2012 4:07 PM**	follow the PTC and other peer committees decsion		help and support faculty to bounce back		promote inter and intra departemntal interactions	
122	**Oct 8, 2012 4:07 PM**	Engage faculty in policy/action considerations early		engage differences of opinion; administration is becoming insular		Attend to fixing institutional infrastructure before committing to 8 moonshots	
123	**Oct 8, 2012 4:05 PM**	eliminate some administrative units (TAA, FAA, etc)		use common sense to eliminate unjustified rules		reduce and eliminate regulatory/unprofessional people	
124	**Oct 8, 2012 4:03 PM**	Need effective leader with verygood communication skills and good administrativ experience					
125	**Oct 8, 2012 4:02 PM**	Increase involvement of clinical faculty in institutional decisions.		Improvement in efficiency in the clinical workflow.		Increase quality of administrative support, thereby, allowing clinical faculty to focus on their work.	
126	**Oct 8, 2012 4:00 PM**	Better policy regarding the encyrption process					
127	**Oct 8, 2012 3:59 PM**	transparency		collaboration with faculty		realistic expectations	
128	**Oct 8, 2012 3:59 PM**	Createye academic recognition program for patient care		Allocate budget to the department to fund research infrastructure		More time protection for clinical research	
129	**Oct 8, 2012 3:57 PM**	openess on recruitment		minimum standard on faculty hiring			
130	**Oct 8, 2012 3:24 PM**	Assuming they are willing to listen! No indication that they are.		Balanced approach to enhancing translational research		Acknowledge by action that clinics run the operation, not grants.	
131	**Oct 8, 2012 3:19 PM**	more communication with clinical faculty		more representation on executive committtees by faculty		more reasonable goals	
132	**Oct 8, 2012 3:10 PM**	Business team work more closely with Clinicians in planning budget		increase patient care resources		Included faculty in major "team" (institution) decisions	
133	**Oct 8, 2012 3:04 PM**	incentivize humility		sincere effort to engage faculty		hold administration accountable,	
134	**Oct 8, 2012 2:48 PM**	More faculty involvement in key decisions		More faculty involvement in key decisions		More faculty involvement in key decisions	
135	**Oct 8, 2012 2:36 PM**	Include faculty representation on key committees		Define institutional goals that are independent of the president's personal goals		Careful oversight of funding-raising activities to assure that they are appropriate	
136	**Oct 8, 2012 2:31 PM**	Far too complex to address in one-liners		Need to address directly bad press that has gone out recently, particularly re the president's activities.		Improve communication about the reasons for changes. These are contributing to the negative gossip about the institution.	

137	Oct 8, 2012 2:30 PM	Encourage stability in departments		Transparency about motives and concerns of the leadership			
138	Oct 8, 2012 1:53 PM	Increased focus on delivery of excellence and compassionate care		Same as 1		Get rid of non-essential non-clinicla programs that drain resources	
139	Oct 8, 2012 7:48 AM	less liberal with compulsary policies		value research faculty with promotion and tenure		offer incentive for salary award for research faculty and clarify the policy	
140	Oct 8, 2012 3:35 AM	balance the work load for clinicians		limit salary on grants to the current 40% for research faculty		provide more leisure and support activities for faculty	
141	Oct 8, 2012 2:09 AM	Reduce red tape and senseless paperwork		Reduce administration, more administrators create more useless work		It has to be clear where decisions are coming from	
142	Oct 8, 2012 1:20 AM	Streamline the process through enhanced automation		Mobile technology (ipads etc.). Automate more of the processes.		More space. Count patient visits rather than new pts.	
143	Oct 8, 2012 12:48 AM	Remove restrictions to ordering molecular profile testing		Lower the costs		Administration needs to be accountable for these delays	
144	Oct 7, 2012 2:02 PM	Rebalance CRC chairs to represent all departments		Chen leaves institution, DePinho gives up Aveo an other corporate conflicts of interest		Hire pollack back (An administrator that works as a regular faculty member too is too valuable to lose)	
145	Oct 7, 2012 3:57 AM	There must be a significant improvement in the transparency and communication of the management/administration of our institution. The administration should consult faculty peers in institutional decision making.		Demonstrate that funds are distributed fairly across the institution.		Better recognition of work effort.	
146	Oct 7, 2012 3:41 AM	Listen to the faculty. majority of the time in the small group sessions are taken up by the President. he speaks but does not hear		equivalent pay		fear is pervasive. tolerance and willingness to hear opposing points of view and discuss are needed	
147	Oct 6, 2012 8:48 PM	Ask each department/s how their Chair's and Division Heads are serving them		Seriously evaluate every Division Head and Chair in position for over 8 years		Evaluate business's practices and the dramatic increases in non clinical staff	
148	Oct 6, 2012 8:18 PM	Double the AA support for each faculty member in order to manage the complexities of the new system		Effective leaders do not simply get rid of people who don't agree with them		Stop it. This is the number one reason clinical trials are failing to accrue.	
149	Oct 6, 2012 6:23 PM	More faculty input for clinic operation and policies affecting them		less bureacracy for research - its too hard and takes too long		Have clerks to enter billing and coding - not MDs	
150	Oct 6, 2012 4:50 PM	Administrators and CADS to be evaluated by physicians		To remove Ms. Kelsick from the IMC center			
151	Oct 6, 2012 3:02 PM	train on programs prior to implementation		verbal dication going into record for documentation		training classes for all new animal manipulators	
152	Oct 6, 2012 1:11 AM	need clear definition of new "Institute of cancer science", define how integrated into our academic culture, or how separate.		fix relationship to CPRIT, if possible. Abstain from promoting own commercial interests. leave SABs : conflict of interest is unavoidable. ok for faculty, not ok for leadership with wide authority.		establish transparent performance criteria for different levels of faculty	
153	Oct 5, 2012 11:56 PM	better integration of services for patients		recognition of need for academic time for clinicians		inclusion of faculty on committees	
154	Oct 5, 2012 11:12 PM	transparency in decision making		reduce bureaucracy			
155	Oct 5, 2012 11:10 PM	remove		remove		new leadership	
156	Oct 5, 2012 9:56 PM	Honest communication		Leadership that listens as well as dictating			
157	Oct 5, 2012 9:56 PM	walk in my shoes for ONE day.					
158	Oct 5, 2012 9:44 PM	Shared governance by faculty		Reduction in layers of administration -will save $$$ too		Reduction in layers of administration -will save $$$ too	
159	Oct 5, 2012 9:37 PM	Less Mandates and more openess to faculty input					
160	Oct 5, 2012 9:21 PM	transparency in the distribution of the work					
161	Oct 5, 2012 8:28 PM	has to be a change on the part of the administration which is unlikely to happen					
162	Oct 5, 2012 8:24 PM	more explanation and time for acceptance of change		reprioritize IT needs - infrastructure on which to build			
163	Oct 5, 2012 8:23 PM	creatively face and improve red tape		move away from a growth based to a quality based paradigm		change faculty governance	
164	Oct 5, 2012 8:03 PM	lissen to senior leaders below the Presiednt and ExVP's		encourage open discussion and even disagreement as long as we are respectfull of each others position		must not loss the clinical strength of MDACC. keep and support crtical personnel	
165	Oct 5, 2012 8:02 PM	A VP for process efficiency: Goal = 10% red tape reductioneach year.		implement cumbersome policies (TB test, encryption) only where truly necessary			
166	Oct 5, 2012 7:35 PM	hire more faculty		hire more faculty		better research infrastructure and faculty experienced in research	
167	Oct 5, 2012 7:19 PM	Too afraid to make suggestions!					
168	Oct 5, 2012 6:45 PM	change in leadership		inclusion of faculty and faculty senate in decision making			
169	Oct 5, 2012 6:32 PM	Instead of placing all leadership and trust positions in a handful of new recruits, involve the world-class faculty you already have. Or, you will loose many of them.		Communicate more often and with greater sincerity with the (obviously few) key faculty that you wish to retain			

170	Oct 5, 2012 6:06 PM	More open discussion of provider specific issues and bottlenecks in the system that restrict clinical productivity in the face of mounting pressure to see more patients.					
171	Oct 5, 2012 5:41 PM	better communication from division/department					
172	Oct 5, 2012 5:19 PM	Schedule faculty meetings on a regular basis with enough notice to permit adjustments to our schedules if necessary.		Honor the open door policy, or at minimum schedule appointments as necessary.		Do not tell us not to spend any of our FY12 budget, then give us one week to spend it in APRIL, and expect that operations will continue for the remainer of the FY without a budget. If I've mis-understood, then we can circle back to the points on communication.	
173	Oct 5, 2012 5:12 PM	top administration needs to speak to faculty directly		faculty need to be a part of the process of budgets, etc		Faculty need to be listened to, and our suggestions taken	
174	Oct 5, 2012 4:48 PM	Change is good but why are so many people stepping down or leaving needs to be urgently addressed		Preserve and encourage the culture of kindness and caring		Better and more timely communication	
175	Oct 5, 2012 4:41 PM	do not use a knee jerk to plan finances		i guess every president has to bring his own administration			
176	Oct 5, 2012 4:35 PM	allow more input		stop the scandalous behavior			
177	Oct 5, 2012 4:19 PM	more transparency		more involvement of faculty and faculty ideas in decision making			
178	Oct 5, 2012 4:18 PM	Display where the money is going and show the true "margin" of the institution		We really need a plan for clinicstation to go away completely!! This is a noose around the clinician		Find elsewhere to take the revenue, ie grants and donations. Learn to cut costs!!!	
179	Oct 5, 2012 3:59 PM	communication		a bigger role of faculty			
180	Oct 5, 2012 3:53 PM	Reward clinical efforts		Create a moonshot for patient care services		Moonshot could incorporate efficiencies desired by admin	
181	Oct 5, 2012 3:32 PM	meaningful faculty input		real transparency (not lip service) and accountability			
182	Oct 5, 2012 3:19 PM	Temporary reduce the salary on grant burden until funding imporves. Also, salary on grant should eventually include personnel in Inst. of Applied Cancer Sciences		Recruitment should be based on free space, and redistribution of existing space should be based on objective criteria		A significant portion of the proposed $3 bil Moonshots Progam support should be set aside for an "RO1-like" internal funding	
183	Oct 5, 2012 3:19 PM	Fire the president and his wife, their inherent conflicts are irreconcilable		Resurrect respect for the Faculty Senate, which should be involved in decision-making as the true representation of the Faculty		Limit the demands on clinical faculty to see more patients and recognize that safety and quality of care is more important than volume	
184	Oct 5, 2012 3:16 PM	commit a few more resources to increase operational efficiency					
185	Oct 5, 2012 3:13 PM	cannot comment, did not participate in 2010 survey					
186	Oct 5, 2012 3:02 PM	Stop hiring administrators		Stop "promoting" full professors to administrator positions		Get physicians back in the clinic	
187	Oct 5, 2012 2:51 PM	Provide assurance that one is working on an issue and wiil get back as soon as possible;					
188	Oct 5, 2012 2:49 PM	If the President needs additional space for Moonshot programs he should not take that space from current departments		Provost should allow chairs of the departments to partition and regulate space.			
189	Oct 5, 2012 2:45 PM	stop imposing on physicians		administration need to releave burden, not create more		aknowledge the importance of clinical research and facilitate it	
190	Oct 5, 2012 2:44 PM	change presidents		Improve communications systematically		Provide forum for chairs to provide input	
191	Oct 5, 2012 2:42 PM	increase chemo slots					
192	Oct 5, 2012 2:36 PM	Reevaluate the criteria to select the president, devision head and chairman		DO something when the surveys are consistently poor (consider new leadership...)			
193	Oct 5, 2012 2:31 PM	Allow more freedom for faculty to pursue fundamental questions		More bridge funding during this troubled economy			
194	Oct 5, 2012 2:28 PM	Better hiring and vetting		Allow current faculty say over their own leadership		Better compensation	
195	Oct 5, 2012 2:25 PM	expand moonshot structures to increase faculty participation - cancer center focus group concept		decrease administrative staff by 10% over 5-7 years thru attrition.		more rank-and-file faculty patrticipation in critical committees	
196	Oct 5, 2012 2:20 PM	More details on how moonshots will be administered, who will participate, and how they will be rewarded		Communicate how rest of institution and science will integrate with IACS		Work hard to retain good faculty, and demonstrate that administration values us	
197	Oct 5, 2012 1:53 PM	Openness between new administration and faculty		Cooperation and willingness to compromise between new administration and faculty		An administration that actually listens and changes policies based on feedback	
198	Oct 5, 2012 1:51 PM	Involve faculty and administration in each clinic to propose infrastructure improvements, and budget for innovative ones that could increase productivity		Drop % salary back to 30% for next 2 years until we see if NIH budget is sustained. This money is a drop in the bucket for our institutional budget, but we will lose a generation of researchers. I suspect, however, that the goal is to get rid of every research faculty member who does not have access to lots of funding.		At least clarify faculty roles in moonshots and give opportunities for salary support equivalent to external funding instead of just hiring external managers	

199	Oct 5, 2012 1:49 PM	LISTEN to your faculty, they are the reason you exist!		HELP faculty be more efficient by providing top quality, efficient support services!		ADDRESS the uncertainty by detailing a plan to provide cutting edge platforms for everyone to benefit from, not the current perception that Dr. DePinho will play with his high-tech toys and only invite some to the party...	
200	Oct 5, 2012 1:36 PM	constructive criticism with help in pathway definition		ancillary staff to help the physician instead of obstruction		prioritize tech support	
201	Oct 5, 2012 1:31 PM	provide more support to major revenue generating programs		provide financial incentives based upon clinical productivity			
202	Oct 5, 2012 1:13 PM	improve ethical choices made by president et al		improve transparency of decision making			
203	Oct 5, 2012 1:05 PM	Faculty involvment in planning and implementation					
204	Oct 5, 2012 12:46 PM	We need a clean sweep of the corruption on the 20th floor					
205	Oct 5, 2012 12:33 PM	Include faculty more often during high level decision making		Be more mindful of actions which may be twisted by the media and put us in a poor light		Be more open with faculty	
206	Oct 5, 2012 11:56 AM	Change leadership		Follow ethical principles and standards		Change to a culture of safety	
207	Oct 5, 2012 11:33 AM	Regardless of COI exist or not. President should remove from any boards or any ties to companies.		Moon Shots need to be an more open process		IAC agenda and regular clinical agenda need to be more harmonized.	
208	Oct 5, 2012 11:29 AM	Transparancy and justification for rapid leadership changes		Significantly improve OR turnover times.		Enact strategies to enable increased productivity and develop realistic budget goals	
209	Oct 5, 2012 3:57 AM	the president needs to embrace the concept of shared governance and put it into practice, not just talk about it (sometimes) but do the opposite!		Add faculty representation to key institutional committees, regardless whether you call them "executive" or "advisory" or whatever else.		stop burdening clinicians with constant pressure to generate more revenue and cut higher-level administration (and their salaries)	
210	Oct 5, 2012 3:22 AM	The conflict of interest needs to be addressed definitively					
211	Oct 5, 2012 3:11 AM	New administrative leadership that is willing to listen to faculty		Ability to provide input without fear of retribution (see what happened to Dr. Pollack)		Clear communication of expectations regarding financial burden to be placed on clinicians to fund the Moonshot and what the productivity increases will be	
212	Oct 5, 2012 2:59 AM	more dialogues, less monologues		Fix the computers, RadStation/ClinicStation		Have Division Heads and Department Chairs communicate with faculty	
213	Oct 5, 2012 2:54 AM	Send an anonymous survey to all faculty who have quit in the last 2-3 years		Greater leadership accountability - limit number of jobs leaders can hold at a time so they can actually do any of them justice		Plan now for how to deal with the coming budget crisis in some way other than greater work load - lower bonuses, fewer administrators, consolidate admin depts	
214	Oct 5, 2012 2:49 AM	More time to actually communicate with referring MDs or consultants		Better nurse management in clinic and better training of support staff especially PSCs		More secure leadership more interested in truly supporting their faculty	
215	Oct 5, 2012 2:05 AM	overhaul/streamline IT infrastructure		make clinical requirements and amount of protected time uniform for given positions		create the option of part-time/shared opportunities for faculty	
216	Oct 5, 2012 1:51 AM	Add a chief research informatics officer		More beds, nurses, less reliance on machinery		Let Faculty vote on retaining their Division Head	
217	Oct 5, 2012 1:31 AM	fix e-prescribing		speed computer access		permit nurses to help in writing orders and prescriptions	
218	Oct 5, 2012 12:30 AM	Decrease overhead costs.		Decreased regulatory burden by changing risk-averse attitude.			
219	Oct 5, 2012 12:22 AM	eliminate or minimize all this travel restriction, priviaged class gets it what ever any why		put the productive people in the forefront, not lazy and back stabbers		we are about 40-50 percent efficient, get rid of all the vp s with few exceptions	
220	Oct 5, 2012 12:18 AM	Work as a team		Streamline leadership		Increase clinical resources	
221	Oct 4, 2012 11:57 PM	greater transparency, open and honest communication consistent with core values		more reasonable demands		dialogue between leadership, faculty, and pertinent others on what we want to be: an academic cancer center or a corporation	
222	Oct 4, 2012 11:39 PM	All our leaders should meet the same high ethical standards of all the rest of us and as well disallow for nepotism		Explanation for just cause of Dr Pollock's firing		Bring Admin down to earth- down from the ivory tower	
223	Oct 4, 2012 11:34 PM	respect the research potential and impact of the clinical faculty (clinical trial design/implementation/accrual; translational research; outcomes research)		reduce unnecessary steps and paperwork for scheduling; provide appropriate midlevel support		consider the opinions of the clinical departments regarding clinical metrics - for example, the pharmacy should not get billing credit for chemotherapy that is ordered/ administered by the faculty; treatment planning visits and chemotherapy clearances generate huge downstream revenues in addition to new patient visits and consults	
224	Oct 4, 2012 11:22 PM	Dr RD divest or blind trust		New operations leaders focused on quality and safety			
225	Oct 4, 2012 11:21 PM	more time for clinical faculty to engage in academic activity		some assurance that non-moonshot programs will not be drastically cut			

226	**Oct 4, 2012 11:16 PM**	Higher level of inclusion of the faculty in said committees		Discussion with the clinical chairs prior to formalizing financial goals for the clincal faculty			
227	**Oct 4, 2012 11:14 PM**	Reel in the personal ambitions of the president to remake MDACC with those interested in money.		Support the clinical faculty, at least be easing up on the workload		Delegate some responsibility to the faculty	
228	**Oct 4, 2012 11:00 PM**	Rules and polices apply to all, no exceptions		Tell the truth even if it hurts		Treat the clinicians with respect	
229	**Oct 4, 2012 10:58 PM**	Faculty members should be able to communicate with institution-level administration when necessary.		Institution administration should effectively evaluate the leaderships of chairs and division heads.			
230	**Oct 4, 2012 10:55 PM**	Define the role of MDACC, academic or private practice		Reduce the number of adminitrative personel and VPs		Match our workload with salaries, as is done in private hospital	
231	**Oct 4, 2012 10:53 PM**	Humility and candor		A transfer to a different institute		Normalized salaries	
232	**Oct 4, 2012 10:49 PM**	Appoint a competent VP for hospital and clinics, somerone with clinical experience and interest		Strngthen the conflict of interest policy for top officials, especially the president		Focus on strengthening the cancer center's infrastructure, so that we can practice safe and effective menicine	
233	**Oct 4, 2012 10:41 PM**	chairs time should be limited to 5 years		division head position limited to 5 years		faculty should have votes to kick out chairs	
234	**Oct 4, 2012 10:40 PM**	Empowered and active faculty senate					
235	**Oct 4, 2012 10:39 PM**	set realistic clinic volume goals		take the threat of increasing % effort on grants off the the table			
236	**Oct 4, 2012 10:37 PM**	Hire more physicians if need to see more patients		Too much middle management, each with their own "metrics" . Need to cut at this level.		Departments need more resources to hire physicians, APNs, RNs, research nurses, and do great clinical trials - what MDACC is known for!	
237	**Oct 4, 2012 10:32 PM**	Improve communications		Improved focus on faculty needs		More reasonable workload and improved rewards	
238	**Oct 4, 2012 10:31 PM**	hire more physicians, nurses and PAs		protect junior faculty from paranoid narcissistic sr's who demand all research ideas, data, resources		Enforce institution-wide transparent guidelines for promotion	
239	**Oct 4, 2012 10:31 PM**	Reward clinicians with bonuses commensurate with their level of training and accomplishments- they are reason we are Number 1!					
240	**Oct 4, 2012 10:29 PM**	Have a term-limit for chairmen		Make chairmanship renewable only based on confidence vote from faculty every 4-5 years		Ensure the chain of command listens to the faculty members' concerns	
241	**Oct 4, 2012 10:29 PM**	constrain bureaucracy		increase real transparency			
242	**Oct 4, 2012 10:27 PM**	Hire a CIO		Get CIO to report to VPs for Clinic and Research not		Leon	
243	**Oct 4, 2012 10:27 PM**	hire appropriate numbers of staff to ensure that the support is there; fire ineffective performers and try harder to retain valuable team members		let nurses do their jobs!!!		stop expecting already high-performing faculty to keep seeing more patients each year--this leads to decreased quality of care and lower morale; why should I work harder if I am just going to be asked to add to that the next fiscal year?	
244	**Oct 4, 2012 10:27 PM**	Develop an objective promotion system, one that is less biased, and subjective.		On an annual basis conduct an in depth evaluation of how the faculty is treated by his/her superiors.		Develop and evaluation tool to assess the "mentor's" ability, skills and willingness to guide his/her mentees.	
245	**Oct 4, 2012 10:24 PM**	MDACC is way to top-heavy. Many of these VPs and administrators positions are not critical to our mission. We have grown too much in too many peripheral areas that are not central to treating and curing cancer.		Chair and Div Head should meet with individual faculty to get to know their strengths and weaknesses in a meaningful way.		President needs to candidly and publicly address these issues rather than sweep them under the rug.	
246	**Oct 4, 2012 10:22 PM**	More transparency from leadership		More reasonable budget/cut costs rather than increase work demands that can't be met with the existing infrastructure		Faculty input/evidence based decision making	
247	**Oct 4, 2012 10:17 PM**	more communication through e-mails or dept chairs		faculty input on all committees		go the 2nd and 3rd candidates in line when #1 says "no"	
248	**Oct 4, 2012 10:10 PM**	EDUCATE LEADERS AND ADMINSTRATORS ABOUT THE IMPACT OF RULES		RECOMMEND TO LEGAL, COMPLIANCE AND GOVERNMENT RELATIONS OFFICES TO THAT THEY NEED TO MAKE RULES AND REGULATIONS THAT DO NOT IMPOSE EXCESSIVE BURDEN ON FACULTY TIME. THEY SHOUL BE ARGUING ON OUR BEHALF WITH EXTERNAL BODIES TO REDUCE THE BURDEN OF BUREAUCRACY.		FEWER MANAGERS AND ADMINISTRATORS. MORE WORKER.	
249	**Oct 4, 2012 10:08 PM**	Stop trying to run MDACC like a corporation		Reduce the compliance burden			
250	**Oct 4, 2012 10:07 PM**	Stop building new buildings		Make administration less "top heavy"		Faculty Senate representation on IREC, ICEC	
251	**Oct 4, 2012 10:06 PM**	Be realistic about future goals		The presidient should be more open about strategy of hiring		Leadership needs to think realisitcally about underpinning moonshots activities with basic science	
252	**Oct 4, 2012 10:04 PM**	More resources to departments		Less regulations and regulatory personnel			
253	**Oct 4, 2012 10:04 PM**	Commitment to involve all levels of institutional leadership		More attention to transition plans for leadership		Improved communication	

