

Raymond Alexanian, MD

Interview Session 1 — May 15, 2014

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Chapter 00A **Interview Identifier** **[00:00:00]**

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. So now we are recording, and I am Tacey Ann Rosolowski, and today is May 15, 2014, and the time is 9:47 a.m. I'm in the Reading Room of the Historical Resources Center on the twenty-first floor of Pickens Tower, the Research Medical Library, and I am interviewing Dr. Raymond Alexanian for the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Dr. Alexanian joined MD Anderson in 1964 as an assistant professor of medicine, and you were in the Department of Hematology at the time. Is that correct?

[00:00:47]

Raymond Alexanian, MD

[00:00:47]

That's correct.

[00:00:47]

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Tacey Ann Rosolowski, PhD

[00:00:48]

Okay. And he served many roles during his time at MD Anderson, including deputy head of the Division of Cancer Medicine and deputy head of the Department of Hematology. And you retired in 2004, is that correct?

[00:01:01]

Raymond Alexanian, MD

[00:01:03]

I believe that's correct, but then I have been part-time until last year.

[00:01:09]

Tacey Ann Rosolowski, PhD

[00:01:09]

Oh, okay. Wow. I didn't realize that. And you hold emeritus status now.

[00:01:13]

Raymond Alexanian, MD

[00:01:15]

Yes.

[00:01:15]

Tacey Ann Rosolowski, PhD

[00:01:17]

Okay. I'm just taking a few notes on that. This is the first interview session together, and I already gave the time, so we are ready to roll. All right. Well, thank you so much for agreeing to participate in the project. I'm glad we could find the time.

[00:01:36]

Raymond Alexanian, MD

[00:01:37]

Yes.

[00:01:37]

Tacey Ann Rosolowski, PhD

[00:01:38]

And let me just take down the time so I've got my notes all straight here. All right.

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Chapter 01

A: Educational Path

An Early Interest in Medicine: Seeking a Well-Rounded Liberal Education

Story Codes

A: Personal Background

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

Tacey Ann Rosolowski, PhD

[00:01:38]+

So why don't we just start with some general background, and let me ask you when you were born and where, and where you grew up.

[00:01:56]

Raymond Alexanian, MD

[00:01:57]

Yes. Well, I was born in Queens in New York in 1932.

[00:02:05]

Tacey Ann Rosolowski, PhD

[00:02:05]

What's your birth date?

[00:02:06]

Raymond Alexanian, MD

[00:02:06]

June 8, 1932. My father was a grocer, and we moved to different—as a child I was moved with my family to different neighborhoods in Manhattan and the Bronx, and I was raised in the Bronx in a, you could say, lower-middle-class neighborhood and went to public high school, DeWitt Clinton High School, which was a large boys' high school. I was successful there so that I was also fairly active in high school, volunteering for many jobs, and I was also a member of the Honor Society and secretary of the Honor Society and then—

[00:03:08]

Tacey Ann Rosolowski, PhD

[00:03:08]

Was anyone else in your family interested in the sciences?

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[00:03:12]

Raymond Alexanian, MD

[00:03:12]

Yes. My mother's father, my grandfather, was a physician who was of Armenian extraction, born in Turkey, but was chosen to be among a small group of young men who were educated in the United States to some degree, so that he returned to Turkey as a specialist in obstetrics, and was drafted into the Turkish Army in the First World War and spared from the persecution of the Armenians because of his status as a surgeon, and managed to save his family from the genocide of Armenians by just fortuitous circumstances, so that my mother, who was then about thirteen, and her family were saved and then eventually immigrated to Philadelphia, where my grandfather was a physician and then—

[00:04:43]

Tacey Ann Rosolowski, PhD

[00:04:48]

That's an amazing story to have in your background.

[00:04:50]

Raymond Alexanian, MD

[00:04:50]

Yes.

[00:04:51]

Tacey Ann Rosolowski, PhD

[00:04:51]

Was that inspiring for you, and did that influence your decision—

[00:04:54]

Raymond Alexanian, MD

[00:04:55]

I think it did. Let's see. I think perhaps also at the age of three I developed polio and so had some handicap and was unable to be as physically active as my peers, but I was able to be somewhat active in terms of being swim team and other kind of non-running activities.

My mother was also very motivated toward education of her children as a way of moving up in our society, so that I was a good student and volunteer, and so found myself at Dartmouth College, which was a, I guess—

[00:06:12]

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Tacey Ann Rosolowski, PhD

[00:06:15]

How did you end up going there?

[00:06:15]

Raymond Alexanian, MD

[00:06:16]

A leap forward from a public high school in the Bronx, as you can imagine.