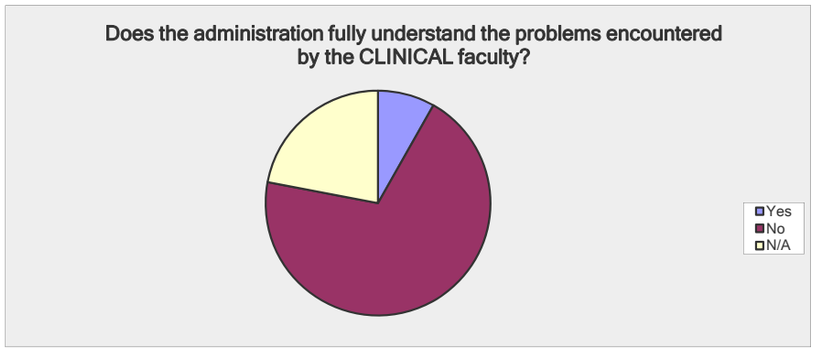
254	**Oct 4, 2012 10:02 PM**	Better representation in decision making		Decrease our bureaucratic and paperwork requirements		Total, 100% transparency and clarity; hold the best and most ethical patient care to be our top priority	
255	**Oct 4, 2012 9:55 PM**	President divest himself of commercial interests and not have wife employed at same institution		"Clean house" in IT starting at the level of the Chief Information Officer down, and hire new competent IT staff with excellent planning skills and IT knowledge. Develop a top down accountability structure in IT.		Cuts in bureaucratic personnel starting at vice-presidential levels and running a lean administrative operation. Remember what the real mission of the organization is - and it is NOT to build a giant bureaucracy.	
256	**Oct 4, 2012 9:52 PM**	Real investment in tools to enhance care		Phase out old systems that were planned to be elimintated long time ago		Focus on health care rather than margin	
257	**Oct 4, 2012 9:47 PM**	Do not provide COI waiver for DePinho/Chin		Restrain administrators; retrain them to serve the institution and its mission - clinical care, research, and education		Engage administrators to help, not to block	
258	**Oct 4, 2012 9:45 PM**	Have a complete disclosure of the facts		streamline admin offices by reducing personnel			
259	**Oct 4, 2012 9:44 PM**	Fair clear criteria for incentives		Administrators should not have seperate reporting lines		Testosterone	
260	**Oct 4, 2012 9:42 PM**	God only knows when the economy will get better		Do not ask for impossible goals		Listne to the facutly, especially "old-timers"	
261	**Oct 4, 2012 9:36 PM**	A more balanced approach to clinical and research administration		More internal support and new programs to help with bridge funding		Recognition the faculty burnout is a reality that can't be fixed by seminars	
262	**Oct 4, 2012 9:35 PM**	hold leadership responsible		fair practices		transparency	
263	**Oct 4, 2012 9:35 PM**	reduce administration size		complete transparency regarding the almighty BUDGET		individual Dept freedom to decide productivity measures	
264	**Oct 4, 2012 9:35 PM**	Think we need a change in VP level of clinical operations to get new ideas		We need clear focus of our clinical identity - who should we see, what is the best way to see them		We need to be ahead of the game in defining and measuring the quality of what we provide as institution and individual -this requires robust IT effort and culture change	
265	**Oct 4, 2012 9:32 PM**	Focused review of al VPs,l Divison Heads and Chairs		Focused review of all VPs, Divison Heads and Chairs		Stop promoting based on "popularity." This is not 4th grade.	
266	**Oct 4, 2012 9:29 PM**	transparency in rationale for leadership changes		more solid foundation for actions		enhanced, more informed strategic planning process and communication	
267	**Oct 4, 2012 9:29 PM**	administration should become more reasonable and consider that faculty has to do clinic/research duties		decrease the number of training courses and surveys, leave only essential ones			
268	**Oct 4, 2012 9:27 PM**	spread out leadership		equitable split of research dollars		listen to faculty	
269	**Oct 4, 2012 9:27 PM**	More leadership engagement and accountability		Realistic clinical workload		Get a functional EMR with better CPOE and data mining	
270	**Oct 4, 2012 9:27 PM**	Further sepaprate research and clinical duties as to allow a open research environment without any of the restrictions related to clinical duties and services.		Examples are the 30 day extramural time limit, the recent IT measurments that protect patients but majority of researchers have no dealing with patients			
271	**Oct 4, 2012 9:26 PM**	use funds to support infrastructure, not esoteric discovery research this year		clinical leadership should spend a full day in each clinic or more, adm leadership should spend a day or so in the dept offices and understand how our time is wasted			
272	**Oct 4, 2012 9:26 PM**	fewer but more supportive administrators		strong commitment to support basic science		evaluate publications (as opposed to funding) more	
273	**Oct 4, 2012 9:25 PM**	Realistic evaluation of Institution's Strength		Greater utilization of Clinical Faculty in Administrative Decisions		Some mechanism to reduce the discretionary/dictatorial power of a few individuals at the top	
274	**Oct 4, 2012 9:25 PM**	no special perks for top administration in grant submission		If MDA research achievements are so great (stated publicly) why must outside high-profile faculty be brought in to boost the institution?		Continue to reward research achievement rather than alignment with cancer relevance	
275	**Oct 4, 2012 9:24 PM**	Restore research integrity to MD Anderson		Maintain independent research quality at MD Anderson, not team work		Reduce the huge beurocracy that cripples MD ANderson	
276	**Oct 4, 2012 9:24 PM**	divestiture of conflicts					
277	**Oct 4, 2012 9:23 PM**	more autonomy at the PI level		fewer changes in lab space			
278	**Oct 4, 2012 9:23 PM**	no encryption on cmputers without patient data!		shuttles should connect each pair of buildings quicker than one can walk		Complete freedom on expenditures allowed on ProCards, and PRS funds, including office supplies, with less justification and "benefit to MD Anderson"	
279	**Oct 4, 2012 9:20 PM**	Hoping to not have that increase in the near future					
280	**Oct 4, 2012 9:20 PM**	Need to recognize that there is a limit on the number of patients in a safe and quality clinical practice		Provide adequate nursing and support staff (as a full professor, I share my AA with 3 other faculty and the dept chair will sometimes ask her to do special projects)			

281	**Oct 4, 2012 9:20 PM**	spell out where the money will be coming from and how it will affect funding for existent IBS centers		spell out how money to be spent in moonshot will affect or not funding to Departments (equipment, resources etc.)		spell out what will be the role of the common researcher in this new approach to manage the insitution.	
282	**Oct 4, 2012 9:19 PM**	Improve clinical care, people here want to work but the layers of compliance have made it more and more difficult. Efforts to improve meeting those compliance issues sometimes increase the workload		Follow though with implementation of new requirements. Meet with the end users, observe them as they go about their day using these new tools. I think you will find that most projects that were introduced with the best intentions actually backfired			
283	**Oct 4, 2012 9:16 PM**	you don't want to know		better patient education			
284	**Oct 4, 2012 9:16 PM**	Control him or fire him.		We spent a lot of money on her: where are the results?		Beg some of them to come back	
285	**Oct 4, 2012 9:15 PM**	cut expenditures in other places rather than taxing the faculty - bonuses for VPs and establishing a new logo are two costly expenditures that either did not need to happen or could be re-evaluated. These are just two examples of costs that faculty have discussed openly.					
286	**Oct 4, 2012 9:15 PM**	the differential between tenure track and non-tenure track time for academics is only 10%, i.e., 80/20 vs 70/30. Whith these nearly identical percent efforts, some of the expectations for tenure track regarding grantsmanship are unreasonable. When I was hired, I was told that there is an understanding that tenure track faculty are actually closer to 50/50. I think 30/70 is actually quite generous, but not sufficient to be successful in competing for NCI R01 level grants (especially in this era of low funding).		Again, incentive funds are generous and we are lucky to get them. I hope that the institution continues to support them.		Communicate to the faculty that all funding is important. I guess I am saying that recent emails have a very negative tone, which are discouraging.	
287	**Oct 4, 2012 9:15 PM**	listen to faculty, not just communicate decisions that have already been made		be forthcoming about programs that are being targetted for replacement			
288	**Oct 4, 2012 9:14 PM**	More opportunity for a breadth of faculty input					
289	**Oct 4, 2012 9:13 PM**	Address clinical excellence		reward clinical excellence			
290	**Oct 4, 2012 9:13 PM**	Dr. DePinho must understand that faculty perceptions are undermining his initiatives		Dissolution of the ECSF - and exclusion of faculty from key decision-making committees - shoud be reconsidered			
291	**Oct 4, 2012 9:12 PM**	Trim the adminstration system		Get rid of abusive and underachieving chairs and division head, they are known, and that will increase the trust of the faculty in the system		Either cancel the BIG SURVEY, or demonstrate its utility by showing how the institution takes the results seriously and build on them	
292	**Oct 4, 2012 9:12 PM**	Less focus on a top-down leadership approach.		Greater sensitivity on the part of management to the needs of the people that make this institution great.		More recognition for positive accomplishments, rather than a focus on negative feedback for perceived weaknesses.	
293	**Oct 4, 2012 9:11 PM**	No place for arrogance in a cancer center		Moonshot for clincal care delivery		Remove all conflicts of interest at the top	
294	**Oct 4, 2012 9:10 PM**	get faculty involved		generate consensus among faculty			
295	**Oct 4, 2012 9:10 PM**	recruit more faculty		streamline bureaucracy		fire chairman	
296	**Oct 4, 2012 9:10 PM**	Do not penalize high-performing clinicians by asking them do more		Use incentives rather than penalties to get people motivated to work hard for the institution		Listen to the faculty, who make this institution the success it is. Allow RNs to put in prescriptions on ePrescriptions.	
297	**Oct 4, 2012 9:10 PM**	Reorganize clinical operations leadership - start at top		Reward faculty for the extra care they are being forced to provide to support new research		Same as number one	
298	**Oct 4, 2012 9:07 PM**	Faculty participation in the Exec Com		The President needs to change his style		Educate the President about cancer center leadership	
299	**Oct 4, 2012 9:07 PM**	Faculty in administration should express care for each faculty member and not delegate this role to business administrators who historically have expressed little appreciation of facutly		Increase support personnel in clinic		Increase salary of faculty and take into consideration their clinical productivity	
300	**Oct 4, 2012 9:06 PM**	Find a new President		Slash administrators by 50%			
301	**Oct 4, 2012 9:06 PM**	Provide promotion opportunities for competitive internal faculty		support the faculty rather than constantly harassing		The top leadership should be held to same standards as faculty	
302	**Oct 4, 2012 9:06 PM**	have faculty participation in key decision making		have a uniform policy for non-tenure faculty cross institution			
303	**Oct 4, 2012 9:05 PM**	Board of reagents needs to reconsider this appointment					
304	**Oct 4, 2012 9:05 PM**	PR to remind patients that they are top priority here.		wait it out		wait it out	
305	**Oct 4, 2012 9:04 PM**	faculty input really needs to be solicited during chair searches. i think our med oncs have left because they fear a new chair would not be easy to work with		strive to only implement quality improvements that are smart and really improve quality			

306	**Oct 4, 2012 9:04 PM**	include junior faculty on subcommittees of larger committees		more transparency		stop the new monetary reward structure for revenue generation by clinicians or make the reward amounts relatively small	
307	**Oct 4, 2012 9:03 PM**	Remove entire executive team		Hire people who understand what we do		Buy an EMR and systems to support research	
308	**Oct 4, 2012 9:03 PM**	Zero tolerance of workplace bullying		Remove ineffectual Chairpersons		Enforce accountability	
309	**Oct 4, 2012 9:03 PM**	Get rid of at least 90% of the VP's.		The U.S.A. has only one VP. Why does MD Anderson need so many?			
310	**Oct 4, 2012 9:03 PM**	More Faculty Participation and Transparency		NEW CIO and Medical Informatics group, NEW EMR~		LESS ENTRENCHED SENIOR LEADERSHIP -Think Different!	
311	**Oct 4, 2012 9:02 PM**	To discuss financial targets openly					
312	**Oct 4, 2012 9:02 PM**	establish a strong clinical leadership independent of the moonshots and finance					
313	**Oct 4, 2012 9:02 PM**	Listen to your hard working faculty		Listen to your hard working chairs and division heads		Listent to the faculty senate	
314	**Oct 4, 2012 9:01 PM**	Reinstate faculty representation into high level committees		Increased internal scrutiny of COI of administration		Comprehensive reporting on revenue generation and expenditures	
315	**Oct 4, 2012 9:01 PM**	be consistent		lead by model			
316	**Oct 4, 2012 9:00 PM**	change the mentality of those in leadership positions					
317	**Oct 4, 2012 9:00 PM**	TRANSPARENCY					
318	**Sep 20, 2012 4:20 AM**	frank discussion					

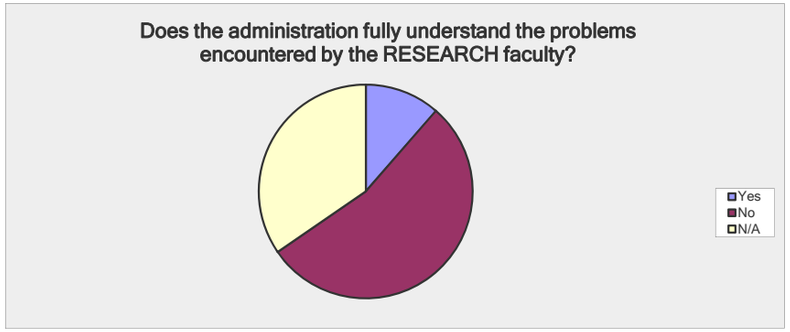
Faculty Survey 2012 (Question 5)

Does the administration fully understand the problems encountered by the CLINICAL faculty?		
Answer Options	**Response Percent**	**Response Count**
Yes	8.2%	40
No	69.8%	342
N/A	22.0%	108
	answered question	**490**
	skipped question	**24**



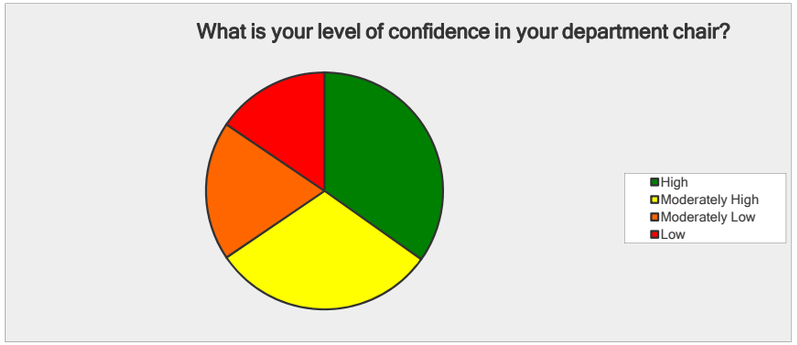
Faculty Survey 2012 (Question 6)

Does the administration fully understand the problems encountered by the RESEARCH faculty?		
Answer Options	**Response Percent**	**Response Count**
Yes	11.4%	57
No	54.0%	270
N/A	34.6%	173
	answered question	**500**
	skipped question	**14**



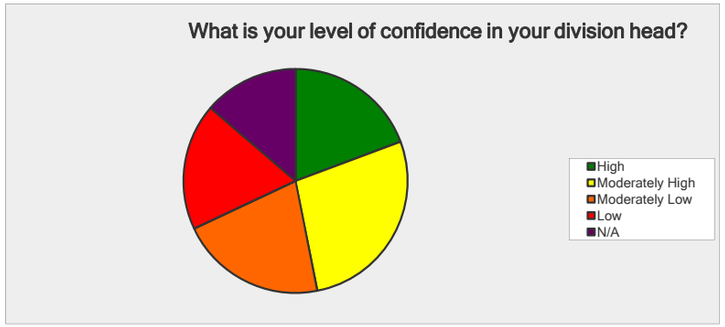
Faculty Survey 2012 (Question 7)

What is your level of confidence in your department chair?		
Answer Options	**Response Percent**	**Response Count**
High	34.8%	170
Moderately High	30.7%	150
Moderately Low	19.0%	93
Low	15.5%	76
	answered question	**489**
	skipped question	**25**



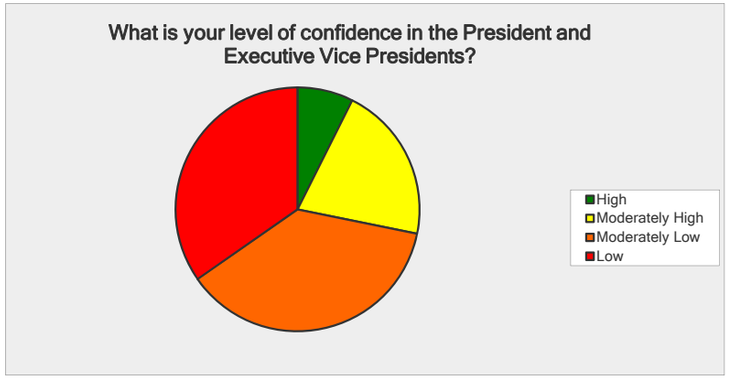
Faculty Survey 2012 (Question 8)

What is your level of confidence in your division head?		
Answer Options	**Response Percent**	**Response Count**
High	19.3%	97
Moderately High	27.6%	139
Moderately Low	21.1%	106
Low	18.3%	92
N/A	13.7%	69
	answered question	**503**
	skipped question	**11**



Faculty Survey 2012 (Question 9)

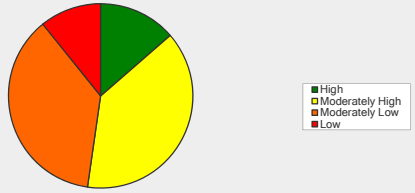
What is your level of confidence in the President and Executive Vice Presidents?		
Answer Options	**Response Percent**	**Response Count**
High	7.4%	37
Moderately High	20.8%	104
Moderately Low	37.1%	185
Low	34.7%	173
	answered question	**499**
	skipped question	**15**



Faculty Survey 2012 (Question 10)

What is your level of confidence in the Faculty Senate and the Executive Committee of the Faculty Senate?

Answer Options	Response Percent	Response Count
High	13.6%	68
Moderately High	38.7%	193
Moderately Low	36.9%	184
Low	10.8%	54
Please share any comments that you may have:		136
	answered question	499
skipped question	*15*	15



Number	Response Date	Please share any comments that you may have:	Categories
1	Oct 20, 2012 2:21 AM	Updates on what actually occurs at the faculty senate would be helpful and to have our concerns get to the upper administration would certainly be beneficial.	
2	Oct 19, 2012 10:40 PM	I am not sure exactly what the faculty senate is doing to address the problems listed in question 3. It would help everyone is this was more transparent.	
3	Oct 19, 2012 2:23 AM	It does not appear that the new administration pays any attention to the faculty or the faculty senate.	
4	Oct 18, 2012 10:04 PM	think the SEnate does very good work but to a large extent remains powerless	
5	Oct 18, 2012 9:39 PM	Keep plugging away for us. We appreciate you.	
6	Oct 18, 2012 9:07 PM	I think that the Faculty Senate is the only voice of the Faculty but I feel that it gets the run around by the administration and it is considered more of an old toothless tiger than a concerned deliberative body that can work effectively in partnership. The Administration has the upper hand and feels no checks or balances and fails to take advice from the Senate.	
7	Oct 18, 2012 8:01 PM	I feel like I can't trust anyone any more. I just keep my head down and keep on shoving patients through the system.	
8	Oct 18, 2012 7:24 PM	It seems ALL are unhappy and uneasy with changes, no one is saying anything because too scared they will be fired like some others have been	
9	Oct 18, 2012 3:45 PM	There is a big pink elephant in the room. You cannot ask us to see more and mroe patients with the same/ lesser support. You cannot then ask us to present every clinical trial concept idea to 3 different committees before considering IRB approval. You cannot then demand that we publish in high impact journals. This all takes time and money (which as far as I can tell - has been given to only 5 cancer types at MDA) We work long hours in clinic and A LOT of hours in the hospital on the weekends. If the administrations response to this is to give millions of dollars to ideas that have been developed over only 5 months' time then it is obvious that our leaders care more about low impact research ideas than patient care. If this is true then we should call a spade a spade. Tell the clinical faculty to keep seeing patients but don't expect any good reserach out of us. It is a slippery slope to have a leader who has never taken care of cancer patients. That's just the opposite of MD Anderson's mission and operating style. We are great doctors and a lot of faculty are unhappy that this fact is basically unappreciated by the administration (thankfully our patients are wonderful and usually appreciative).	
10	Oct 18, 2012 2:18 PM	It seems that the most important thing to the top level executives is growth for the sake of growth. What happened to being a non-profit doing what is best for our patients and cost is secondary. What happened to feeling like we are all part of a family or a team trying to help our patients and cure cancer. There is a rumor going around that the executives want to see a 10% growth in patient appointments with no additional personnel or equipment being added. We are already at or over capacity in many areas and really can't do it. Thus moral is not all that great.	
11	Oct 18, 2012 1:29 PM	The dept and Faculty senate/committe are doing their job. But hope be heard by leadership.	
12	Oct 18, 2012 12:55 PM	This institution cannot be responsive to patients needs until it rewards the people who take care of patients, instead of placing all promotional opportunities in research.	
13	Oct 18, 2012 2:25 AM	MDACC has always been a model of excellence for faculty to work. I fear the current changes will change this aspect of working at MD Anderson.	
14	Oct 18, 2012 2:20 AM	Physicians have no say at mdacc.	
15	Oct 18, 2012 12:28 AM	It is concerning to have the president and his wife in the news frequently for concerns of ethical conduct. In addition, it is concerning to hear rumors of them trying to bypass internal protocols. Unfortunately, they should have made a better effort to prevent the perception of nepotism given their relationship ; perhaps even consider having jobs at different instituation. I have concern that the president and his wife will make decisions which will benefit our institution, our patients and the staff rather than making it just for themselves.	
16	Oct 18, 2012 12:17 AM	Nothing changes if nothing changes	
17	Oct 17, 2012 11:59 PM	We went from bad to WORSE	
18	Oct 17, 2012 11:06 PM	But that only works when all parties believe in and will practive shared governance.	
19	Oct 17, 2012 11:02 PM	Bark, no bite	
20	Oct 17, 2012 10:57 PM	The Faculty Senate no longer has any standing within the institution	
21	Oct 15, 2012 5:04 PM	President doesn't appear to care what senate has to say or about the faculty.	
22	Oct 14, 2012 7:11 PM	The faculty really have no voice. We are systematically being replaced or pushed aside by upper administration for faculty that are being recruited from outside and are perceived as being better.	
23	Oct 11, 2012 8:45 PM	I feel as if this president is too heavily interested in his own legacy and not necessarily the well-being of the institution itself. He has done everything in the opposite way to which a good leader would begin his/her tenure at an institution. I believe that the reputation of MD Anderson in the public arena is already damaged and will continue to get worse as long as there are questions on the legality and ethics of what he, his wife and his staff are trying to accomplish with the creation of the new pharmaceutical development programs at MD Anderson.	

24	Oct 11, 2012 2:44 PM	Faculty Senate seems to have the interests of the physicians at heart, but they are powerless. I have worked in many different institutions before, federal government, two different state university systems, private sector multispecialty groups. This is by far the worst of anything I have ever seen. Bloated bureacracy beyond what I have ever experienced at previous government agencies combined with the money hunger of a private corporation. The loser in all of this - quality time spent with patients, and declining morale of those who actually provide patient care. The clinical #'s and targets seem to be artificial, not based on reality or the practicalities of how patients can be followed. It is certainly easy for administrators to just keep putting higher numbers in a spreadsheet, putting pressure on clinical providers, without having to invest any additional effort or provide anything to help providers achieve these artificial numbers.
25	Oct 10, 2012 7:10 PM	I appreciate the work of all the faculty senate leaders and executive staff. My Moderately Low confidence is not in their leadership skills, tenacity, ability to represent the faculty nor their desire to lead and effect change for the improvement. My Moderately Low confidence relates to my belief in the Higher Admin to "hear" and the willingness or desire of the institute to change. I strongly believe in the Faculty Senate and respect, honor and admire the dedication and vision inherent in the leaders and memebers.
26	Oct 10, 2012 5:49 PM	I have confidence in the faculty leaders but I still think there is a big disconnect between them and the administrative leaders...seems a bit like a dictatorship.
27	Oct 9, 2012 11:42 PM	Anticipate that the changes in health care delivery and anticipated changes in reimbursement will reduce clinical revenues, putting increased pressure to increase clinical productivity. My concern is that at some point the clinical machine will implode because of what I perceive will be increased financial demands to support greater basic research activities. At some point the clinical machine will not be able to meet current expectations. Planning will be needed.
28	Oct 9, 2012 11:23 PM	My division head was fired 2 weeks ago. He was a tremendously well respected person who we trusted and who stood up for us in high councils. This leaves a very bad impression i.e. that the administration doesn't want to keep around those who challenge its decisions. I also have little confidence in the ability of the Faculty Senate to make a difference, as it has no administrative authority and seems to act mainly as a release valve for faculty frustrations.
29	Oct 9, 2012 10:34 PM	Change is often stressful, and this seems to be the case during the current transition in leadership, even as ambitious programs offer in
30	Oct 9, 2012 6:34 PM	MDACC is too bureaucratic, political, and inefficient. This is translated to frustration and expensive clinical practice.
31	Oct 9, 2012 6:12 PM	MD Anderson is being taken over and reorganized so that everything benefits the President and his immediate colleagues. All others are either dismissed or given no support.
32	Oct 9, 2012 5:16 PM	They are out of touch with the real world.
33	Oct 9, 2012 4:31 PM	Extremely frustrated with the "Moonshot" process. Details should have been thought about and worked out before it was advertised and marketed. Very frustrating for the investigators as well as the clinicians who are repeatedly asked by patients about this effort and nothing really exists.
34	Oct 9, 2012 4:04 PM	Hopeful that they continue to challenge leadership on issues that seemingly are decided upon with no input from the faculty.
35	Oct 9, 2012 4:02 PM	Faculty Senate is wellmeaning and motivated, but lacks power to make any real impact.
36	Oct 9, 2012 11:13 AM	president and executive VPs should be seperate.
37	Oct 8, 2012 11:11 PM	Our institution is getting too big and there is no communication between administative officers who stay distant from our clinic. We are threthend to move to a new bulding which is far away from our patients treatment area. We need to serve more patients convienience.
38	Oct 8, 2012 9:12 PM	I feel it's vital that the institution's leadership maintain a constant, open and equitable dialog with the senate. Otherwise they will continue to be viewed as closed and intransigent to faculty opinions and faculty may become disenfranchised. Representation from the senate should be present on critical institutional committees.
39	Oct 8, 2012 9:10 PM	It is clear a small hierarchy are making all the decisions. It seems most of us, despite some reasonable track records may not fit into future plans, as obviously evident by the number of high profile departures.
40	Oct 8, 2012 9:08 PM	A lot of discussion about important issues, but not sure how much influence will occur, in part, likely a function of limited interest in faculty participation in decision making processes by top administrators .
41	Oct 8, 2012 9:03 PM	Dept chair is not engaged in day to day issues and is not supportive of junior faculty.
42	Oct 8, 2012 8:56 PM	I think at times, they attend too much to what they 'don't have', without fully appreciating all of the things they 'do have'. They always seem to be able to find something to complain about.
43	Oct 8, 2012 7:42 PM	Faculty senate can do little without real power
44	Oct 8, 2012 7:34 PM	The adminstration does not pay attention to the Faculty Senate.
45	Oct 8, 2012 7:22 PM	The senate doesn't appear to be completely involved in the process and would appear to find out things at the same time that the faculty does.

46	Oct 8, 2012 6:17 PM	1) M.D. Anderson has a severe leadership crisis. 2) Both the Clinical and Research faculty are in rapid decline. 3) These problems can only be fixed by aggressive external intervention. 4) Even if fixed immediately, which is not realiistically possible, it would take years to re-build what has been lost in human resources and the MD Anderson's reputation.
47	Oct 8, 2012 4:52 PM	The problem is that the Division head in Surgery who was completely trustworthy was fired. No a good sign when the only reasonable, trustworthy high level administrator was fired. I trust the Faculty Senate greatly; unfortunately the administration completely ignores the faculty senate. The faculty need a much greater voice.
48	Oct 8, 2012 4:37 PM	We have a brand new administration and therefore, my confidence is biased toward the high end in that I want to grant the benefit of the doubt when it comes to the next stage of addressing internal workings at MDACC. Obviously the first stage appeared to be mostly posturing and positioning. Hopefully, with the distractions behind us, we can now start to return to the business of the institutional mission. After all, that is why we, the faculty, CHOSE to come to MDACC. We need to return to quality over quantity. The diseconomies of scale are eating this institution alive. You simply cannot get this big and run things like traditional administrators do. Are administrators would all likely be highly effective ... at smaller institutions. Here, they turn in circles, proliferate and come up with highly questionable programs that appear to be a combination of job justification and appeasing of attorneys at the sacrifice of the institutional mission, values and faculty.
49	Oct 8, 2012 4:25 PM	The current leadership is weak and does not have the ability to present the concerns of the faculty to the blustering and aggressive president and his minions.
50	Oct 8, 2012 4:24 PM	We no longer have a division head.
51	Oct 8, 2012 4:22 PM	The Faculty Senate should incorporate faculty department chairs and division heads among its ranks...those people are faculty also. To not do this is disenfranchising them.
52	Oct 8, 2012 4:07 PM	Senior administration has only one priority: its moonshot program. No concern regarding patient care or any of the rest of the institution's missions.
53	Oct 8, 2012 4:05 PM	Fac. Senate has no say.
54	Oct 8, 2012 3:56 PM	I believe that fear of retribution keeps most people quiet. How can one speak out against the very people who sign your annual contract, and decided on promotion and tenure?
55	Oct 8, 2012 3:24 PM	Confidence in the Faculty Senate and ECFS is not the relevant issue - they obviously dont have any influence.
56	Oct 8, 2012 3:10 PM	My only concern is sometime Faculty Senate approach is to identify problems but not offer solutions which results in "executives" just thinking "faculty complaining again" - we need to formulate realistic solutions - including some compromise but creating win-win solutions.
57	Oct 8, 2012 2:48 PM	Our department chair? We've met him once. Does not seem to have the interests of the department in mind.
58	Oct 8, 2012 2:30 PM	While the Senate and EC have the concerns of faculty at the forefront, there is no belief that the upper levels of the institution will listen to them, or even that those in the upper levels of the FS will maintain their jobs if they disagree with upper management.
59	Oct 6, 2012 8:48 PM	I am not sure, as I am not on the Senate. I am not open to their deliberations. The little I have seen them interact with the President/s, it was like partisan politics.
60	Oct 6, 2012 6:23 PM	The faculty has almost no input in issues that affect their ability to see patients or do research here and are faced with more and more time wasting innane job functions. It is too hard and takes to long to get a protocol up and running. the IT systems here are terrible and 4-info does nothing except give a ticket for someone who rarely arrives. If I had the time back for entering my passwords or doing data entry billing, I could see more patients and do more research. It has become impossible to get things done. Faculty senate does not use their power enough to stand up for the faculty.
61	Oct 6, 2012 3:11 PM	NA
62	Oct 6, 2012 3:02 PM	When there is a leadership change operations also change. If they were satisfied with status quo, which was at a high level they would have hired the inside candidate. Did the selection committee get their choice in the leadership and if so was that candidate chosen?
63	Oct 6, 2012 1:11 AM	Faculty Senate needs to play larger role. needs to develop CONSTRUCTIVE PROPOSALS
64	Oct 5, 2012 11:10 PM	Faculty senate need to be more proactive. There are obvious issues that need to be addressed that require courage....I have not seen this yet.
65	Oct 5, 2012 9:56 PM	Unbelievable that the faculty are not are off
66	Oct 5, 2012 8:24 PM	I think that faculty, generally, are acting out and need to be more understanding of change and need for it. Faculty Senate is allowing itself to be used to fight individual people's battles.
67	Oct 5, 2012 8:03 PM	I understand and appreciate strong leadership and the Moon Shot is a great/fantastic idea/goal that we all can work for.However, it is precieved that it will be done at the expense of all others including clinical practice and loss of key and criticla personnel. Also ClinicaStation as an EMR is outstanding and has so much potential if the Ex team would support it where faculty can get involved and design a EMR that can lead the nation. This is as important as our research because it provides tools to impliment improved and efficent clinical care and leverage our understanding and experience with our integrated skills.

68	Oct 5, 2012 8:02 PM	There are too many people implementing policies who don't seem to understand, from experience, what the policies really mean on the work floor. There needs to be accountability of those who put these policies in place; i.e. putting unnecessarily cumbersome or broadly implemented measures need to be marked as negative on their performance reviews. There needs to be someone (a VP) with real power with a mandate to review and cut or streamline bureaucratic procedures.
69	Oct 5, 2012 7:19 PM	For questions 5 and 6 I believe the answer is YES, but the administration does not care!
70	Oct 5, 2012 6:32 PM	There is low confidence in the Faculty Senate simply because it has been rendered impotent by the new President. This contributes to the low morale because it reinforces the sense of impotence and bitterness that has settled into the organization - at a time when each of us is asked to increase our clinical activities to keep our financial margin in the black.
71	Oct 5, 2012 5:23 PM	Faculty Senate has minimal authority to actually do anything even if their hearts and minds are in the right place.
72	Oct 5, 2012 5:12 PM	OUr division head was recently fired from his position, purportedly for representing the interests and views of the faculty in our division. If this has any truth to it, this is an example of completely unacceptable behavior on the part of the administration.
73	Oct 5, 2012 4:18 PM	Faculty senate is useless. We really need cost cutting proposals instead of taxing the clinician. Too many people work at the institution and God only knows what they do....
74	Oct 5, 2012 3:55 PM	I don't know who is my division head.
75	Oct 5, 2012 3:53 PM	Financial leadership does not seem to understand ancillary services well.
76	Oct 5, 2012 3:35 PM	To do clinical research has become so difficult in the institution. There are now more hurdles and more difficulties with new CRC and IRB changes making one wonder if it is really worth developing a new idea or a protocol. There are lot of disincentives but very few motivating factors from administration.They are punishing a lot of innocent people to catch and suppress a few guilty ones.
77	Oct 5, 2012 3:32 PM	confidence in effectiveness in faculty senate ECFS is reduced not because i doubt their effort/intentions but because i have seen their efforts thwarted repeatedly by administration - it is discouraging to see this group become increasingly powerless.
78	Oct 5, 2012 3:19 PM	The faculty senate is not as effective as it was in the past, but this may largely be due to the way the administrators have systematically reduced the role of faculty senate in instituional governance.
79	Oct 5, 2012 3:19 PM	See above comments, and read up on Simone's maxims; no one is able to give it all in a high position for more than ten years, after which the main focus is to preserve one's own power rather than energizing the program as a whole.
80	Oct 5, 2012 3:13 PM	N/A
81	Oct 5, 2012 3:02 PM	Please see my other comments, but the bottom line is that the Senate continues to blame "administration" for the institutions troubles when the physicians are the real problem. Physicians don't want to see patients. They prefer to consult for pharmaceutical companies and they view administrative positions as the pinnacle of their careers. Until the physicians actually value clinical care no one else will.
82	Oct 5, 2012 2:42 PM	I am dismayed to read of a seemingly unending stream of negative press regarding MD Anderson and Dr. Depinho. He has developed a reputation in Houston of ethically dubious decisions, which reflects poorly on the institution. I have had patients ask me about the CPRIT grant, and why we would expect to bend the rules.
83	Oct 5, 2012 2:40 PM	The faculty senate, though well meaning, is a completely useless, powerless organzition. We are under the control of an oppressive, retaliatory administration that has only their public perception (which obviously reading the houston chronicle and faculty blog is not a good perception) as their main interest.
84	Oct 5, 2012 2:31 PM	More and more basic research faculty are needing to leave this institution; some will be compelled to leave academic research entirely. This will get worse without more interim support from the administration. The current trend to suspend basic research projects in favor of those with more immediate translational impact is understandable in this climate of tight funding, but will be detrimental in the long term. To ignore the impact of our current economy on research funding is extremely shortsighted. There needs to be leadership at the institutional level to weather this crisis.
85	Oct 5, 2012 2:28 PM	Importance of research over clinical work is worsening
86	Oct 5, 2012 2:20 PM	I would like to see upper administration be more responsive (and certainly not dismissive) of faculty concerns. I would like for Faculty Senate to be more proactive in identifying important issues and initiating dialogue with upper administration
87	Oct 5, 2012 1:51 PM	MD Anderson will certainly be a different place in 5 years. My concern is, will it be a better place for patient care and for nurturing a broad variety of research, or will it continue to lose many excellent clinical and research faculty members. Will term tenure mean anything or will the administration just declare a financial emergency and fire everyone who does not meet external funding criteria? (That would be my guess in the next 2 to 3 years)
88	Oct 5, 2012 1:49 PM	The faculty senate has fought to carry out its mission, but with the change in faculty senate participation enacted by the new leadership, I worry that the Faculty Senate will become less effective than it was before.
89	Oct 5, 2012 1:13 PM	Poor ethical behavior of president is diminishing institution's public and professional reputation.
90	Oct 5, 2012 3:57 AM	The Faculty Senate meetings need to be more exciting and engaging. Only then will attendance and engagement of senators improve. Each meeting should include at least one controversial and exciting topic that people will want to comment on. Out of ideas? Include one case study of bullying each time you do not have anything engaging on the agenda. If the author wishes to remain anonymous, another senator can read his/her story and/or put it on the screen.
91	Oct 5, 2012 3:11 AM	Even the Senate is disheartening. Whining and complaining by senior members. No leadership or mentoring for younger members. An Executive Committee that is like an 'old boys' club.
92	Oct 5, 2012 2:59 AM	We need to start up the Sentinel
93	Oct 5, 2012 2:05 AM	While the Faculty Senate is well intentioned, it has little power to bring about change. The meeting seems to be primarily a session where information is disseminated, and complaints are voiced, but no real movements for change or discussions about how to bring about change are discussed. My department chair is a good person, and a good mentor, but appears to accept the demands made by the division/institution on our behalf without negotiation. This results in increased clinical workload and less protected time for the faculty.