[00:06:20]

Tacey Ann Rosolowski, PhD

[00:06:20]

Yeah, no kidding. How did you make the decision to go there? How did that work out?

[00:06:27]

Raymond Alexanian, MD

[00:06:29]

Well, in those days you applied to a mixture of colleges, as you do now, I assume, and I guess I had a good record and good recommendations.

[00:06:49]

Tacey Ann Rosolowski, PhD

[00:06:55]

Were there any teachers who helped you along the way or kind of mentored you?

[00:07:01]

Raymond Alexanian, MD

[00:07:02]

Well, I think almost all. I had very good teachers, because in our Honor Society cadre at this large public high school we had some of the best teachers in the school, who were all New York bred and raised, so that we were encouraged to apply to the best colleges if possible.

[00:07:34]

Tacey Ann Rosolowski, PhD

[00:07:39]

Did they identify you as a person—I mean, did you have an intention when you went to college that you were going to become a physician? When did that interest start?

[00:07:47]

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Raymond Alexanian, MD

[00:07:47]

Yes. I think that interest started very early in high school.

[00:07:49]

Tacey Ann Rosolowski, PhD

[00:07:50]

Did it? Okay. Why?

[00:07:52]

Raymond Alexanian, MD

[00:07:53]

Well, I had been exposed to my own personal illness that required regular doctor visits and physical therapy, and I guess my mother's motivation to emulate her father. I also had a great-uncle who was a somewhat famous dental surgeon. His name was Kazanjian, K-a-z-a-n-j-i-a-n, who was a First World War pioneer in reconstructive maxillofacial surgery and was given an award by the king of England—

[00:08:59]

Tacey Ann Rosolowski, PhD

[00:08:59]

Oh, wow.

[00:09:00]

Raymond Alexanian, MD

[00:09:00]

—and other things at that time, because he was based at a British military facility and there all kinds of horrible face traumas that were sent to him for working out methods to make a new face. I'm not that familiar with his work, but there have been books written about his work and activity.

[00:09:32]

Tacey Ann Rosolowski, PhD

[00:09:33]

So those are two pretty amazing figures from your past, your grandfather and your great-uncle.

[00:09:37]

Raymond Alexanian, MD

[00:09:37]

Yes. Right.

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[00:09:38]

Tacey Ann Rosolowski, PhD

[00:09:38]

And your grandfather's name is?

[00:09:40]

Raymond Alexanian, MD

[00:09:40]

His name was Bynderian, B-y-n-d-e-r-i-a-n.

[00:09:45]

Tacey Ann Rosolowski, PhD

[00:09:48]

And his first name?

[00:09:48]

Raymond Alexanian, MD

[00:09:51]

Nishan, N-i-s-h-a-n.

[00:09:54]

Tacey Ann Rosolowski, PhD

[00:09:55]

Great. Thank you.

[00:09:56]

Raymond Alexanian, MD

[00:09:57]

As you can recognize, they're Armenian names, because they end in i-a-n.

[00:10:01]

Tacey Ann Rosolowski, PhD

[00:10:01]

Yes. Do you have a strong sense of yourself as an Armenian American?

[00:10:06]

Raymond Alexanian, MD

[00:10:07]

Not so much. Not as much as my parents. My mother and father were very—it was very

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important to them to have assimilation in American society, so that she contradicted my father's preference to study Armenian at the school and says, "Well, we don't have time for that. He has to learn his English and other things," and so on. So—

[00:10:40]

Tacey Ann Rosolowski, PhD

[00:10:41]

Yeah, it's interesting how different immigrant families sort of dealt with that whole issue differently.

[00:10:45]

Raymond Alexanian, MD

[00:10:45]

Yeah. So I think a lot of that was inspiring and—

[00:10:52]

Tacey Ann Rosolowski, PhD

[00:10:54]

So you said when you went to college you had the intention of becoming a physician.

[00:10:59]

Raymond Alexanian, MD

[00:11:00]

Yes

[00:11:00]

Tacey Ann Rosolowski, PhD

[00:11:01]

So tell me about your college experience.

[00:11:02]

Raymond Alexanian, MD

[00:11:04]

Well, I think I had a full experience. A college like Dartmouth is a very absorbing place where everyone is part of an academic and social kind of environment which has all kinds of sports and social life and academics, in a small village in New Hampshire, as you may know. I don't know if you visited there. You're somewhat isolated, and in those days, there were all men, and so it was also a very important growth experience, which you might call—what do they call that when teenagers develop, go through an initiation into adulthood? I forget the term. So it was a very good experience.