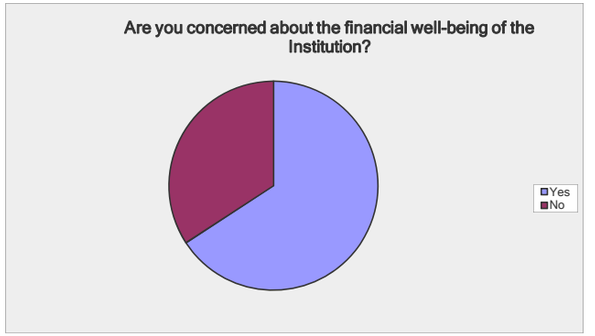
94	Oct 5, 2012 1:51 AM	Faculty Senate and ECFS are relatively powerless due to a high-level lack of ethics combined with flouting of UT and MDACC COI rules. The administrative leaders are bullies who "won the election" and are not interested in dialogue. This is already affecting the CVs of current Faculty as there is a major resistance to publishing papers submitted by MDDACC faculty.
95	Oct 5, 2012 1:31 AM	M. D. Anderson needs to stop trying to squeeze extra money out of clinical encounters. The New York Times front page stories recount government concern over unwarranted upgrades of billing. The administration must realize that we will not get away with it in the long run, to say nothing of the ethics.
96	Oct 5, 2012 12:30 AM	We were informed that we need to see more patients to meet increasing costs. However, there has been no substantial effort to decrease the overhead costs. Most faculty members' attitude is to refuse to see more patients until we see that the administration is streamlined. Clinical faculty are very angry about this. Likewise, research faculty are getting funds from non-NIH sources that do not allow much overhead.
97	Oct 4, 2012 11:57 PM	Looking in from the outside, there appears to be a deliberate effort by the leadership to marginalize the FS and ECFS, which does not bode well for either one to influence institutional decisions that affect its constituency.
98	Oct 4, 2012 11:34 PM	Unfortunately, I don't think that the administration is interested in what the Faculty Senate has to say.
99	Oct 4, 2012 11:21 PM	Not sure what these bodies (in number 10) accomplish
100	Oct 4, 2012 11:14 PM	The level of advocacy seems to have diminished. What about fairness with contracts. There is now a two-tiered scale that exceed evident accomplishment. The academic basis for MDACC is on a slippery slope. Let's hear some faculty uprising against the proposed waivers of the COI policies..
101	Oct 4, 2012 11:00 PM	It is disheartening to read in the papers and learn within our department that basic rules governing conflict of interest and credentialling do not appy to individuals in leadership position. The leadership has no credibility touting ethical behavior or QA when they do not follow the rules themselves. The institution's reputation is suffering as the Regents and leaders put up with behavior that is clearly in violation of stated policy. If a mere assoc professor tried some of these stunts, they would be out on the sidewalk in no time.
102	Oct 4, 2012 10:55 PM	Thank you for listening!!!!
103	Oct 4, 2012 10:53 PM	These committees now have diminished roles due to the new leadership- hard to have confidence in the powerless.
104	Oct 4, 2012 10:49 PM	The Faculty Senate has been largely ineffective in being heard by institutional leadership and despite worthy efforts, has not changed the downward spiral in faculty morale.
105	Oct 4, 2012 10:41 PM	Why same old faculty are sitting on the executive committee of the faculty senate?
106	Oct 4, 2012 10:39 PM	I fear the Faculty Senate and the ECFS are perceived as overly whiny, thus not taken seriously by the senior administration.
107	Oct 4, 2012 10:32 PM	The faculty senate does little more than argue and focus on trivial issues.
108	Oct 4, 2012 10:31 PM	Top Morale Killers: 1. Favoritism 2. An overall feeling that promotion/ allocation of resources is not based on merit but rather on the needs/whims of senior leadership. 3. Seeing greed get rewarded time and time again.
109	Oct 4, 2012 10:31 PM	It pains me to see our reputation being destroyed in the Chronicle. There are way too many administrators. who do not generate revenue, yet reward themselves with giant bonuses. This leads to burnout and low morale by the faculty. The clinical faculty spend inordinate numbers of hours working, yet receive no consideration by the administration. Case in point: we still have to pay too much for parking.Yet we are the ones generating the revenue. I have worked at several other top-tier institutios, and at each faculty parking is subsizided; Faculty were also provided food/meals, as the institutions knew it was difficult to leave the clinic to go for lunch. We get nothing here. Furthermore, why are we not allowed access to all garages in the evenings? Do you realize when we come in the middle of the night to see a patient we have to walk across campus from our respective garages. This is suboptimal for our patients, and inconsiderate for our time. I get the feeling that Administration could care less about us. All they want is more clinical revenue to pay themselves bonuses and build new buildings. They need to remember that the clinical faculty here are what has made this the number one cancer center. Just see how fast that ranking would drop if a number of highly-regarded clinical faculty leave.
110	Oct 4, 2012 10:29 PM	There is no process in place to formally file a grievance against a chairman who may be misbehaving or abusing his/her power . The ombuds office that is touted among the faculty and administration as the problem solving and conflict resolution force has absolutely no impact whatsover ; it does not keep any records of wrong doings by the chairperson and there is no formal penalties that it brings about for a chairman who may have treated a faculty member unfairly or in a discriminatory manner. There is also much vagueness around the role of HR for protection of faculty members. Is there an alternative to HR or an HR component that focuses and specializes in faculty issues?
111	Oct 4, 2012 10:27 PM	I have noticed that through the years nothing has changed at MDACC. Every time the institution does the "BIG SURVEY" the majority of respondents rate the morale at MDACC Very Low. What has been done, NOTHING. I don't even know why the institution spends so much money doing the "BIG SURVERY" if they should already know what the responses will be.
112	Oct 4, 2012 10:24 PM	I have a great deal of confidence that the Faculty Senate recognizes the important issues. I have little confidence that the President cares.
113	Oct 4, 2012 10:17 PM	Faculty Senate has no power in decision making.
114	Oct 4, 2012 9:58 PM	There is a feeling that the higher ups only care about the people who bring in big money.
115	Oct 4, 2012 9:47 PM	It's not a matter of whether administration understanding the needs of clinicians or research faculty; it's whether they care to do anything to help. I see them as blocking and creating ever more burden and approvals by others and not helping faculty figure out how to get done what needs to get done. As for level of confidence, it's embarrassing to have DePinho not seem to care how our institution is regarded publically and it says a bad message to everyone about his disregard.

116	Oct 4, 2012 9:44 PM	MDA is massively top-down, and hugely clumsy because of this. Gifted departmental leaders are very rare, and mostly powerless to improve what is obvious to those working in the trenches.
117	Oct 4, 2012 9:36 PM	Don't feel that the Senate has any power to direct change or even be heard as a voice of the faculty
118	Oct 4, 2012 9:32 PM	At least I understand the goals of the President. At least is moving in some kind of direction. Everyone else around here is only interested in saving his own skin. These people are damaged goods. By the way, I am not even sure who the EVPs are at this point.
119	Oct 4, 2012 9:27 PM	The faculty senate appears to have little power on executive decisions.
120	Oct 4, 2012 9:25 PM	As a basic scientist here at MD Anderson I am highly confused by the Moonshot effort. I see no place for traditional, relatively undirected basic research efforts (developmental biology, cell biology, molecular biology) in the rhetoric of this effort. If we have all the dots to cure cancer and all we need to do is connect them (or if gathering the right dots is simply a question of doing the right "omic" approaches in certain cancer models) then what is the future, if any, for basic science at MD Anderson? This is a timely question with some of the formerly premier basic science departments here currently withering on the vine....
121	Oct 4, 2012 9:24 PM	Faculty senate has been removed from representation on any executive committees so therefore they have no voice.
122	Oct 4, 2012 9:24 PM	What is going on within Anderson is very public. I receive emails, phone calls and am forwarded "Cancer Letter" [containing the multiple issues with the DePinho/Chin issues front and center] on a weekly basis from professional colleagues outside of the institution to ask what is transpiring at this institution. The decisions and the actions of the president, Dr. Depinho, and his wife, and those who are following his leadership style are damaging to the reputation of the institution. It is clear that theirs is an ongoing pattern of behavior that is visibly starting to devastate faculty at all levels, with increased anxiety about what the future holds. This is reflected in the multiple faculty members who are interviewing elsewhere in preparation of leaving this institution. With the exception of Dr. Chin, few leaders are being chosen who are balanced for gender with a bias towards Harvard cronies. Meanwhile the members of the Institute of Applied Cancer Science are paid much higher salaries (2-3 x what faculty at similar experience levels make), with no demand for IACS members to obtain salary support from grants, no need to publish and no "metrics" from DePinho. What has transpired is that faculty are second class citizens.
123	Oct 4, 2012 9:23 PM	It takes too long to accomplish anything. Too much talking, too little done. I am not sure how - but our issues should be addressed much quicker.
124	Oct 4, 2012 9:20 PM	The Faculty Senate became simply a meaningless entity within the Institution, a caricature of what real representative Senate should be.
125	Oct 4, 2012 9:16 PM	Morale seems to be the lowest in many years. At every level, faculty members voice a feeling of emotional and intellectual exhaustion. Ask the wives of faculty members and you will get an ear-full.
126	Oct 4, 2012 9:16 PM	I do think highly of the Faculty Senate. I am worried that the Senate and the faculty as a whole have been made virtually toothless by the "reorganization" at top levels.
127	Oct 4, 2012 9:15 PM	I think the institution is not the priority of top leadership. I don't think the Faculty Senate and ECFS have much power to change anything.
128	Oct 4, 2012 9:13 PM	The faculty senate and ECFS have essentially been disempowered by the new administration.
129	Oct 4, 2012 9:10 PM	need Mike Siciliano and David Farquar back
130	Oct 4, 2012 9:10 PM	My moderately low confidence in the Faculty Senate and Executive Committee is that this institution is clearly a dictatorship. The Senate has no teeth.
131	Oct 4, 2012 9:10 PM	I feel that the division heads and executive committees are afraid to voice the concerns of their faculty. The President's manner is inflexible and domineering. This leads to distrust and wariness from the faculty.
132	Oct 4, 2012 9:06 PM	- All faculty representative has been largely marginalized - The senior leadership seems completely disconnected with the faculty - Lack of merit-based selection for career advancement
133	Oct 4, 2012 9:03 PM	I feel that the P and EVP just over-rule and shut-out the FS and ECFS
134	Oct 4, 2012 9:01 PM	My confidence in the Faculty Senate and Executive Committee of the Faculty Senate is low because I feel they are made powerless by the administration.
135	Oct 4, 2012 9:00 PM	i don't know that the faculty senate has any power to bring about changes with the current presidential leadership in place
136	Oct 4, 2012 9:00 PM	We no longer have a division chair. He "resigned" immediately as of last week.

Faculty Survey 2012 (Question 11)

Are you concerned about the financial well-being of the Institution?

Answer Options	Response Percent	Response Count
Yes	65.8%	325
No	34.2%	169
Please share your comments:		138
answered question	*answered question*	*494*
		494
	skipped question	20



Number	Response Date	Please share your comments:	Categories
1	Oct 20, 2012 2:21 AM	With Obamacare and the cuts we are experiencing despite increased revenue in our own dept, it's difficult to see how the institution, or any institution for tha matter, survive without cutting back on employees.	
2	Oct 19, 2012 10:40 PM	1. Reimbursements are going to go down with Obama care, Medicare/Medicaid 2. Pressure to do more surgical cases with inadequate infrastructure & support personnel may lead to adverse events & near misses that can cause significant financial loss to the institution and to the institution's reputation as the #1 cancer center in the USA.	
3	Oct 19, 2012 2:23 AM	An exorbitant amount of money is spent on administration. For instance, there are so many people assigned to monitor clinical research, they can only justify their jobs by finding minor problems that are then magnified. Why do we have to continually report adverse events for retrospective chart reviews? Why does a simple, low to no risk diagnostic protocol take 3 years to get through the IRB? The same problems abound in clinical care. Too much effort and expense is spent on checking for faculty transgressions, rather than expediting patient care and clinical research. Each year the clinicians are asked to increase numbers of new patients and billing, yet no efforts are identifiable that increase new patient referrals, clinic space, radiographic imaging capacity, or OR room availability. Do more with less appears to be the philosophy, with no recognition for the increased faculty time and effort required. What happens when we are no longer the #1 cancer institution due to decreased clinical satisfaction results? Are clinicians not valued for their research efforts anymore, or are we only expected to "put out" with regards to clinical productivity?	
4	Oct 18, 2012 10:46 PM	Budgetary projections seem wildly unrealistic.	
5	Oct 18, 2012 10:04 PM	particularly vis a vis the moonshots	
6	Oct 18, 2012 9:07 PM	I do realize that the future is uncertain but I do not think that it is a dire as projected. The sky is not falling	
7	Oct 18, 2012 8:01 PM	Are we really going to be able to get THAT much more money for the moon shots from philanthropy and drug companies? What sort of payback to pharma wil THAT require? I am concerned over conflicts of interest.	
8	Oct 18, 2012 7:24 PM	Risking reputation with ethical problems as well as on goals that are un obtainable (just like von eshenback and the NCI Risking whole care and warmness of MDACC to commercial goals very unhappy place right now-good people leaving	
9	Oct 18, 2012 4:25 PM	Too many unnecessary steps and inefficiencies obstruct patient care	
10	Oct 18, 2012 3:45 PM	Just wondering where all this Moonshot money is coming from? Consdering people took on extra clinics in 2008 just to make up for our financial problems then... so does that mean the faculty will have to do more clinics and see more patients so that someone can do a gene expression profile fishing experiment? The arithmetic is not adding up (or perhaps there needs to be better disclosure? maybe I am too busy in clinic to make it to the town hall meetings....)	
11	Oct 18, 2012 1:51 PM	The administration dictates a bottom line without regard to the quality of care that can be delivered. The more the system is stretched, the faster the qulait declines. As reimbursement becomes tied to patient satisfaction, this will become a problem. Of course, then the administration will be concerned because the bottom line is involved. MDACC is not a business. It is a hospital caring for and treating people whose lives are threatened by cancer. We must be cognizant of the bottom line but we should not be ruled bu it.	
12	Oct 18, 2012 1:29 PM	No idea of situation, but assumed that the operation should keep going	
13	Oct 18, 2012 2:20 AM	We are too fat. This will crush us at some point. Think ahead people	
14	Oct 18, 2012 12:17 AM	MD Anderson has money and will continue to get money	

15	Oct 17, 2012 11:59 PM	Too many employees that don't generate any revenue Too many people
16	Oct 17, 2012 11:09 PM	Faculty and administration are trying hard to maintain financial security of the institution. However, major health care change in coming years is more thar challenging.
17	Oct 17, 2012 11:06 PM	The clinical operations are already running under strain---5-15% more is unrealisitc, even punitive
18	Oct 17, 2012 10:49 PM	Increases in patient volume may not suffice to pay for planned investments in research (eg, "moon shots"). This is particularly troubling if quality of patient care is compromised.
19	Oct 16, 2012 7:11 PM	I am concerned about how we plan on paying for all the buildings we continue to build and the moon shot program. About a decade ago we came to work and did not worry about budgets, bottom line, financial graphs, etc. These days that is all we are concerned about.
20	Oct 16, 2012 3:11 PM	The recent significant leadership turnover is concerning. This has been a very successful institution and I hope it will continue to be so
21	Oct 15, 2012 4:21 PM	We have money, but concern is it will all be diverted into the Presidents projects
22	Oct 12, 2012 5:54 PM	Capital plan and moonshots do not appear to be funded and will pinch existing resources
23	Oct 12, 2012 12:23 AM	We are an administrators dream- MANY worker bees
24	Oct 11, 2012 8:45 PM	If the public's confidence in MD Anderson falls and the other hospitals/care centers in the area can provide the same level of service as MD Anderson, ou clinical revenue will continue to decline as patients choose to go elsewhere.
25	Oct 11, 2012 8:44 PM	Too many new buildings and VPs with inflated salaries and staffs
26	Oct 10, 2012 10:25 PM	We are entering challenging times. MD Anderson is great fro three reasons - 1. definitive diagnoses 2. definitive procedures 3. unique clinical trials denigrate any of these three columns and you risk destroying our atractiveness to patients.
27	Oct 10, 2012 7:10 PM	yes and no.. i am not sure what to believe when i get emails re financial well-being. I don't trust the the facts reported, and certainly don't pretend to know the decisions behind the institutional finances. What I see and what is revealed to me seems UNREAL On a dept level. my leaders do not understand the department finances. They tend to defer to admin individuals.. and staff. instead of understanding or trying to educate themselves. an example: A. Re billing of clinical activity. our division leaders just say " oh lets ask XXXXX".. now the person they are relying on for an enlightened answer is not trained in billing, or coding.. and has never been to a professional coding course ... nor ever dealt with the fickleness of insurance companies much less seen an EOB or observed a coder at work reviewing charts. B. Re expenditures: " oh XXXXXX does a great job".. again relying on others ,, and excepts what they say.. I could go on and on.... with multiple examples... If this happens on a dept level.. i can only think it happens all the way up .. Perhaps i am wrong. It is annoying to be asked to work harder to make up for financial managers inadequacies and mistakes.
28	Oct 10, 2012 5:49 PM	some concern of course about health care changes but i imagine MDA will be safe for a while
29	Oct 9, 2012 11:42 PM	see above
30	Oct 9, 2012 11:23 PM	I am quite concerned that the clinical revenues (which form the bulwark of our financial strength) will be diverted to pay for research programs not covered by grants in this increasingly difficult environment for research funding. Also, the mania for building more and more buildings needs to stop. This is expensive and in the long run, I don't believe we can sustain it with never-ending growth.
31	Oct 9, 2012 6:12 PM	Sooner or later the public will find out that MDACC is imploding
32	Oct 9, 2012 5:16 PM	Not sure funds are managed well.
33	Oct 9, 2012 4:31 PM	YES! We are asking clinicians to do more with fewer and fewer resources. We can only increase volume so much
34	Oct 9, 2012 4:04 PM	Faculty are skeptical about the ability of Moonshot programs to deliver - multiple reasons but key factor is how will these be funded? Will the money for MS programs come at the expense/detriment of other existing programs/revenue streams?
35	Oct 9, 2012 4:02 PM	Pt care is eroding and our reputation is damaged. Soon patient referrals will follow It is inevitable that salary on grants and pt loads will be increased to pay for moon shots. Quality will deteriorate and we will be unable to bring in enough money. It's nuts to start such a program with no funds and with health care finance reform on the horizon.
36	Oct 9, 2012 1:13 PM	All we hear is do more with less or we'll cut your pay
37	Oct 9, 2012 11:13 AM	like federal goverment, spending too much and taxinbg the faculty too much

38	Oct 8, 2012 11:11 PM	How can we get post-docs salary? I havbe been using my own funding to support them. Our research nurses have been using up the funding which I am the PI. Some of research nurses are not doing any of my protocols. Departmental research funding is not high enough to send our residents and post docs to scientific meetings.
39	Oct 8, 2012 9:00 PM	The current retirement infrastructure to support the "old system" may not be sustainable
40	Oct 8, 2012 8:45 PM	Compared to surrounding institutions, we are in much better condition. We take the approach of "cutting grass with a razor blade" by failing to upgrade technology. Therefore, rather than efficiently doing the work and not having to do the same work multiple times (write note in chart, dictate, then edit, rather than doing just one step), we require the same number of people to spend more time doing each component of work rather than having a system that would allow them to do more components of work, for example, patients. In surrounding institutions and those around the country, they upgrade their EMR and CPOE to make work more efficient and save money because they can't afford NOT to be more efficient since it is so wasteful in terms of personnel time and efforts. For unclear reasons, it seems that we have failed to make this a priority, or at least a detectable priority for those of us who have to use ClinicStation and have worked in other hospitals before.
41	Oct 8, 2012 8:43 PM	Discussion of finances is focused on clinical revenue and expenses, but revenue-consuming groups are not discussed
42	Oct 8, 2012 8:42 PM	I am encouraged by the Moon Shot Program and am grateful that Research will be highlighe
43	Oct 8, 2012 7:42 PM	We need to invest in people, not fancy buildings or large admin structure and non-science non clinical structure
44	Oct 8, 2012 7:34 PM	More and more high-paid non revenew generating personel is hired. Besides being a burden on our resources, they generate new problems, more reporting more paperwork, taking away doctora and nurses away from our patients.
45	Oct 8, 2012 6:55 PM	Too many changes on the horizon at the federal level not to be concerned
46	Oct 8, 2012 6:23 PM	Not at the institutional level, per se. However, financial issues within the department due to poor managment by the departmental administration/financial team will have major (negative) impact on future research productivity due to necessary downsizing and inability to support current, high impact research efforts. In addition, I have major concerns about the institution's ability to provide the infrastructure to support the influx of patients that would accompany the planned moonshots. It is not clear how we can increase clinical volume without spreading ourselves to thin on the research side (for those faculty who have major research efforts in addition to clinical duties). For this to be successful, we will need more support at every level (more chemo suites, more radiologists, more nursing staff, etc).
47	Oct 8, 2012 6:19 PM	health care is undergoing changes in reimbursement
48	Oct 8, 2012 4:37 PM	We build and expand with no coherent business plan (at least not one that is obvious). We often find out, much too late, that any reasonable business plan cannot be executed because of some institutional compliance issue which may, or more often, may not, be justified. This constant 'chaff' in the face of progress in an institution this size is basically the equivalent of cell signaling run amok. We build where and when we should and desperately hack together a way to feed the satellites, often at the expense of our necrosing core. In the end, it's a pretty acidic, stressed, ineffective and toxic environment. It's just a matter of time before we see everything collapse if action isn't taken to get MDACC back into the business of being one of the few places on Earth where cancer care and cancer research come together in a balanced way which makes the level of care here unmatched to any place on Earth. If we're 'too big' and 'too consumed' with finding The Cure to do that ... we will fail. We must find our balance again.
49	Oct 8, 2012 4:25 PM	Extracting more funds and effort from the clinical faculty to fund the president's and his wife's drug company at MDACC will lead to burn-out and mistakes in the clinic. Would I go to a hospital for treatment of cancer where the clinicians are burnt out and have low morale, and where I could be harmed? Taking these funds from the clinic will result in less effective clinical care. As time goes on and the population the number of patients coming here will decrease reducing income to fund the new drug company, a.k.a IACS. It currently costs $0.65 for MDACC to administer each dollar of direct costs of research grants. This is because we have a severely top-heavy administration with over 70 vice presidents and their staffs. The bureaucrats hired to create and implement the Language of Caring program, the people we hire to create the EEE, the giant HR (that can never find me a decent technician) are examples of wasted financial outflow. These unnecessary costs and movement of funds to the new drug company will hurt the financial position of MDACC.
50	Oct 8, 2012 4:24 PM	The budget projections are too high. Input from the faculty and DA was not solicited. If the budget is not reached (even if we make a profit), financial awards will not be paid out and SAP may be decreased by the percentage that the budget is missed by.
51	Oct 8, 2012 4:07 PM	I don't see where the moonshot funds will come from, I fear their funding will compromise all other institutional operations
52	Oct 8, 2012 4:05 PM	spend too much on offices and regulations
53	Oct 8, 2012 4:05 PM	Too much expansion/ new buildings
54	Oct 8, 2012 4:00 PM	Times of economic and political change, should bring concern and strategic planning at all levels My concern is for how to cope with diminishing resources and increased demands for health care services.
55	Oct 8, 2012 3:24 PM	In the long run, clinical care will suffer, patients will figure it out and go elsewhere, and the "number one" status will be lost
56	Oct 8, 2012 2:48 PM	Massive amounts of money being spent on the President's people
57	Oct 8, 2012 2:30 PM	The institution will do well financially, provided that we have concerned and committed CFO and staff

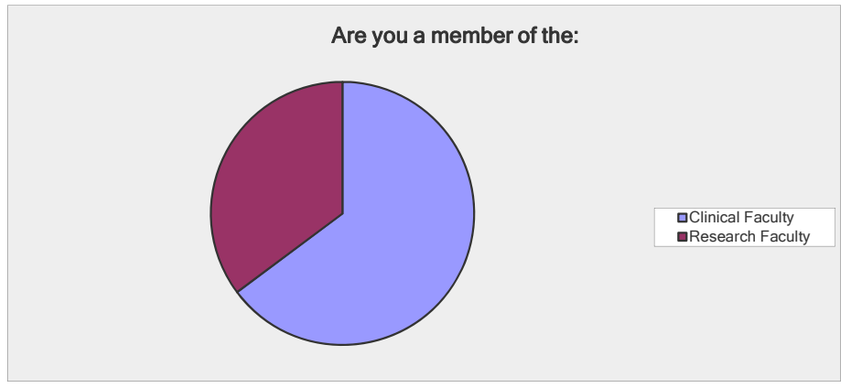
58	Oct 7, 2012 3:41 AM	we cannot keep recruiting individuals and giving them huge packages and expect that the clinical revenue can sustain this. While the moonshot programs ae t be supported by philanthropy and not by clinical revenue according to the President, the huge packages and huge salaries of the institutes are supported by the insititution. The infrastructure for the clinical services need attention. Processes on both the research and clinical side are outdated and need attention. Htere is inadequate personnel to support the required increase in patient numbers. The Executive Team is not listening but merely dictating. This will destroy morale and the very thing that we are most noted for, our clinical excellence and unique clinical care.
59	Oct 6, 2012 8:48 PM	It appears that we do not learn our lessons. We panicked in spring of 2009, with the financial situation- fired a few people, harassed the rest to work hard. Whe the situation improved, we went back to our old habits of indiscriminate hiring, building and spending. Every stumble in financial numbers we proclaim " work hard " to the clinicians. We keep building our portfolio of non-clinical staff. While I understand we run a business, we need to evaluate the layers and layers of administrative folks we have at the senior levels. Really, what other hospital our size has the number of Associate VP's, VP's, Senior VP's and Executive VP's ?
60	Oct 6, 2012 6:23 PM	The new policies make it more and more difficult to take care of patients in an efficient manner the Physicians have no input into clinical operations affecting their efficiency in the clinics. The lawyers have made it almost impossible to conduct clinical research. Too many consent forms - takes too long to get protocols and policy is against clinica research. There are too many surveys and not enough support for activities that will increase revenue. The administrators dont seem to have enough to do other than making work for people (MDs) or complaing that the physicians need to see more patients - yet they make this harder. The administration makes it sound like we are responsible for the budget revenue whereas they are the costly part of the problem. We dont control the front door or how many patients we get scheduled to see.
61	Oct 5, 2012 11:56 PM	need to comply with affordable care ac
62	Oct 5, 2012 11:12 PM	uncertain about the impact of the changing healthcare and moonshot program on the institution
63	Oct 5, 2012 11:10 PM	funding the moon shots off of clinical revenue is insulting and unfair to those who are already overworked...clinicians saved the institute in 2008 and now they are being asked to fund an effort so DePinho can get famous (or infamous)
64	Oct 5, 2012 9:56 PM	No - we keep beating the clinical faculty to see more patients and work harder will less so we can pay executives more and build more buildings
65	Oct 5, 2012 9:21 PM	we're better off than most other academic institutions in the US
66	Oct 5, 2012 8:24 PM	We are not doing badly in financial areas. We do need to be careful about where we spend. Changing priorities before people are onboard with them an creating hardship by telling clinical faculty to see more patients seems unrealistic. Doctors are not the marketing department. Yes, they need to be good communicators and see patients with some speed, but not to detriment of patient care as a whole. Research faculty are already working hard to bring in dollars to support their work. The institution itself needs to do more to bring in those dollars so researcher are conducting research and not having to do the work of the development function.
67	Oct 5, 2012 8:03 PM	Margin is critical to our growth and success in research and supporting our clinical investment. The balance between the two is the question. It is precieved that margin increase with out the necessary equipment and personnel support to achieve these goal will only creat frustration and critical personnel loss.
68	Oct 5, 2012 8:02 PM	Our leadership knows how to keep us financially sound
69	Oct 5, 2012 6:32 PM	Naturally. Negative margins and increasing (impossible!) our clinical activity for what?? to support the "moon shots"'
70	Oct 5, 2012 6:06 PM	I dont feel like the administration is being transparent with how bad things are
71	Oct 5, 2012 5:41 PM	The immediate information from administration to financial is incorrect and non attainable
72	Oct 5, 2012 5:23 PM	We continue to spend big on new programs and buildings based on very optimistic increased patient volume and reimbursement projections at a time when the country is broke and medical care reimbursement is very likely to be cut, we could face a very painful time of program and personnel cuts and layoFfs in the next few years.
73	Oct 5, 2012 5:12 PM	Each year i hear of the financial issues, and each year i am told the goals have been met. If we are not making our budget this year, the budget needs to be revised.
74	Oct 5, 2012 4:18 PM	Learn to cut costs and streamline. The people we hire have open check books to waste company funds. Highly inappropriate unless they are bringing in money. Less managers (mid level managers). As well if I see another group of people walking around with a clip board I would fire at least 60% of each of these groups.
75	Oct 5, 2012 3:53 PM	Effect of episodic billing proposals and ACOs
76	Oct 5, 2012 3:19 PM	It is unclear how the instituional budget can support the rapid influx of the new personnel and the Moonshots Program
77	Oct 5, 2012 3:19 PM	It is all a racket where Faculty for decades have been continuously told that if you don't create more revenue we go to H- - l but the truth is that we have over .! Billion in profit before write-offs annually in spite of a very top-heavy bureaucracy.
78	Oct 5, 2012 3:16 PM	No money, no mission; but also too much concentration on money, also no mission
79	Oct 5, 2012 3:13 PM	N/A
80	Oct 5, 2012 3:02 PM	MDACC will do well despite its dysfunctional administrative organization
81	Oct 5, 2012 2:49 PM	I am concerned the publicity of the Moonshot programs will alienate patients whose type of cancer is not part of a Moonshot program. MD Anderson is a comprehensive cancer center and is world renown for treating all types of cancer. I am concerned we will lose patients if we prioritize specific cancers and ignore other types of cancer.

82	Oct 5, 2012 2:34 PM	We have far too many administrators and other non-revenue building positions compared to faculty. In my division alone, several new manager/administrative positions have been added, but my department has the same number of clinical faculty as when I started with growth every year in clinical responsibilities.
83	Oct 5, 2012 2:31 PM	Because of our outstanding clinical services, M. D. Anderson will come out well financially. However, the priorities are almost certainly shifting away from basic research and academic training and more towards treatment and trials. Without basic research, the continuing development of innovative trial treatments will dry up in a few years. We cannot depend on others to continue to pioneer in the field while we sit back and reap the benefits of their efforts.
84	Oct 5, 2012 2:20 PM	Yes and no. I am confident that we are doing exceptionally well financially, especially considering the state of the economy, but I am concerned about severa things moving forward: 1. The effect of the health care reform on our financial models. 2. The effect of the moonshot program and IACS on other research on campus -- will all margins, etc. be funneled into these programs at the expense of other research initiatives, especially if moving forward the margins shrink because of reform?
85	Oct 5, 2012 1:49 PM	- I am concerned about overspending, for example on buildings which will need to be filled with employees. Consequently, to increase revenue for such spendings and not only, Faculty is asked to be more productive - I am concecerned about large variations in work load among different Faculty members; some will barely make their salary - I cannot appreciate more Dr. DePinho's approach to focus on outcomes and avoid doing research for doing reseach - great point Mr. President!
86	Oct 5, 2012 1:49 PM	We're a $3B a year business who is nearly always in the black. We need to adapt to the economy and increase efficiency while improving patient care. If 1,80(faculty cannot figure this out than we will be in trouble, but for now, the administration needs to give the faculty the authority to address that problems they face and help design a successful plan for the future.
87	Oct 5, 2012 12:33 PM	Uncertain what the full long term impact of Obama-care will be
88	Oct 5, 2012 11:56 AM	Yes, I do not feel the institution is prepared to provide the "best care.'
89	Oct 5, 2012 3:57 AM	What can I say? I just hope Romney wins and the Obamacare drowns. We need a health care reform, but not this monstrosity cooked by this neomarxist-in chief. Sorry I had to vent.
90	Oct 5, 2012 3:11 AM	Moonshot financing done with no investment in clinical infrastructure. Increase productivity targets with no increase in hospital/ICU beds, staffing, operating rooms, etc. We are putting patients at risk while paying lip service to patient safety.
91	Oct 5, 2012 2:59 AM	I am not so concerned about the amount we generate, I am concerned where the money is diverted to
92	Oct 5, 2012 2:49 AM	Institution is highly focused on money.
93	Oct 5, 2012 2:33 AM	Obamacare could kill us.
94	Oct 5, 2012 1:51 AM	The erosion of confidence in upper-level management will decrease the willingness of patients to come to MDACC. There will be a snowball effect with plummeting revenues.
95	Oct 5, 2012 1:31 AM	We are selling our standards cheap, and once sold, they will be gone forever
96	Oct 4, 2012 11:57 PM	very much so: how much is being set aside for the moon shots and new buildings at the expense of existing programs'
97	Oct 4, 2012 11:21 PM	Moonshot programs cause financial uncertainty.
98	Oct 4, 2012 11:14 PM	We can't just keep forcing the clinical staff to do more and more. There is a major diversion of funds to support the moon shot platforms, particularly the IACS which doen't seem to have direction that is evident to the faculty. The rate of loss of truly outstanding clinical faculty will only accelerate if they are not given some substantive appreciation and the time to conduct some academic research in their disciplines.
99	Oct 4, 2012 11:00 PM	Our planning horizon is one year. This is inadequate. We waste endless man hours on a budgeting process only to have some edict come down from above that the target for next fiscal year is X. Why waste all those resouces creating a budget for next year when it is going to be found inadequate? Why not just wait for the President to have his epiphany as to the right target number and work off that? It would save money and the next result would be the same, targets that are impossible to achieve without far more resources and planning. It is amazing we do well with the leadership that is in place. The institution and its mission deserves better.
100	Oct 4, 2012 10:49 PM	I am concerned because the hard earned income generated by the clinical faculty is being wasted by institutional leadership which is unaccountable to the faculty.
101	Oct 4, 2012 10:37 PM	We are burdened by excessive middle managers and even vice presidents, each with their own metrics that we must follow which only serve to justify their (the manager's/vice president's) importance. Most do not enhance patient care or research, and are a burden on the departments. Rules and regulations are extremely onerous, creating work at multiple levels which detracts from our mission.
102	Oct 4, 2012 10:32 PM	Financially the institution seems to be doing quite well
103	Oct 4, 2012 10:31 PM	There is plenty of money, but people at the top know how to negotiate the channels to procure ever more funds for their own small groups. The rest of us do not.
104	Oct 4, 2012 10:29 PM	I wonder how we will withstand the wave of health care reform which is bound to occur one way or another with all the wasteful procedures and inefficiencies that go on at this institution. I don't believe we reward our clinicians for good outcomes or efficient outcomes.
105	Oct 4, 2012 10:27 PM	I am not concerned about the financial well-being of the institution, what I am concerned with is the financial well-being of faculty members who may be at risk of loosing their jobs, within a few years of retirement.
106	Oct 4, 2012 10:24 PM	Yes, we are growing in too many directions that are only loosely related to the central mission of treating and curing cancer. We are trying to grow into a comprehensive medical school + teaching hospital, which is significantly weakening our ability to solve cancer.
107	Oct 4, 2012 10:15 PM	Currently we are fine , however we need to become more cost efficient, value based (quantifying in $$ and outcomes), prepare for DRG exemption change bundled payment models etc.
108	Oct 4, 2012 10:06 PM	It seems that the President is not aware that his personal involvement in negative publicity toward MDACC is likely to affect donation income and gran opportunities.

109	Oct 4, 2012 9:58 PM	In the end, the institute will remain financially strong but at the cost of becoming less of a comprehensive research instititute
110	Oct 4, 2012 9:55 PM	The institution has plenty of money. I am very concerned that the money is being spent wisely to achieve our primary goals
111	Oct 4, 2012 9:49 PM	Long term issues
112	Oct 4, 2012 9:44 PM	I am concerned about a growing army of unaccountable administrators who live off clinical revenue, and act to preserve their source of sustenance by disempowering their hosts.
113	Oct 4, 2012 9:36 PM	Recent research investments seem overly excessive and burdensome to clinical productivity
114	Oct 4, 2012 9:35 PM	I really have no idea how we have a sustainable environmen
115	Oct 4, 2012 9:35 PM	a lot of waste in our system; john bingham's group focused on 12 centers is a step in the right direction, but will administration do with the information they are given
116	Oct 4, 2012 9:32 PM	The internal fighting that goes on in this instituion is unbelievable. The stress is resulting in mass schizophrenia among members of upper-level management. The new president needs to clean house. Useless VPs (several of them use to be noting more than office managers), Division Heads, and Chairs from hell should be the first to be asked to justify their utility to this institution. And, do not take their words for anything--verify, verify, verify.
117	Oct 4, 2012 9:26 PM	Absolutely -- patients and doctors are our steady base of support. This is being eroded and continues to decline for many reasons, internal as well as external We can improve the internal for sure. this does not appear to be happening.
118	Oct 4, 2012 9:26 PM	MDACC made over 25 million USD profit in the worst year of financial crisis (2008)
119	Oct 4, 2012 9:25 PM	I am worried that philanthropic funding, after spiking for the initial moonshot effort, will dry up after if becomes apparent that we cannot fulfill our overblow promises in the short time-frame that has been laid out. Donors want time-frames met and do not have infinite patience...
120	Oct 4, 2012 9:24 PM	Am concerned with the damage that DePinho's has done (his many conflicts of interest and nepotism) to our reputatio
121	Oct 4, 2012 9:24 PM	The use of revenues from the hospital funds to build the empire for the President and his wife to the exclusion of supporting programs for successful faculty wh were here prior to their arrival will ultimately jeopardize all of us. It is clear that nothing has been learned from the debacle of 2008 which was post-election and this is sure to re-occur here.
122	Oct 4, 2012 9:23 PM	The recent CPRIT scandals and the Chronicle trying to find ways to badmouth MD Anderson will likely have a financial impact (donors, patients
123	Oct 4, 2012 9:20 PM	Several new faculty in high position with large packages when they come in could definitely hurt in the long run if we cannot sustain i
124	Oct 4, 2012 9:20 PM	Every year we hear "the sky is falling, the sky is falling". And, every year, it doesn't! By this I mean, part way through the fiscal year, administration will say tha we are behind on patient activity and budget and to see more. And, every year we do so. However, we are behind because the budgeted volumes were unrealistic in the first place. Nonetheless, the faculty jump in and see more, getting more overwhelmed and morale sinking. Then, when we achieve budget, we are given a new budget for the next fiscal year asking to see even more.
125	Oct 4, 2012 9:20 PM	Not if we keep buildings that we don't need and talk of millions of dollars for grandiose undertakin Not if we provide 'huge' salary increases to Top level administrators and I mean huge, some received up to 17% increase in income (salary + bonus + perks) in the previous FY. Not if our leaders earn 'huge' disproportionate salaries It is however absolutely incongruent that the little minions , the ones who do the work both in the clinical and research side, many received 'ZERO' salary increases . In Research for instance because we don't bring our full 40% share from grants we were punished with no salary increase at all, even though we ar in an extremely difficult funding environment. It is clear that the top level administrators don't have to worry about their 40%...
126	Oct 4, 2012 9:16 PM	We can't afford the bad publicity we've been getting. And we can't afford to lose the people we've been losing
127	Oct 4, 2012 9:15 PM	I am concerned about the financial well being of health care which translates to a concern about the institution
128	Oct 4, 2012 9:15 PM	I am concerned about where the money for the Moonshots will be obtained. Off hand statements about additional philanthropic support are not reassuring. I an concerned that institutional money is being used to support commercial ventures.
129	Oct 4, 2012 9:13 PM	With all the attnetion lately placed on media and research, I am concerned about the primary reason MDACC is so good and that is the excellent oncology doctors, nurses and down to the cleaning poeple the deal with patients in the wards. These clinicians are leaving. We will not be the leading cancer center without an extremely stonrg clinical practice. The clinical practice has lost its glory its seems, in the eyes of administration.
130	Oct 4, 2012 9:12 PM	The likely diversion of profits from the clinical revenue stream to support basic science research efforts such as the Moonshots, as opposed to reinvesting them into clinical infrastructure, will undermine the ability to deliver top notch care. Also, the focus on the Moonshots will likely marginalize support for other cancers that were not selected as Moonshots.
131	Oct 4, 2012 9:11 PM	Too much money going directly into moonshots, very little will be left for anything else
132	Oct 4, 2012 9:10 PM	The institution is obviously making money. We are building new administrative buildings continuously, while the clinicians are crammed into tight workrooms and teams are disjointed because the schedulers and nurses need to sit elsewhere.
133	Oct 4, 2012 9:10 PM	We are poorly poorly positioned to compete in the community
134	Oct 4, 2012 9:07 PM	Wasting money all over.
135	Oct 4, 2012 9:07 PM	The President is only concerned about himself and his moonshot. This has become a dictatorial state, you don't do or you opine the man gets mad an retaliates. His wife has made clear that she holds the power.
136	Oct 4, 2012 9:06 PM	Not yet. If faculty keep leaving then we are in trouble
137	Oct 4, 2012 9:04 PM	The top management needs to have reckless spending under control
138	Oct 4, 2012 9:03 PM	Fixed costs too high. Revenue being challenged by health care reform and adverse shift innpayer mi

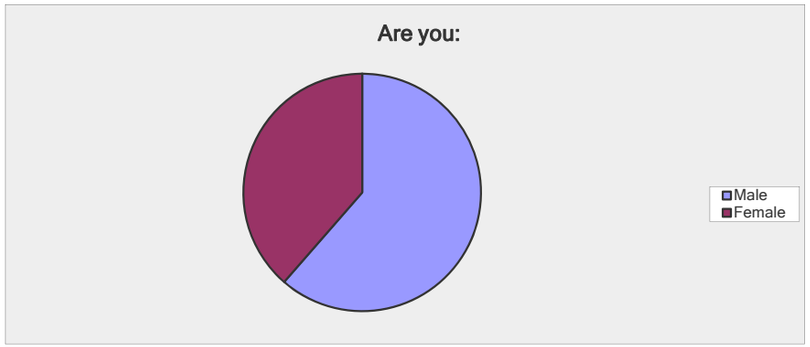
Faculty Survey 2012 (Question 12)

Are you a member of the:		
Answer Options	**Response Percent**	**Response Count**
Clinical Faculty	64.8%	326
Research Faculty	35.2%	177
	answered question	**503**
	skipped question	**11**



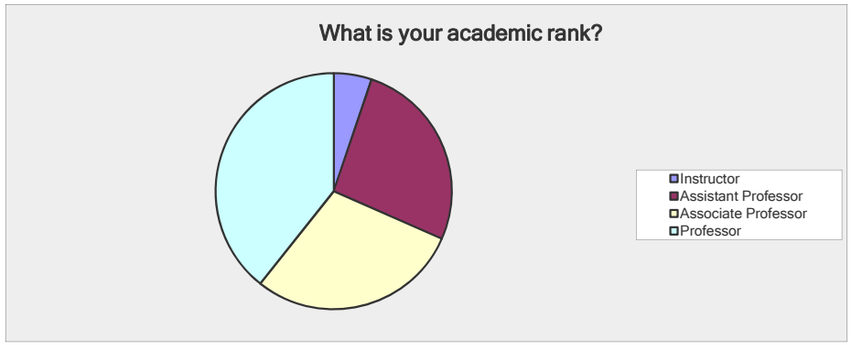
Faculty Survey 2012 (Question 13)

Are you:		
Answer Options	**Response Percent**	**Response Count**
Male	61.4%	296
Female	38.6%	186
	answered question	**482**
	skipped question	**32**