[00:12:26]

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Tacey Ann Rosolowski, PhD

[00:12:27]

What were the classes that you took that began to make you feel you were evolving into the person that you would become professionally?

[00:12:36]

Raymond Alexanian, MD

[00:12:37]

Well, from the very beginning, I felt it was very important to have a broad liberal arts education, so I was very happy that there were requirements for English, social studies, language, history, in addition to the scientific requirements.

[00:12:56]

Tacey Ann Rosolowski, PhD

[00:12:57]

Why did you believe that?

[00:12:58]

Raymond Alexanian, MD

[00:12:59]

I guess in high school I was imbued with the idea that the well-educated person should be educated in as many areas as possible as he's able to absorb, in terms of music, philosophy, literature, history, so that I sort of was motivated that way and throughout my life have continued to study and read. I read books and history and things like that. I feel I guess I was maybe somewhat old-fashioned, but that the well-educated physician is a well-educated person and sensitive to society and has to contribute to society in more ways than his medical work, that we live in an imperfect world that will always be imperfect, and that we should do whatever we can to improve it. So that has been sort of my creed. (laughs)

[00:14:25]

Tacey Ann Rosolowski, PhD

[00:14:27]

No, that's lovely. (laughs)

[00:14:29]

Raymond Alexanian, MD

[00:14:32]

Well, it's kept me comfortable. My wife puts up with it and she helps me with it. (laughter) She volunteers with the homeless and all that, so it's something to do.

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[00:14:45]

Tacey Ann Rosolowski, PhD

[00:14:45]

Yeah. Well, it's interesting, because, I mean, in the course of interviewing people, I discover, you know, sort of pockets of interesting—there are a number of physicians who create art, for example. They have different dimensions of their lives that round out the science, the science focus. Others are very uniformly focused on science or clinical work, so that there are different ways of constructing that way of being.

[00:15:11]

Raymond Alexanian, MD

[00:15:11]

That's right. Sure.

[00:15:12]

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Chapter 02

A: Educational Path

College, Medical School, and a Brief History of Medical Education in the U.S.

Story Codes

A: Personal Background

A: Inspirations to Practice Science/Medicine

D: Understanding Cancer, the History of Science, Cancer Research

A: Character, Values, Beliefs, Talents

Tacey Ann Rosolowski, PhD

[00:15:13]

Yeah. So tell me about the balance. So you created this liberal education for yourself. What were the classes that helped you develop your interests in the direction that they would go in, in terms of your research or your understanding of yourself as a doctor focused on patients?

[00:15:35]

Raymond Alexanian, MD

[00:15:38]

Well, as I mentioned, even as I began high school, I intended to become a doctor or try to become a doctor, so that I followed the requirements to do that, which were in many ways interesting and challenging, but also part of my overall educational goals, so that many times the requirements were just secondary. I did not like all my science subjects.

[00:16:21]

Tacey Ann Rosolowski, PhD

[00:16:22]

What were your favorites?

[00:16:23]

Raymond Alexanian, MD

[00:16:25]

Well, I think in college I liked comparative anatomy, where the anatomy of different creatures, birds, reptiles, snakes, and all that are evaluated. I found that challenging. I didn't like botany. I found that boring. And I think botany was probably required because of the ancient requirements to understand all the plants and chemicals that they were the only source of in the old days, that my faculty advisors felt were important but really not important. (laughs)

[00:17:21]

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Tacey Ann Rosolowski, PhD

[00:17:21]

Yeah, so it was kind of a holdover. (laughter) Interesting.

So tell me about going to medical school, when, how did you decide? So you ended up going to—you continued at Dartmouth for your MD.

[00:17:37]

Raymond Alexanian, MD

[00:17:38]

Yes, at Dartmouth, Dartmouth had a two-year medical school in those days—

[00:17:41]

Tacey Ann Rosolowski, PhD

[00:17:41]

Oh, really?

[00:17:42]

Raymond Alexanian, MD

[00:17:42]

—so that you could enter in your fourth year of undergraduate. So as a senior in college, it was combined with my first year in medical school. Now, we had had a small medical school class of twenty-four, twenty-four men, boys, and after two years, we were all required to transfer to a four-year medical school that would absorb us into their third year.

[00:18:14]

Tacey Ann Rosolowski, PhD

[00:18:15]

Why did they set it up that way?