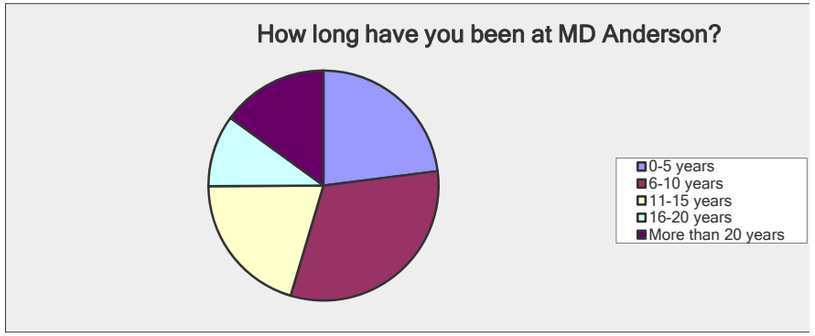
Faculty Survey 2012 (Question 14)

What is your academic rank?		
Answer Options	**Response Percent**	**Response Count**
Instructor	5.2%	25
Assistant Professor	26.4%	128
Associate Professor	29.1%	141
Professor	39.3%	190
	answered question	**484**
	skipped question	**30**



Faculty Survey 2012 (Question 15)

How long have you been at MD Anderson?		
Answer Options	**Response Percent**	**Response Count**
0-5 years	23.0%	112
6-10 years	31.6%	154
11-15 years	20.3%	99
16-20 years	10.1%	49
More than 20 years	15.0%	73
	answered question	487
	skipped question	27



Faculty Survey 2012 (Question 16)

Are you likely to leave the Institution within:

Answer Options	Response Percent	Response Count
1 year	9.3%	43
3 years	22.0%	102
5 years	20.5%	95
Not likely to leave	48.3%	224
Please give any reason(s) below:		168
	answered question	464
	skipped question	50

Number	Response Date	Please give any reason(s) below:	Categories
1	Oct 19, 2012 10:40 PM	If things get worse, I will either retire or get another job. If I am going to do full time clinical work, I may as well go somewhere that I will get paid more money for the work.	
2	Oct 19, 2012 2:23 AM	I am tired of fighting. Kids will be out of high school, giving me freedom to move.	
3	Oct 18, 2012 10:46 PM	Hard to move with school age kids	
4	Oct 18, 2012 10:04 PM	I would like to stay if it is fun and productive to work here.	
5	Oct 18, 2012 9:39 PM	This is the finest medical insitution in the world. No amount of problems changes the fact that we provide hope to our patients, and the prospect of fighting the best possible fight against their cancer. No one does this better than MD Anderson.	
6	Oct 18, 2012 9:07 PM	Hope to retire and get out of the beaurocratic mess.	
7	Oct 18, 2012 7:24 PM	Unsure	
8	Oct 18, 2012 4:25 PM	I believe MDACC is a great place to work with a good vision, though it needs to evolve in a thoughtful and intelligent way.	
9	Oct 18, 2012 3:45 PM	Houston. Love my dept chair.	
10	Oct 18, 2012 2:18 PM	Overall MD Anderson Cancer Center is a good place to work. It just seems to me that we spend way too much time on worrying about how much we we can get out of our patients and not doing everrything we can to help our patients.	
11	Oct 18, 2012 1:51 PM	I have personal ties to Houston and I know the greatness that can be accomplished at MDACC. However, the administration is making it harder and harder to do great things. They take advantage of the drive and determination of the faculty who works until the goal is accomplished and the barriers are overcome.	
12	Oct 18, 2012 1:29 PM	Will try to survive here.	
13	Oct 18, 2012 2:20 AM	No ability to make changes. Beuracracy just keeps getting bigger and bigger. Solving problems are just done by more beuracracy. Please somebody study derek ragahvan and act like he acts. We need that badly	
14	Oct 18, 2012 1:51 AM	Overworked, underpaid, ignored, frustrated.	
15	Oct 18, 2012 1:19 AM	I have no support from my division head because I have never met him. As an Assistant Professor justing starting out a career, I feel zero support from my divsion chair and nominal support from my department chair. It seems to me that my department chair, all full professors, and associate professors in my department are very worried about the encroaching adminstration and do not have the ability to lead the department or support young faculty. Because of these reasons, I feel that it is very likely that I will be leaving MD Anderson in the near future.	
16	Oct 18, 2012 12:17 AM	Promotion and tenure is not objective at this institution. I see people hired with limited experience into tenure track positions and folks like myself are stuck in non-tenure positions despite grant funding and productivity. Its sad when department chairs run departments like dictators. I should have left a long time ago	
17	Oct 17, 2012 11:59 PM	I want to stay , but if it continues to be so dysfunctional, I will be forced to find another job.	
18	Oct 17, 2012 11:09 PM	About time to retire.	
19	Oct 17, 2012 11:00 PM	I don't want to leave, but the future seems increasingly nebulous. I have little faith in the institution's commitment to the welfare of individual faculty members	
20	Oct 17, 2012 10:49 PM	Limited role for academic physicians in the "new" MD Anderson.	
21	Oct 16, 2012 9:33 PM	MD Anderson is the best place to work at.	
22	Oct 16, 2012 7:11 PM	I love my work, patients and people I work with and only want what's best for MDACC,	
23	Oct 15, 2012 10:21 PM	The institution will fail within 10 years	
24	Oct 15, 2012 5:04 PM	Not sure. I am hoping my spouse wants to move so that I can get out of here.	
25	Oct 15, 2012 4:21 PM	In the past people in my department passed on external chairs to remain at MDACC and further their efforts/careers here. I think in the future, more will jump on external chair options.	
26	Oct 14, 2012 7:11 PM	Basic Science seems to have a low priority in the institutional mission. I feel like my research may no longer fit.	
27	Oct 12, 2012 4:56 PM	Current administration focus and priorities. Lack of confidence	
28	Oct 12, 2012 12:23 AM	Cannot sustain this kind of lack of facilitation of effort Working 13 hr days on average	
29	Oct 11, 2012 8:45 PM	Natural progression of career path.	
30	Oct 11, 2012 2:39 PM	In the past I would not even have considered leaving, but currently I am at least considering alternatives.	
31	Oct 11, 2012 1:41 PM	Maybe-- I want to be able to provide the best clinical care I can to patients, and the institution makes this difficult. If things don't improve, I think I can serve patients better in a smaller system or private practice.	

32	Oct 10, 2012 10:25 PM	Currently, I would pursue other positions should a good one become available. I am very concerned about the environment being created at this institution under the current administration.
33	Oct 10, 2012 7:10 PM	Because of family restraints I am unlikely to leave soon, but will at the drop of a hat "jump ship" .I keep my eyes and ears open for an alternative.
34	Oct 10, 2012 5:49 PM	Hard to say at this point
35	Oct 10, 2012 4:34 PM	If I'm unable to secure grant funding, which is increasingly difficult, I may be forced to leave.
36	Oct 10, 2012 3:10 PM	Too big an organization without personal relationship and contact with administration.
37	Oct 9, 2012 11:23 PM	I am very proud to work at MDACC and have not yet found another institution with the special opportunities this one has provided me in the clinical and research spheres.
38	Oct 9, 2012 6:12 PM	I would leave now if I could find the right position. MDACC is poisonous now. We have internal competition rather than teamwork.
39	Oct 9, 2012 5:16 PM	Retirement.
40	Oct 9, 2012 4:10 PM	Really not sure about it.
41	Oct 9, 2012 4:02 PM	The institution no longer values its faculty. Why should I continue to beat my head against a wall.
42	Oct 9, 2012 1:13 PM	Too old to change now, but would love to be able to walk out the door.
43	Oct 9, 2012 11:13 AM	loss of academic time. working for revenue.
44	Oct 8, 2012 11:11 PM	Retirement.
45	Oct 8, 2012 10:08 PM	MD Anderson continues to be a very hostile working enviroment. I am very happy with the care I provide to my patients and I feel great personal satisfaction for that, but my department chair continuously expresses disappointment that I don't publish. He expects me to dedicate my little time off to being in my office and writing papers, instead of being home with my children. He makes me feel that I should be in private practice and not in an academic institution.
46	Oct 8, 2012 9:29 PM	Aggressive competition, lack of moral support.
47	Oct 8, 2012 9:12 PM	I'm interested in a successful career.
48	Oct 8, 2012 9:10 PM	As long as I am productive and feel wanted, I will stay. If either is no longer the case, I will be very uncomfortable remaining in my job.
49	Oct 8, 2012 9:00 PM	This is unclear at the moment. Never say never....
50	Oct 8, 2012 8:45 PM	Superior technology (diagnostic and IT) and commitment to comprehensive quality care, a constant effort that requires measurement and change. I can give specific examples, but am certainly concerned that it would give away identity, at least of department.
51	Oct 8, 2012 8:43 PM	MDACC is a great institution and I am a hopeless optimist that the situation can be improved.
52	Oct 8, 2012 8:39 PM	I like what I do -
53	Oct 8, 2012 7:42 PM	basic research not as strong as I hoped
54	Oct 8, 2012 7:36 PM	I am a positive person and will try to make things work here and try to raise the morale of people around me. It is sad to see my colleagues leaving, and it is not fun to have long-term uncertainly. Instead of waiting a long time for an external leader, perhaps we should make faster decisions and make use of our excellent internal candidates instead of watchng them being recruited away.
55	Oct 8, 2012 7:22 PM	Lack of support and rapidly fluctuating priorities in the institution.
56	Oct 8, 2012 7:11 PM	I feel a certain amount of commitment to the institution and to my colleagues, but things have got to change for me to want to stay much longer
57	Oct 8, 2012 6:17 PM	This is no longer a desirable place to work.
58	Oct 8, 2012 4:52 PM	I am well compensated, but find the institution unwieldy, excessively bureaucratic, and within my department, much more isolating than other institutions I have been. People are friendly, but at the same time, it feels very non-collegial.
59	Oct 8, 2012 4:52 PM	Would consider a chair position elsewhere. Actively looking.
60	Oct 8, 2012 4:37 PM	I've already pledged to stay and fight the good fight. I'm not leaving unless asked to or we reach a point where my ability to provide for my family becomes an issue. At this time, I continue to pass up offers abroad as politely as I can believing that this is all 'temporary'.
61	Oct 8, 2012 4:25 PM	Why would I stay at this new biotech company run by the president and his wife? If I wanted to be in pharma or biotech, I would have left a long time ago.
62	Oct 8, 2012 4:24 PM	Working here is no longer fun.
63	Oct 8, 2012 4:08 PM	Need better enviroment to conduct research. Previously, I loved to work here and declined offers for job outside. Now I am open to finding better enviroment.
64	Oct 8, 2012 4:07 PM	personal
65	Oct 8, 2012 4:05 PM	Cannot stand the amount of paperwork and slowness of hiring new people hopefully some reforms will be done within 5 years
66	Oct 8, 2012 2:48 PM	I do not like the new attitude or approach of the new leadership.
67	Oct 8, 2012 2:36 PM	Retirement
68	Oct 8, 2012 2:31 PM	retirement
69	Oct 8, 2012 2:30 PM	At this point, if I had a chance, I would highly consider leaving. However, given the investment I've made in time and effort at this institution, I would have to give up a lot.
70	Oct 8, 2012 1:53 PM	I believe we still have potential for greatness and providing the world with better opportunity for improved care and survival from cancer. I will likely assume a leadership position as more disgruntled and burnt out current leaders exit. Fresh ideas and a positive vision on the individual faculty basis will lead to vast improvements. We are stepping up our game.
71	Oct 8, 2012 3:35 AM	The pace and rythm of work leads to burn out.
72	Oct 6, 2012 6:23 PM	There is a point at which I will chose to retire rather than put up with another unpaid mandate or edict which interferes with my ability to care for patients and do research here.
73	Oct 6, 2012 4:50 PM	I have received some offers from other academic institutions. One of them is very attractive.

74	Oct 5, 2012 11:10 PM	how can we stay and work in the caustic environment where the rules are different for the Prez and his wife than for the rest of us.....it is too late for an apology...they need to go, so MDACC reputation is restored...we are not going to cure cancer, but we are going to impact patient care with increased demands on clinicians, and will tarnish the institute for decades to come....pathetic
75	Oct 5, 2012 9:56 PM	The last time I took a survey like this, I said that I would never leave. now, the morale in my Division is so bad and our ability to accomplish necessary things so impared, that I think I might have to leave. I hope not.
76	Oct 5, 2012 9:56 PM	Not likely - unless the President decides get rid of people besides the leader who disagree with him. How can anyone be expected to be able to give their ideas with this kind of retribution.
77	Oct 5, 2012 9:44 PM	If I was offered a position elsewhere tomorrow, I would accept it
78	Oct 5, 2012 8:28 PM	Retirement
79	Oct 5, 2012 8:24 PM	I have thought about leaving already. I stay because I think that what we do is important and cannot be done by others at this time. If the work I do is not appropriately supported (by example and inclusion) I will go to where the work itself is appreciated. My chair and division leaders do support me and my work. It just does not feel as though higher leaders care enough.
80	Oct 5, 2012 8:03 PM	I know that I am complaining but I have so much appreciation for MDACC , its programs and faculty that I want to see this through and improve our research and clinical practice so that MDACC is better off because of our activities and achievements.
81	Oct 5, 2012 5:59 PM	unsure, will have to see how things go
82	Oct 5, 2012 5:23 PM	Retirement
83	Oct 5, 2012 5:12 PM	If the administration continues to ignore and treat poorly the faculty, I will leave
84	Oct 5, 2012 4:48 PM	As of now, don't know.
85	Oct 5, 2012 4:35 PM	the working conditions are getting worse. we are expected to see more and do more just because admin demands it. doesn't add up.
86	Oct 5, 2012 4:18 PM	No room to grow. People do not have the incentive or brains to cure the diseases and therefore we will be stuck.
87	Oct 5, 2012 4:08 PM	Lack of upward mobility.
88	Oct 5, 2012 3:55 PM	I love to work at MDA. I do not fill the survey in the issues I have no comments because I don't have contact with patients. In five more years I will probably retire. I think that the institution may improve in some particular issues like the travel expenses. Usually it takes long time to collect the money back. And also the air tickets that have been purchased through the institution are usually higher price than if we buy ourselves.
89	Oct 5, 2012 3:19 PM	I would like to stay, but the current track the instituion is on may not be sustainable to retain good investigators. Some of the outstanding faculty have already left. likely from sensing the foundation being overstressed.
90	Oct 5, 2012 3:19 PM	I have finally got so fed up with the charades here and cannot see that it will go anywhere but worse. I will leave when I cannot take it any more even though my research and patient care responsibilities still are as exciting as twenty years ago.
91	Oct 5, 2012 3:16 PM	maybe retire or at least cut to part time
92	Oct 5, 2012 3:13 PM	family
93	Oct 5, 2012 3:02 PM	MDACC rewards physicians by promoting them to administrators. This is how the current MBA/MHA administrators protect themselves. They figure if they promote an outspoken physician to administrator it will dampen their enthusiasm for complaining. And they are correct. It is very troubling to see my own colleagues view administration as the pinnacle of their careers and I see no end of this behavior. I believe the only way out for me would be to go to a smaller institution where clinical care is valued and where there are fewer administrative layers. I have actually been offered administrative positions within MDACC and have respectfully declined because I see it as a dead end.
94	Oct 5, 2012 2:42 PM	Ever increasing clinical demands which results in decreasing time for academic activity. The majority of the clinical faculty do not practice at M.D. Anderson so that we can have a "private practice-lite" career. We choose to work here so that we can conduct clinical research to advance our field, which is increasingly difficult when our clinical load is increased every year. If we wanted to increase our clinical load, we could work in private practice and make at least double our academic salaries.
95	Oct 5, 2012 2:40 PM	Afraid we will go bankrupt before i can access my retirement
96	Oct 5, 2012 2:34 PM	I believe in the MD Anderson mission and our potential to do great things. I am dedicated to taking care of the patients we have before us right now and would not want to abandon them.
97	Oct 5, 2012 2:31 PM	I am approaching retirement age and will probably retire within the next year. However, even if I were not, I would be looking for a new position. I do not feel that the changing academic climate at M. D. Anderson is conducive to the pursuit of the sorts of basic biological questions that are of passionate interest to me.
98	Oct 5, 2012 2:25 PM	retirement
99	Oct 5, 2012 2:20 PM	I am committed to MD Anderson. I am enthusiastic about our potential for increasingly impactful science, but am also at the same time concerned about the direction we are moving.
100	Oct 5, 2012 2:13 PM	I doubt I will live up to new leadership's standards for promotion at this institution
101	Oct 5, 2012 1:51 PM	As senior as I am, and with term tenure, I feel undervalued (except for my salary and benefits) and very concerned about research funding for the remaining years of my career. I see no opportunities for leadership for myself in this institution and the increasing demoralization is driving me to look elsewhere.
102	Oct 5, 2012 1:49 PM	Due to the increasingly burdensome IRB and clinical research environment at MDACC it is very difficult to do the work I love. The IRB/clinical research oversight should be trying to HELP us do clinical research, rather than impose further rules.
103	Oct 5, 2012 12:48 PM	While I gripe a lot, MDA is really a great place to work. I like the people I work with, and my chairs over the years have been very supportive

104	Oct 5, 2012 12:33 PM	I am fully engaged in my work and enjoy the scope of activity here.
105	Oct 5, 2012 11:56 AM	Patients
106	Oct 5, 2012 11:33 AM	Great institution to work. But, hard to see how the promotion will be decided for the administrative side.
107	Oct 5, 2012 3:57 AM	The pay is not bad, compared to other academic institutions. Plus, faculty oppression by administration is common nationwide.
108	Oct 5, 2012 3:22 AM	I think that the new leadership has decided what needs to be done in many avenues, and is not listening to the input provided from the current faculty, even when it is solicited. While the leadership has tremendous knowledge and expertise in laboratory research, this is not necessarily translating into an understanding of the reality of clinical operations. The reasons that we are hearing that support several recent dismissals seem unrealistic and unfair. Between this and the highly publicized ethical conflicts, it is becoming difficult to be proud to be a member of this institution, and thus difficult to strive to make it succeed.
109	Oct 5, 2012 3:11 AM	Loss of trust. External retribution against faculty given unethical behavior of our upper administration.
110	Oct 5, 2012 2:59 AM	I am going to retire before they turn the place into the number 1 Cancer Corporation
111	Oct 5, 2012 2:49 AM	No confidence in leadership.
112	Oct 5, 2012 2:33 AM	Warts and all (both the institution's and mine), there is not a better place to ply my trade than at MD Anderson.
113	Oct 5, 2012 2:05 AM	Family in Texas
114	Oct 5, 2012 1:51 AM	Depends on the job offers.
115	Oct 5, 2012 1:31 AM	still a great place to work.
116	Oct 5, 2012 12:30 AM	My fellow faculty are amazing people and I am inspired and energized by them.
117	Oct 4, 2012 11:57 PM	Given the changes and developments over the last year and resulting changes in vision and culture, I am asking myself if there is any room for a basic scientist like myself. The reasons why I decided to join the institution have mostly fallen by the wayside.
118	Oct 4, 2012 11:34 PM	When I started here - I thought this would be a permanent position. However, I am now exploring other options because the academic support for clinical faculty has become much less of a priority since I began my position. I did not stay here after fellowship to be a clinical workhorse - I have interests in advancing the field through translational and clinical research. There is less respect for clinicians that participate in research. If I am going to be asked to meet metrics equivalent to those clinicians in private practice, then I should be compensated as such.
119	Oct 4, 2012 11:22 PM	Until recently have not seriously considered leaving.
120	Oct 4, 2012 11:21 PM	Time to go
121	Oct 4, 2012 11:14 PM	It's the president's perogative to hire whomever he wants and lead the institution in whichever direction he wishes. I feel that this effort is not likely to generate advertised results, which appear to be being less and less bold ast time goes on. I feel that granting a waiver for the president to pursue his own financial interests with MDACC resources wil be a fatal error for the institution. So really, who wants to work under these demoralizing conditions when there are other options?
122	Oct 4, 2012 11:00 PM	Despite my gripes about leadership from my department up, I like my colleagues, patients and support staff. We are doing good work. We need a leadership that truly appreciates the clinical effort that is put forth each and every day.
123	Oct 4, 2012 10:58 PM	chair and division head have poor leaderships and poor understanding of novelty of basic science research.
124	Oct 4, 2012 10:55 PM	I might leave is a better opportunity arises
125	Oct 4, 2012 10:53 PM	The institution has become a dictatorship ruled by the new president and his royal family and entourage. There is an atmosphere of "before" and "after" with most of us from the "before" era viewed with contempt.
126	Oct 4, 2012 10:49 PM	This is no longer an institution, but a corporation run by lawyers and entrepreneurs. There is no concern for our patients or for our faculty or staff. We are no longer physicians, we are "providers"
127	Oct 4, 2012 10:41 PM	this is still a better place but concerned about the long term future and would consider outside opportunities.
128	Oct 4, 2012 10:37 PM	The burden the administration is placing on us is excessive, and leaves less time for research. I am concerned that we are losing sight of what makes M. D. Anderson great, and what works well. Patients come here for clinical trials. Without them, they will go elsewhere. We need more support at the department level. I personally feel my own department and chair is great, but is feeling pressured by the burden to do more with less. Patients can tell when it is compromising their care and will vote with their feet if they no longer get the best possible care.
129	Oct 4, 2012 10:32 PM	At this point have no plans to leave but would certainly consider it if an offer that was too good to refuse were to come along.
130	Oct 4, 2012 10:31 PM	I value my health and well-being. I have to get out of here while I still can.
131	Oct 4, 2012 10:29 PM	I don't wish to leave the instituton as I am passionate about the potential this institution with all of its resources has; however, I dont believe we are paying enough attention to really delivering the best patient care. Too often other motivations drive our operations. How are we (MD Anderson) going to be judged comapred with Mayo Clinic or Cleveland Clinics of the world where far more attention is paid to being at the forefront of healthcare reform- - we deliver rather spotty and wasteful care; albeit most often compassionate. We need to become more focused on rising up to the challenge of limited resources in health care and health care reform. I
132	Oct 4, 2012 10:27 PM	Retirement
133	Oct 4, 2012 10:27 PM	Lack of funding. For the last 16 years I have always being able to cover my salary, but is seems that in the very near future, I may be out of a job.

134	Oct 4, 2012 10:24 PM	I am growing increasingly disillusioned with MDACC. I am having increasing clinical pressures put on me, which is causing my research time and academic time to shrink. I have a hard time adequately supervising graduate students and trainees in my research lab. I like to work hard, but everyone has their limits, and I think I am rapidly approaching mine. I have 10+ years experience here, yet it is much harder for me to complete my clinical duties today than it was when I first started here! How can that make sense?? I can work less hard at any number of equally prestigious insitutions and have far greater job satisfaction. I would have checked the 1 year circle above, but I have sworn to myself to gut it out here for a few more years until my children finish high school. I would rather punish myself than punish them.
135	Oct 4, 2012 10:17 PM	Overall, faculty have great positions and opportunities here. However, working with the administration -- who have decision making authority on key hires and policies -- can be frustrating!
136	Oct 4, 2012 10:06 PM	lack of confidence in direction of institution policy and overburdening adminitration.
137	Oct 4, 2012 9:58 PM	I will probably be told to leave in 5 years because I won't live up to MDACC standards, I would consider leaving if I obtain more extramural funding
138	Oct 4, 2012 9:55 PM	Run out of funding and unable to secure additional funding.
139	Oct 4, 2012 9:47 PM	I don't know. It really depends on how the leadership ends up leading.
140	Oct 4, 2012 9:45 PM	Academic freedom is in jeopardy.
141	Oct 4, 2012 9:45 PM	might retire
142	Oct 4, 2012 9:44 PM	Glass ceiling. Research environment is degrading due to lack of leadership in my area.
143	Oct 4, 2012 9:36 PM	There is no respect for non tenure track faculty in the Department of Experimental Radiation Oncology (ERO). NTRAs are not allowed to participate in ERO's faculty meetings and other meetings that could benefit us.
144	Oct 4, 2012 9:36 PM	Worried about job security
145	Oct 4, 2012 9:35 PM	Need to see some innovative, effective approaches to managing a research and clinical enterprise with appropriate alignment of incentives, strategy, and financial goals. If not, then I will look for a place that will.
146	Oct 4, 2012 9:27 PM	1. Many decisions are made by the same small group of influential individuals. But only few of these individuals have any knowledge of my dield (computational biology) i feel that my input could be valuable to the institute but I do not see a way of communication. The recent massive operation on securing laptops and desktop computers is an example of the wrong people in charge of IT affairs. It is frankly ridiculous that a hospital the size of MDACC wakes up in 2012 to realize that their systems are unprotected when stolen or lost. 2. I am getting tired of the amount of unnecessary and restrictive regulations. MDACC is ran by administrators whose aim seems to be to regulate everything in life from behind their desk. 3. I do not feel any binding with the institute whatsoever, whereas I certainly felt connected to the institutes where I worked previously.
147	Oct 4, 2012 9:26 PM	chair-imposed absence of possibility to transition from NTR to tenure track, despite track record of publications, funding and leadership.
148	Oct 4, 2012 9:25 PM	This is no longer a hospitable environment for the type of relatively undirected basic science research that I perform.
149	Oct 4, 2012 9:24 PM	This is not academia any more, where quality science it valued. It is becoming a pharmaceutical company whose goal it to make drugs that make DePinho richer, that are very likely to not work in the clinic if the past predicts the future.
150	Oct 4, 2012 9:24 PM	It is very disappointing that 2 people can bring this institution down in such a short period of time. Even with participating in the "Moonshot" programs, it is clear that if we don't all get in line with their agenda, meet their goals and milestones, in the words of Dr. Chin, we will be fired. I came here because I wanted to be part of the greatness that is MD Anderson. These individuals, who have little in the way of true drug development experience, are in the process of dismantling what worked here and replacing it with a pseudo-pharma company. This is lunacy.
151	Oct 4, 2012 9:23 PM	Low priority on young faculty coupled with monopolization of internal grant funds. Low perception of institutional loyalty to young faculty.
152	Oct 4, 2012 9:23 PM	Looking for less administrative burden, more support for faculty, real tenure (not just "term" tenure).
153	Oct 4, 2012 9:20 PM	I am in my 1st year of tenure position. I will likely stay for another 6-7 years (hopefully more).
154	Oct 4, 2012 9:20 PM	Am invested in the mission and my patients. Nonetheless, would like a better work environment.
155	Oct 4, 2012 9:19 PM	This is an unclear question. I am not looking to leave however I may recveive an offer in the next 1 to 5 years that may justify the need to leave. I cannot answer this question
156	Oct 4, 2012 9:16 PM	I hope not to leave. Ask me again in a year.
157	Oct 4, 2012 9:15 PM	I am concerned about the integrity of the institution, the diminishing value placed on the faculty by the administration, and the increasing institutional bureaucracy. I worry about the sharp turn towards pharmaceutical-oriented goals the institution has taken.
158	Oct 4, 2012 9:13 PM	I once would've said that I would work for MDA until I couldn't work any more - now I hope I can hold out until my retirement at 65. It has become a race between my growing disquiet and meeting my financial goals.
159	Oct 4, 2012 9:12 PM	Tired of dealing with abusive leaders and monstrous adminstration system that becomes larger every day. Importantly, doesn't seem that there is any hope for change or imporvement. The institution is great, unfourtnately administration and some of the leadership are just horrible,and the sad thing is that everybody knows, remember the BIG SURVEY.
160	Oct 4, 2012 9:12 PM	Promises that were made to me when I was being recruited, including many that were in writing, were not kept. My perception prior to arriving was that there was room for academic and personal growth at this institution, but in fact the overwhelming administrative burden results in more effort being spent on support tasks rather than on clinical or basic research.
161	Oct 4, 2012 9:10 PM	had enough. No fun anymore.
162	Oct 4, 2012 9:10 PM	See above. I can't wait to get the hell out of here!
163	Oct 4, 2012 9:10 PM	If the support of clinical faculty does not improve in a meaningful and sustainable manner, faculty will look to other institutions or job prospects. We believe in the mission of MDA and care deeply for our patients. Our colleagues are amazing. But that may not be enough to hold excellent faculty if the administration does not listen to our concerns, change their management style, and enable changes to improve our work environment.
164	Oct 4, 2012 9:06 PM	- I don't feel there is any opportunity for me to advance in my career here

165	Oct 4, 2012 9:05 PM	Even if I receive a career development award (as an Instructor), I probably won't have the opportunity to move to a higher faculty position.
166	Oct 4, 2012 9:04 PM	Funny you should ask!
167	Oct 4, 2012 9:03 PM	Only if they don't change how things are going !!!
168	Oct 4, 2012 9:02 PM	If I don't see that things improve over the next couple of years then I will give serious consideration to finding another appointment at another academic institution. We are constantly being asked to do more and more to the point that my quality of life is very poor.

Faculty Survey 2012 (Question 17)

Please share any additional comments you may have.

Answer Options	Answer Options	Response Count
		114
answered question	*114*	**114**
skipped question	*400*	**400**

Number	Response Date	Response Text	Categories
1	Oct 20, 2012 2:21 AM	Really, my biggest concern is with Clinicstation. It is, by far, one of the slowest and cumbersome systems I have encountered and is quite behind when you think of how great it could have been and when you consider how much funding and effort has been put into it. Before starting my medical career, I spent 5 years as a software developer and engineer. As someone who has created systems from the ground up and understands these systems, I can tell you that if ClinicStation was implemented and design appropriately from the start, we wouldn't have these current problems, and that was over 10 years ago. Now I hear that more decisions are going to be made about a possible new system that I have also worked with, and having met those making these multi-million dollar decisions, I worry that a "ClinicStation II" instance will occur. Decisions are being made by those that don't understsand these intricate computing systems and the advice they are receiving is also coming from those that are also limited in their understanding. When I started here, I asked to be on the steering committee and sent along my credentials and experience; however, I never even received a reply. I can tell you that I have more experience than the people on your current committee regarding computing systems and if you don't put people with computing knowledge on the team, well, you see what can happen and it looks like it's going to happen again.	
2	Oct 19, 2012 10:40 PM	I really care about the welfare of the institution! Also, I understand the importance of the moonshot program and I support it in principle. However, I am really very concerned that the program is underfunded and the difference is being funded, at least in part, by the revenue generated by the clinical faculty. If too much pressure is applied to the clinical faculty to do more clinical work at the expense of their own academic goals to conduct research and such that it potentially jeopardizes patient safety, MDACC's world class clinical faculty will start leaving the institution to find places where they can conduct their research and still carry a reasonable clinical load. This could ruin MDACC's reputation as the leading cancer center in the US while the goals of the moonshot program may or may not be realized.	
3	Oct 19, 2012 2:23 AM	The lack of input into decision making for the institution is not new, but nevertheless disconcerting. Recent upheavels in the top levels of administration of faculty and clinics, may be beneficial or not, but the lack of communication to the faculty creates anxiety.	
4	Oct 18, 2012 9:39 PM	I am very chagrined that the new administration of this institution has managed to provoke the local media into a witch hunt against us. Many faculty are concerned that our culture is changing for the worse.	
5	Oct 18, 2012 9:07 PM	I think that the Administration should put its money where its mouth is in a ral way. I believe that we are here first and foremost to take care of patients. The beaurocratic quagmire needs to be streamlined and make things work better instead more complexity is created.	
6	Oct 18, 2012 8:01 PM	No matter what Ken Shine promised the DePinhos, there is a major conflict of interest and they need to know that it taints how they are viewed within MDACC by the faculty.	
7	Oct 18, 2012 7:24 PM	Believe Ethics should be involved	
8	Oct 18, 2012 3:45 PM	I love working at MD Anderson but it can't start on this negative slide. We have to keep it #1 and the doctors are at least some part of that. I can't believe I'm saying this but please don't forget about the doctors!!	
9	Oct 18, 2012 1:39 PM	The morale is also worse because there is increased internal politics (at least in my section).	
10	Oct 18, 2012 1:51 AM	The changes in leadership brough drastic changes to my day to day practice. I accept changes in the health care industry as a painful and unavoidable reality but I feel you are asking me to carry a heavy load while walking on a shifting floor... My part is to work harder but the administration part is to make sure I have the tools to do it efficiently. I just do not feel this has happened.	
11	Oct 18, 2012 12:17 AM	The institution needs to do a better job recruiting and retaining minorities	
12	Oct 17, 2012 11:59 PM	I think that Div/Dept leaders really have NO idea of what we do, how we work and what might be improved.....	
13	Oct 16, 2012 7:11 PM	I am concerned about faculty burn-out with the increasing pressue and demands of see more patients, publish more manuscripts, write more grants, do more with less, become more efficient, etc. Each year we are asked to do more and more.....By the time I return home daily, I am exhausted and cannot enjoy family time.	

14	Oct 15, 2012 5:04 PM	Good faculty are leaving!!! Why??? President appears to be doing what he wants, to his and his wife's benefit. Dr. DuBois' leaving is a big hit to research faculty and departments. Does Schein even realizehow badly faculty feel right now? Maybe we need to survey the thoughts of the public?? I think they made a mistake bringing Depinho in.....
15	Oct 12, 2012 12:23 AM	HELP the rainmakers!
16	Oct 10, 2012 10:25 PM	Moral is poor. The President is increasingly losing the trust and good will of the faculty.
17	Oct 10, 2012 9:03 PM	promotion and salary incentives should incorporate performance more heavily rather than the usual time in rank criteria.
18	Oct 10, 2012 7:10 PM	I see a world of possibility at MDACC esp within the faculty. I believe in the mission and have a strong desire to help patients by providing high quality care. I believe in my colleages. But I see a faculty beaten down and burned out. A departmental and divisional environmental mileau teaching faculty to keep their mouth shut, eyes closed and move under the radar to avoid being stompled and pulverized kills creativity and vision. .. Very unfortunate.
19	Oct 9, 2012 6:12 PM	I am very unhappy with MDACC at this time. I would like to leave and will try to find a position soon. The corruption and heavyhanded take over suggest worse days ahead.
20	Oct 9, 2012 4:31 PM	There appears to be a huge disconnect between the Administration and everyone else. People feel like their concerns are not being heard or addressed, and that the President is supporting his own agenda rather than doing his job and taking care of the institution.Also lack of confidence around president and his wife...they should be role models rather than repeatedly asking for exceptions.
21	Oct 9, 2012 4:04 PM	Morale is bad because several individuals who have had dissenting voices have decided to step down or leave their positions on the Faculty Senate, the IRB; lots of negative publicity in local media, oncology press (COI, CPRIT, nepotism) and skepticism in press/media about Moonshots; perceptions that leadership has removed strong division head who was willing to challenge leadership decision making. many concerned that reputation of MDACC is quickly eroding
22	Oct 9, 2012 1:40 PM	Too many rules! Everyone should be held responsible and to the high standards set. In other words the playing field should be more even!
23	Oct 9, 2012 1:25 PM	Although I feel the overall morale of the faculty in my Department has improved since the time of the last survey, I feel the institution as a whole has NOT improved in three major areas: (1) transition to a fully functional, "real-time" EMR system--by continuing to "patch" Clinic Station, rather than incorporate a newer EMR software program, I feel the Clinical Faculty and ancillary personnel will continue to experience inefficiency which ultimately negatively impacts patient care & the "bottom line" (2) transparency between upper level management, whether it is for physicians or staff, continues to be an issue which had led to distrust (3) inefficiency of communication systems--for example, requiring physicians to carry a Black Berry, cell phone AND pager (due to Black Berry outages & inconsistent AT&T cell signal in many parts of the Houston area (including my own house) in order to be fully functional needs to be re-visited
24	Oct 9, 2012 1:13 PM	Not one faculty member would still be here having done what DePinho and his wife have done. They are changing the clinical excellence of the institution. Patients complain a LOT about front services: ie, phone calls and appointments. This is going to lead to loss of lots of patients. No matter how hard we work in the clinics, if it is too frustrating to get to us, we'll loose our patients.

25	Oct 9, 2012 11:13 AM	we have to renew our cultural commitment to fearless attack oncancert--leading to cure, not becoming bigger and more controlled by financial-legal coalition
26	Oct 8, 2012 11:11 PM	We have to get more clear view of how the donation for us has been spent. I am the PI of cooperative group, but I never gets explanation how the funding was spent by our administrative people. Some of my patients donated money formy research which never came to me.
27	Oct 8, 2012 9:12 PM	The salary structure for the clinical faculty needs to be more transparent.
28	Oct 8, 2012 9:12 PM	I have not given up on DePinho yet, but I think there is a major communication gap with the hard core basic science departments (Immunology, Genetics, BMB, Molecular Carcinogenesis). Large areas of space are being reallocated, labs are being crunched, funding avenues are drying up, our bridge funding program is pathetic (<$ 1 million for the whole place compared to over 600X that for moonshots/year). There is no clear path forward for many investigators who sit in their offices all day and write one after another grants that will not be funded - what a waste!!!!!!! The Provost's office has instituted numerous overbearing and cumbersome policies that inhibit faculty success - faculty recruitment is overly complicated, our most successful faculty can't get sufficient extramural leave to attend study sections, and participate in other science activities that are highly beneficial to their careers and the institution. Worse, policy decisions affecting faculty are made by mid-level career bureaucrats in this office rather than by academic scientists. There are aspirations for enhancements to graduate programs but no actions have been taken that will signal to faculty that it is "safe" to increase participation at GSBS. Without this, efforts by our new deans may fall flat for lack of interested faculty. There is also a good deal of concern that the antagonism between the local press and our president has wasted a tremendous amount of goodwill from MDACC supporters. Whether well-intentioned or not, better sensitivity to public opinion going forward is vital.
29	Oct 8, 2012 9:00 PM	I love MD Anderson: our core values, the care we provide to our patients, and its potential, ambition, and vision. Unfortuately, without an oversight on the departmental level, positive energy and enthusiasm are at risk of completely being extinguished.
30	Oct 8, 2012 8:45 PM	There is a failure to convey understanding of the clinical workload and commitment to make patient care efficient and safe for the sake of the patients who come to us with the highest level of trust that we are a top institution delivering the best possible care. Changes are happening (e.g., bar codes, ePrescription), but some critical aspects are so slow (e.g., data-mining capacity, CPOE/EMR) that it gives the impression that leadership is not aware or not committed to developing a system that allows efficient care with ability to measure and change. We have outstanding people who work at every level of our institution, but it is frustrating to see these committed individuals "cutting grass with razor blades". In other words, they are working with technology infrastructure barely adequate for a 100-150 bed community hospital, but wholly inadequate for a hospital with the size and complexity of patient population that we have. I'm concerned that patients may pay with their lives for mistakes made from lack of infrastructure. Nothing is perfect, but we are simply too far behind without evidence of a strong investment to move forward in this regard.
31	Oct 8, 2012 8:42 PM	I have been a faculty for less than a year, so I do not feel qualified to make opinions to all of these questions contained in this survey. Nevertheless, I have been at this institution for more than 5 fives.
32	Oct 8, 2012 7:42 PM	The new leadership needs to listen and do more from bottom up
33	Oct 8, 2012 7:34 PM	The current trend goes against the institution's Vision and Mission. Using computer technology we would be able to cut down on paperwork, improve efficiency and alow doctors and nurses spend more time with their patients rather with their computors.
34	Oct 8, 2012 7:11 PM	It's the lack of transparency that drives me crazy; i used to know where i stood and now i don't; leaders are losing their jobs for no apparent reason; the faculty are on edge
35	Oct 8, 2012 4:52 PM	I was not here at the time of the last faculty survey and therefore cannot answer most questions. Research Instructors are merely post-docs - perhaps not at the institutional level, but at the department level it is the case.
36	Oct 8, 2012 4:52 PM	The administration has run this place into the ground.

37	Oct 8, 2012 4:37 PM	I love MDACC, but the flood of bureaucrats and professional administrators, who each seem to be further removed from cancer care, but endowed with more power than the last, appear to be dragging this institution into the ground. It seems to really boil down to: How do we manage an enterprise this large effectively? How do we implement the cancer care expertise of our faculty effectively over such a large enterprise? How do we learn, from each patient, how to more effectively treat the next? Where is the balancing point between clinical care, clinical research, research, education and faculty time? Why do we continue to grow brick and mortar, add beds, and add equipment, but not add appropriate levels of staff and faculty? It would also appear that, for an institution of this size, the staffing models may go non-linear and need to be re-evaluated. Competition is like fire, it burns hot, fast and along any random path that feeds it. Competition, is for short term projects, it most certainly isn't for long term stability, sustainability and effectiveness. All that comes from taming the fire and using it judiciously ...
38	Oct 8, 2012 4:32 PM	I am a relatively new employee and thus could answer ONLY a few questions.
39	Oct 8, 2012 4:25 PM	I am losing desire to work at this institution. I would prefer to make my contributions to science at an institution that is more conducive to collaboration and that is not run by a Politburo.
40	Oct 8, 2012 4:22 PM	Thank you for doing this survey.
41	Oct 8, 2012 4:05 PM	I would suggest a 20-30% budget cut to administrative units so that they can learn how to operate more efficiently. Also, eliminate TAA and FAA to that some work can be handled at Dept/Div levels.
42	Oct 8, 2012 2:30 PM	This is a very scary time for academics here. One feels the need to keep one's head down and not draw notice for fear of losing one's job. Not pretty!
43	Oct 8, 2012 1:53 PM	Fear is in the air and a sense of doom and gloom. The faculty are waiting with bated breath for the system to crumble, for our leaders to be asked to leave, for there to be a mass firing of non-essential employees and clinical personell. Sounds sad and it is. Not sure how we can reverse this but it must happen or else it will become reality.
44	Oct 8, 2012 7:48 AM	Research faculty need to be able to apply for extramural funding competitively. If a research faculty is not on tenure track or tenured, he or she is ineligible for many grant opportunities. The non-tenure-track research faculty has to work harder to find other opportunities, he or she is at a competitive disadvantage, his or her career is hindered, and he or she is not rewarded by the university at an appropriate level. In this scenario, retention of our best research faculty is impossible.