[00:18:16]

Raymond Alexanian, MD

[00:18:20]

In the history of medical education in this country, there was a more or less major change in medical school standards at the turn of the century, where several hundred medical schools were evaluated and many of them were considered to be well short of the standards required for medical school education, and so they—

[00:18:58]

Tacey Ann Rosolowski, PhD

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[00:18:58]
Is this the Flexner Report?
[00:18:59]

Raymond Alexanian, MD

[00:18:59]
The Flexner Report. So many of those were dropped from the roster of medical schools, but a small number, approximately six, were retained as two-year schools because they were usually in rural areas without access to a large clinical population, and their undergraduate students were well qualified for medical education. Since all my classmates were Dartmouth graduates, usually above-average graduates, they qualified as students almost anywhere in the country, so that for many years between maybe 19—I'm guessing now—1920 and 1955, that was a two-year medical school.

Then as the facilities expanded and patients—the problem was that there weren't sufficient numbers of patients with a broad range of disorders to fulfill the requirements for third- and fourth-year medical education. You had to have a lot of sick people—
[00:20:35]

Tacey Ann Rosolowski, PhD

[00:20:36]
Right.
[00:20:36]

Raymond Alexanian, MD

[00:20:37]
—to show students.
[00:20:39]

Tacey Ann Rosolowski, PhD

[00:20:40]
Strange needs, but— (laughs)
[00:20:42]

Raymond Alexanian, MD

[00:20:43]
There was a Veterans Hospital in a nearby town, but that was not sufficient.
[00:20:52]

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Tacey Ann Rosolowski, PhD

[00:20:53]

So you ended up transferring to—

[00:20:56]

Raymond Alexanian, MD

[00:20:56]

To Harvard.

Tacey Ann Rosolowski, PhD

[00:20:58]

And just for the record, you left Dartmouth in '53, and then in 1955, received your MD from Harvard Medical School.

[00:21:09]

Raymond Alexanian, PhD

[00:21:09]

Harvard, yes.

[00:21:10]

Tacey Ann Rosolowski, PhD

[00:21:10]

So was there a big difference between the two schools? Tell me about your training. What was your evaluation of your training through those programs?

[00:21:19]

Raymond Alexanian, MD

[00:21:20]

Well, as you can imagine, the medical school training is kind of in stages for basic science and then clinical training so that, of course, the environment from a rural, small agricultural area in New Hampshire to a big city was a geographic change, but I don't think the scholastic demands were any different. I think the clinical rotations through multiple teaching hospitals required a different schedule. Harvard in those days—I'm not sure now—every day there was a morning lecture, and then in the morning and afternoons you had rotations through the different clinical facilities in the different specialties: pediatrics, surgery, medicines, so on and so on.

[00:22:38]

Tacey Ann Rosolowski, PhD

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[00:22:38]

What did you gravitate toward during that time as a specialty?

[00:22:41]

Raymond Alexanian, MD

[00:22:42]

At that time I had the notion, with my friends, that it was important to become a well-rounded physician, so I thought at that time that I would be the best possible general practitioner that could be attained. And within a few years, it was obvious that that was not logical, because as you—even through my internship, I felt that that was a good idea, because I—in those days you could elect a rotating internship, which would mean you rotated among the different specialties, you know, gynecology, obstetrics, surgery, medicine, so on, and that's what I did at the University of Washington in Seattle, the King County Hospital.

In those days, choices of internships were as random as they are now, I think, but you had a wider choice. You could have rotating internships or specialty internships. Most of them at that time were rotating internships because there was still the notion that primary care, rather than specialty care, was the dominant future for physicians. But shortly after I began my internship, I also wanted to do something constructive in medicine, so I then proceeded into a medical residency.

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Chapter 03

A: Professional Path

Committed to Academic Medicine

Story Codes

- A: Military Experience
- A: Character, Values, Beliefs, Talents
- A: Personal Background
- A: Professional Path
- A: Inspirations to Practice Science/Medicine

Raymond Alexanian, MD

[00:22:42]+

I also spent two years in the army. In those days, there was a required draft of physicians, so that I was classified as an obligated volunteer, if you can see the kind of inconsistency there. (Rosolowski laughs.) That was the designation.

[00:25:12]

Tacey Ann Rosolowski, PhD

[00:25:12]

Really? An obligated volunteer. And this was 1956 to 1958.

[00:25:16]

Raymond Alexanian, MD

[00:25:16]

Right.

[00:25:16]

Tacey Ann Rosolowski, PhD

[00:25:17]

Yes. And you were a captain.

[00:25:18]

Raymond Alexanian, MD

[00:25:18]

Yes. It was important to do that because there were no residency programs that would accept you if there was a risk of being drafted—

[00:25:29]

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Tacey Ann Rosolowski, PhD

[00:25:29]

Oh, how interesting.