45	Oct 6, 2012 8:48 PM	My Division Head (Anesthesiology and Critical Care) has been in position for over 10 years. Under his watch two Chair's of National prominence in Anesthesiology have come and gone, because of his paranoia and incompetence. While all my points are directed at him, I am writing this so that the senior executive team can wake up from their slumber and open their eyes and ears to the issues we have had. This is not new news. We have had these issues for a long time. Being a division in the number cancer center in the world, we have not had leadership to advance our specialties (in the three departments) in the cancer care continuum. There is a great opportunity for the three departments to be the national and international leaders in this field. Where better to start that than at MDA ? Forget the Moon Shots, this is a realistic shot in our mother earth. Attempts locally have not been encouraged and openly discouraged. The three departments have great talent in their Faculty. However, the Division head does not believe in his Faculty. At a time when the Division could have lead the nation and the world in contributing to perioperative cancer care delivery, he has not supported such interests and activities and in fact has discouraged them. He does not engage in any activities of his departments at local, State or National levels. If he is disengaged how can he support his Faculty advance their innovative ideas and careers? He has openly stated that " we are not into educating others ", in direct contradiction to the institutional mission. Most Faculty are not comfortable going to him for any advice. In fact they are scared. People don't speak their mind when he is at faculty meetings or M&M meetings. His comments at M&M are accusatory and demeaning rather than being constructive. He does very little clinical work, how would he know the challenges ? When he does, the people running the board give him healthy patients coming for minor procedures and a good CRNA so that no harm comes to the patient. I wonder how doing a 2 hour anesthetic at most once a week, can be OK to be given privileges for clinical anesthesia in a highly demanding patient care environment. Let him perform cases on his own and evaluate if indeed he can be given privileges. His world is all about "looking good". He does not encourage new ideas and does not " want attention ". He is risk averse. Faculty and staff who have interacted with him at all levels (Nursing, Surgery, PI, Anesthesiology, Faculty Development, and his own administrative staff) openly joke about his unpredictable personality. However, the sad thing is in spite of senior leadership being fully aware they have turned a blind eye. You will get a true picture if the Ombuds Office conducts a strictly confidential inquiry with representatives from all groups in the Division as to the leadership in the Division. He may have value he brings to the institution, and the institution has to leverage his value that best serves the institution, being a Division Head, being a role
46	Oct 6, 2012 8:18 PM	Dr. Hong's new mandate is short-sighted and not supported by facts or data. The decline in clinical trial efficiency is not from poorly-designed trials, but from the incredible explosion in regulatory burden, persistence of dysfunctional outdated systems, and slow response/process times. Dr. Hong's new system did not fix the problem, he just made it worse.
47	Oct 6, 2012 6:23 PM	It has become increasingly impossible over the last 5 years to DO ANYTHING here that is novel or creative here. We are seen as money generating providers rather than physicians who need to have input into the policies that are made and passed down from above.
48	Oct 6, 2012 3:11 PM	NA
49	Oct 5, 2012 9:56 PM	The "witch-hunt" mentality of those overseeing clinical research rules and regulations is having a disasterous effect on this institution.
50	Oct 5, 2012 9:56 PM	M D Anderson has a long a proud history of providing excellent- novel lfe saving therapy. In the newpapers we appear to be a money making operation for the president and his wife at the expense of the faculty and the institution. I am embarrased and disappointed.
51	Oct 5, 2012 9:44 PM	Faculty need to Stand-Up-2-Bullies in the Senior Leadership
52	Oct 5, 2012 8:03 PM	There is so much opportunity with Dr DePinho , his programs and leadership but he needs to give others in the organization the opportunity to assist, even disagree and contirbute to these goals so that they can become a part of the process as we go forward. If we are all in this with open communication and consenses building then the height of our achievements can truely be stellar.
53	Oct 5, 2012 7:35 PM	I love my job, and really enjoy working at M.D.Anderson, but it is a huge clinical workload, senior faculty often dump clinical and teaching responsibilities to the junior faculty (while running off to deal with administrative duties or research) and there is increasing pressure to do novel research without allowing time, without experienced mentors, and without appropriate resources.
54	Oct 5, 2012 4:18 PM	Good luck. It is near impossible to chenge the poor habits/ work ethic that the people have here.
55	Oct 5, 2012 4:08 PM	MDACC is a terrific place to work (most of the time)! Our President's emphasis on clinical and academic excellence is correct. It will take time for this to percolate through the institution. And, it is clear that changes are needed if we are to remain successful and complete the moonshots.
56	Oct 5, 2012 3:55 PM	The breach between salaries and PRS benefits between Clinical and research is too big. The top level of salaries within a particular department among researchers at the same academic rank doesn't allow to award the individuals that work and and obtain more benefits to the institution than others.

57	Oct 5, 2012 3:19 PM	I am very fond of MD Anderson, but it may unravel at the seams if the instituional resources (especially the personnel) are placed under greater stress.
58	Oct 5, 2012 3:19 PM	N/A
59	Oct 5, 2012 3:13 PM	N/A
60	Oct 5, 2012 3:02 PM	I have only been faculty for one year and cannot truthfully answer the questions.
61	Oct 5, 2012 3:02 PM	We should put together a task group of physicians to address the issues of administrative bloat within our own ranks. We keep hiring more physician administrators who need people to administrate over. So they hire more physician administrators. Four recent examples would be the Provost position where we now have 3 provosts, the department of radiation oncology where there are now two department chairs, academic affairs where there is a new Vice President of Medical Education, and the Vice President of Regional Care position being held a very capable sarcoma surgeon. I am all for professional development, but who is supposed to see the patients when we keep "promoting" physicians to these administrative positions? We are taking physicians that could be generating millions of dollars in revenue and should be curing patients of cancer and the only activity MDACC values is having them sit in meetings telling other people what to do. This problem needs to be addressed by the Senate. While the Senate often blames the administrators for our troubles I believe many of MDACCs problems are actually self imposed by the physicians themselves.
62	Oct 5, 2012 2:40 PM	Perhaps the senate should suggest that the administration read the faculty blog if they want an opinion of how the faculty views the atmosphere here
63	Oct 5, 2012 2:34 PM	I certainly understand the importance of research. My experience is that the bureaucracy, red tape, and egos encountered when trying to do research often doom projects to failure. The disconnect between the clinical utility and practicality of research efforts and the expectations/aims of administration and "pure" researchers seems greater than ever and truly "lost in translation". Excellent clinical faculty are rewarded in terms of the appreciation of patients, but I do not personally feel that they are valued by much of the administration. With the (atleast perceived) firing of Dr. Pollack as the division head of surgery, this point is hammered home, and we have lost the guidance (and will probably lose as faculty when he is snapped up by another institution) of an amazing clinical advocate. "Other patient-centered, practical clinicians be warned!" is my perception of the environment. I hope there is still a place for faculty who want to concentrate on helping our current patients, but the pressure I have personally felt/experienced to do more "bench-type" research and obtain grants/write scientific papers is considerable.
64	Oct 5, 2012 2:25 PM	I support the moonshot concept and initiative generally but the great risk is relegating uninvolved faculty to second-class citizens and damaging morale further Informatics is woefully underfunded and IT needs a major structural and managerial makeover. Greater involvement of users in the IT management structure is a must. The key short-term success metric for the moonshots will be fundraising. Hard targets need to be established and shared with evefryone in the institution, as painful as this will be for the leadership. Failure to do this is a real warning sign.
65	Oct 5, 2012 1:53 PM	I believe there are numerous great things that the new administration is bringing, that will ultimately raise the caliber of science and medicine at MDACC. I am fully confident in the new president as a capable leader who can really change the face of cancer. He is the real deal and is an amazing and talented person. However, the new administration is implementing its policies by bullying its way, disregarding what has already been established and WORKING WELL at MDACC. Although the caliber of scientists is increasing by the day through outstanding recruitments, let's not forget that there were many outstanding scientists here before the new administration came about. Also, MDACC is a well-tuned clinical machine. Boston had great science but not the best clinical cancer care, and I would wish the new administration work together with the existing clinical infrastructure that has kept MDACC at the top. There is a strong divide that is forming between scientists and clinicians, and resentment that is emerging between the 2 groups. It would be much better if the leadership worked to unite these 2 groups, rather than foster this unnecessary divide. Lastly, the leadership needs to relinquish any perceived conflict of interest (COI). I believe our leaders need to set a good example to the rest of faculty (and the nation) that MDACC has no ulterior motives other than helping people overcome the horrors of cancer. If the leaders can't set this example, then I question whether or not they should remain our leaders.

66	Oct 5, 2012 1:51 PM	The current direction may possibly lead to more basic science and translational discoveries, but it is a very high risk strategy. The current administration is ready to fuel this direction with energy that I believe will be generated by burning up many faculty members and programs that have taken many years to grow. I hope we do not just end up with a lot of ashes.
67	Oct 5, 2012 1:49 PM	I personally believe that with the leadership needs to invest in the clinical research infrastructure/staff throughout the institution to assure that we all have the resources to perform high quality, compliant clinical research.
68	Oct 5, 2012 12:48 PM	I find the increased emphasis over the years on administration and finances can be a bit depressing; While I tend to believe (hopefully not falsely) that my job is relatively safe, I find many junior faculty more anxious with regards to their productivity & benchmarks vs security. I also find the (what seems like) constant barrage of "mandatory" activities from nonsensical research billing meetings, to a rush to encryption can grow tedious, and I often feel like I am treated like a kindergartner.
69	Oct 5, 2012 12:33 PM	The reputation of the institution appears to be at risk - media seem to have targeted Dr DePinho and are seeking any and all opportunities to discredit him, and by association, all of the faculty. The fact that reporters are being provided with sensitive internal information highlights the dissatisfaction of at least a few of our staff who apparently are eager to stir up more trouble for our president. This is extremely difficult to combat - even when given corrected information and background, media are very focused on reporting negative stories and are unlikely to undo damage already inflicted on the institution. Somehow Dr DePinho needs to change the attitude of our staff so that this type of material is no longer leaked and the negative reporting will end. There also seems to be a lot of suspicion about the formation of the new Institute and the whopping salaries being paid to those personnel. Leadership should be developing strategies to calm the negative attitudes being formed. Internal dissent and jealousy will most certainly foster bad outcomes for the institution.
70	Oct 5, 2012 3:57 AM	(1) I am not sure that our president has a compass that works... He certainly thinks he does, but this whole moonshot enterprise looks more like a russian rulette to me. (2) Bureaucracy is rampant and only getting worse. (3) If IT does not improve, and fast, this ship will go down. (4) Institutional Compliance needs to see a shrink. Their paranoia does not serve us well.
71	Oct 5, 2012 3:11 AM	Would like to have an administration that works with rather than against the faculty.
72	Oct 5, 2012 2:59 AM	The President of the Institution should not be given permission violate the institutions conflict of interest rules.
73	Oct 5, 2012 2:54 AM	I don't see any collection of data making a difference to the leadership. Nothing is done about the big survey results. Distrust is seen as paranoia among faculty rather than recognized as a symptom related to witnessing bullying, lying, and corruption. Leaders don't spend time leading locally - they seem consumed with the business above them. They aren't advocating for their people they are working toward the next promotion, making sure to please their boss. Most are overly consumed by their own goals to pay due attention to the group they lead. There is very little transparency or accountability.
74	Oct 5, 2012 2:49 AM	No confidence in dept chair
75	Oct 5, 2012 1:51 AM	There are many toxic individuals within the system. The Senate or ECFS should be asked to advise the CEO on which Department Chairs and Division Heads need replacing. Alternatively make these elected positions. The high-level COIs need to be fixed and soon.
76	Oct 5, 2012 1:20 AM	Phrasing of questions (predictably!) very biased. The Faculty Senate would have much more credibility if they were not so reactionary. I'm very ambivalent about even participating in this.
77	Oct 4, 2012 11:34 PM	With all the faculty and chairs leaving, there is a feeling of people abandoning a sinking ship. Clearly, the administration needs to re-evaluate policies which may be impeding the academic and clinical success of the faculty. This is becoming an unpleasant place to work.

78	**Oct 4, 2012 11:22 PM**	I believe that Dr RD is honorable and the COI and nepotism charges do not have substance. However the APPEARANCE is bad and has not been rectified. The deal negotiated by Dr RD and Ken SHine should be re-examined and changed other wise doubts will always remain. We are far behind the leaders in quality, safety, technology. We are not patient centered. This is the biggest threat to MDACC reputation. If we do not reach the Moon, and do not cure cancer, it will be OK. If we loose our reputation excellence, quality, safety...it will rock our foundation.
79	**Oct 4, 2012 11:14 PM**	No one instituition can do everything. I feel that we are being forced away from the core function of patient care by subsidiaztion of the moon shot issues.
80	**Oct 4, 2012 10:58 PM**	Institution administration should effectively evaluate the legal leaderships of chairs and division heads.
81	**Oct 4, 2012 10:55 PM**	Let's learn from our experiences trying to find out 1. Why many faculty members are leaving? 2. Why MDACC is not listed as one of the best places to work as others hospital across the street (e.g. Methodist)? 3. Why do we need dozens of VPs and 18,000 employees with only few hundred physicians? I suggest: 1. Stop reminding us every month that more money needs to be generated. 2. Stop the expansionist policies generated by our administrators (e.g. satellites clinics or hospitals). We are not here to compete with general hospitals but to provide outstanding patient care to those coming to our premier center. Finally, I congratulate Dr DePinho who is trying to take us to a higher academic level.
82	**Oct 4, 2012 10:53 PM**	There should be an additional survey to access the faculty's opinion of the new leadership, specifically Dr. Depinho and his various dramas.
83	**Oct 4, 2012 10:41 PM**	Chairs such as Xifeng Wu from my epidemiology department are extremely bossy and rude but it seems no action is taken against her even though there are numerous complaints against her (from secretaries, department administrators, faculties). They keep talking about mentoring her but there seems no change in her behavior (constant shouting at staff, faculty) but since she is publishing papers putting names of her bosses on the paper they don't want to taken any action against her and are instead protecting her. Why will morale be better in such situation?
84	**Oct 4, 2012 10:32 PM**	I am hopeful that things will improve but do have concerns that the clinical workload will increase to provide capital for the new programs. This would be fine if the rewards to those of us in the clinic are commensurate with the increased effort.
85	**Oct 4, 2012 10:31 PM**	M.D. Anderson has been good to me and I think Dr. DePinho and the vice Presidents are well-intentioned, but have little idea of the machinations going on behind their backs. The M. D. Anderson reputation of eating their young is well-deserved.
86	**Oct 4, 2012 10:31 PM**	Nobody I know here feels safe airing their feelings under the current regime, lest they be fired or exiled immediately.
87	**Oct 4, 2012 10:29 PM**	I have felt professionally harrassed by my chairman. I am concerned and frustrated by how limited the options are to bring about any change in this regard. We need much better accountability for our chairs of departments, Divison heads, and administrators. They should be viewed as servants to our talented and hard-working faculty members rather than power mongers who throw their weight around and jokey for the next "leadership" position up the chain of commnad. Term limits for chairpersons is a good start. Initial appointment of only 5 years with option to get voted in (or our) by the faculty is a model that is practiced at many academic centers of excellence. We are way behind the curve in this regard.

88	Oct 4, 2012 10:27 PM	I have obseved during my years at MDACC that some individuals are promoter at a faster rate than others who also deserve to be promoted. For example, when I was a post-doctoral fellow, I was awarded a grant that I considered it to be an RO1 based on its funding level ($350,000 p/y). Instead of being promoted to Asst. Professor, I was promoted to Instructor. When I wrote and submitted the continuation grant, which was also funded ($333,000 p/y), I still did not get promoted. In addition to the grants, I have been the recipient of 8 awards during my years at MDACC, one of them the prestigious "Fulbright." All of these, I have done without receiving what I call "REAL MENTORING." The knowledge that I have gained at MDACC have been self-taught, without the help of those who were supposed to be my "MENTORS." I have received more mentoring from individuals outside of MDACC. But from within MDACC, none. Thus, it would very hard for me to find a job at this point in my life because anyone evaluating my CV will wonder why I am still an Instructor after 16 years. What they do not know is that I have worked in an institution that is full of biases and favoritisms. I am really dissapointed!!!!
89	Oct 4, 2012 10:24 PM	No more surveys! Let's do something!
90	Oct 4, 2012 10:17 PM	Good luck!
91	Oct 4, 2012 10:15 PM	I love the vision of the President , his energy and commitment to the mission. We must continue to leverage IT in a way to help clinical and research operations. We should abandon ClinicStation. It has served its purpose, but the off the shelf solutions are plenty good and developing much faster--we are in the cancer business, not the software business. Build systems to improve patient care, productivity and hold faculty accountable. performance expectations must have some consistancy across divisions and % effort must mean something similar across the institution.
92	Oct 4, 2012 10:11 PM	We need to have term limits in leadership positions. No Chair should remain in power over 10 years. At that point they are not building but just holding on to power. The term limit should be 8-10 years. That would fix much of what ails MDACC.
93	Oct 4, 2012 9:58 PM	The current situation at MDACC reflects the current state of the country's economy where the middle class is at risk of being stumped on while a select few will build empires.
94	Oct 4, 2012 9:45 PM	The issues regarding grant submission by our president is quite depressing. Also, they are hiring people away (one from my lab) because they pay substantially higher slaries.
95	Oct 4, 2012 9:44 PM	MDA is a truly great institution, with a truly massive leadership deficit. The place groans under a massive hierarchy stacked with non-performers (of mostly non-clinical administrators) who want to preserve the status quo. A decentralized power structure would work wonders here, but the vested interests (non-faculty and faculty executives) are very afraid to let go of the reins (and in many cases they are right to be afraid... gifted departmental leaders don't come to a command-and-control environment unless heavily bribed). Five hot-shot MBAs cannot replace one gifted faculty leader. Far too many non-faculty administrators have forgotten that they are there to support the faculty, and not the other way around.
96	Oct 4, 2012 9:36 PM	There is no respect for non tenure track faculty in the Department of Experimental Radiation Oncology (ERO). NTRAs are not allowed to participate in ERO's faculty meetings and other meetings that could benefit them.
97	Oct 4, 2012 9:36 PM	I strong believe that the quality patient care is being eroded on a daily basis.
98	Oct 4, 2012 9:32 PM	I am sure that I can offer no information of which that you are not already aware. I loved this place, but the bulling and the infighting has brought this instituion to its knees.
99	Oct 4, 2012 9:26 PM	This is a fabulous institution, and my criticisms are meant to be constructive. We all must work together to fix the problems. Of all of my years here, this has become the most onerous for research as well as patient care. We all need to help and much cleaning and introspection is due urgently.
100	Oct 4, 2012 9:26 PM	The increased stress and existential worries among faculty will lead to higher burnout rates, and hence to lower job performances (scientific innovation, patient care etc).
101	Oct 4, 2012 9:24 PM	This is a very depressing time to be here, morale is the lowest that I have seen for any academic instititution that i have been part of.

102	**Oct 4, 2012 9:24 PM**	Power corrupts and absolute power corrupts absolutely. the examples continue to come to light: CPRIT grants submissions without institutional oversight, DePinho's performance on May 18th Stockwatch and the $$ millions that this couple gained personally due to this activity, Dr. Chin's use of her time and institutional funds to support travel to Metamark and Aveo to oversee their businesses, the waivers filed to allow the Aveo drugs to be tested here,.... it goes on and on. If any one of us did these things, we would be fired.
103	**Oct 4, 2012 9:23 PM**	The institution has been losing its brightest faculty over the last 5 years. Three people have left who could really make a difference. There is no effort to keep really good researchers here. Only the cancer enterprise matters.
104	**Oct 4, 2012 9:20 PM**	The number of online training modules that we are expected to do each year is outrageous. I did 7 this past fiscal year, many of them taking over an hour each.
105	**Oct 4, 2012 9:16 PM**	The longer the problem remains unfixed, the longer the recovery period is going to be.
106	**Oct 4, 2012 9:15 PM**	It seems the administrative leaders who are making the decisions have no clear understanding about the reality of the benchmarks placed on clinical and research faculty. There are no comparable benchmarks for administration. Administration needs to be mindful of the funding climate and the pressures on providers of clinical care.
107	**Oct 4, 2012 9:15 PM**	Despite my general impressions regarding morale, my direct supervisor, my chairman, and division head are all exceptional. This institution offers many advantages that are unparalleled by any institution and our clinical care can not be matched. So, yes, I think there are problems here, but there are problems everywhere.
108	**Oct 4, 2012 9:13 PM**	I hope we are able to fulfill at least some of the goals of the moon shot program before too much damage is done to the morale of current faculty and the image of MD Anderson. The message I am hearing from the administration is: if you are not with us you are not just against us - you are against curing cancer.
109	**Oct 4, 2012 9:11 PM**	Please remove all conflicts of interest now.
110	**Oct 4, 2012 9:06 PM**	M.D. Anderson is an incredible institution. It is truly sad to watch the decline over the last year. I wish there were opportunities for me to advance because I would gladly spend my entire career here if there were.
111	**Oct 4, 2012 9:05 PM**	I only answered questions on #2 that related to my type of work.
112	**Oct 4, 2012 9:03 PM**	OUR DEPARTMENT (PATHOLOGY) NEVER PRESENTED THE ORIGINAL BIG SURVEY DEPARTMENTAL SURVEY RESULTS TO US, PRESUMABLY BECAUSE THE RESULTS WERE BAD. WHEN CAN WE SEE THESE REULTS?
113	**Oct 4, 2012 9:03 PM**	somebody better prepare for the Obamacare fiasco!
114	**Oct 4, 2012 9:00 PM**	I'm nervous.