[00:25:30]

Raymond Alexanian, MD

[00:25:30]

—during the program.

[00:25:33]

Tacey Ann Rosolowski, PhD

[00:25:33]

Right.

[00:25:33]

Raymond Alexanian, MD

[00:25:34]

So any of the selective residencies made it clear that, “You’d better get this behind you, or else we’re not interested.”

[00:25:42]

Tacey Ann Rosolowski, PhD

[00:25:43]

Did that military service develop any skills for you that were important later?

[00:25:49]

Raymond Alexanian, MD

[00:25:51]

After I was drafted and sent to the what they call U.S. Army Physician Training Center at San Antonio, which I think still is active—all physicians went through a six-week program there—they made it clear that they were seeking volunteers in certain specialties which were in short supply in the army, and they were in short supply because there were military bases all over the world in the Cold War period, and there large numbers of dependents at many of these bases.

So the choices were in areas such as pediatrics, anesthesia, radiology, ear, nose, and throat, areas that were meant to provide coverage for dependents in a greater way than their normal draft could do. So I elected to have training in anesthesia for somewhat selfish reasons, because I felt it might be interesting and useful, but also I knew for certain that I would be based at a large hospital in a comfortable area, because there was a rumor that you might have potential assignments to Greenland, Alaska, or the Eniwetok Atoll and isolated places like that if you did

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not having something special. So, in a way, I was lucky so that I had anesthesia training at Fort Benning, Georgia, which was a large military facility, and was assigned to a hospital in Japan, which was my first trip abroad and opened up a whole new society of interest. Of course, it was approximately ten years after the war, so that there was not the society that we know of today.
[00:28:37]

Tacey Ann Rosolowski, PhD

[00:28:38]

Right. A very different attitude towards Americans, too, I imagine.

[00:28:41]

Raymond Alexanian, MD

[00:28:43]

Well, actually, by then, the public was very receptive. As you probably know, General MacArthur had a very enlightened rule. He retained the Emperor and many of the customs as the old military hierarchy was disbanded. So it was a pleasant time. It wasn't very challenging, but it was a time I had to pass over.

[00:29:28]

Tacey Ann Rosolowski, PhD

[00:29:30]

So when you finished that, you came back and went to a clinical residency at the University of Washington in Seattle.

[00:29:38]

Raymond Alexanian, MD

[00:29:38]

University of Washington, in medicine.

[00:29:39]

Tacey Ann Rosolowski, PhD

[00:29:40]

Yeah.

[00:29:40]

Raymond Alexanian, MD

[00:29:41]

And I returned to the place I had my internship because I liked the atmosphere and was impressed with the training program, and I thought this would be a way to begin my career, and

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went through the normal rotations in internal medicine for two years and then elected a specialty in hematology for two more years.

[00:30:19]

Tacey Ann Rosolowski, PhD

[00:30:19]

And that was your research fellowship from '60 to '62.

[00:30:23]

Raymond Alexanian, MD

[00:30:23]

Yes. I met my wife, which was certainly a very important event. (laughs)

[00:30:30]

Tacey Ann Rosolowski, PhD

[00:30:31]

And her name is?

[00:30:31]

Raymond Alexanian, MD

[00:30:32]

Lois. We're still married; same lady.

[00:30:35]

Tacey Ann Rosolowski, PhD

[00:30:36]

Yeah, that's an achievement these days. (laughter)

[00:30:39]

Raymond Alexanian, MD

[00:30:40]

Right. And have one daughter.

[00:30:43]

Tacey Ann Rosolowski, PhD

[00:30:44]

And her name is?

[00:30:44]

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Raymond Alexanian, MD

[00:30:45]

Is Jane, J-a-n-e, who has her own family, and whom we visit.

[00:30:52]

Tacey Ann Rosolowski, PhD

[00:30:54]

So tell me about your hematology residency, because that, of course, ended up being—

[00:30:59]

Raymond Alexanian, MD

[00:31:00]

Well, the hematology residency was a clinical hematology program for the first two years and then a research program in the third year, and that was followed by another year of research in Manchester, England, with a research leader in the field where I did my first research and wrote my first papers. His name was Lajtha, L-a-j-t-h-a.

[00:31:44]

Tacey Ann Rosolowski, PhD

[00:31:47]

Yeah, Laszlo, the first name.

[00:31:49]

Raymond Alexanian, MD

[00:31:48]

Yes.

[00:31:49]

Tacey Ann Rosolowski, PhD

[00:31:52]

You very kindly put all these names on your CV, so I have them down, which is great. (laughs)

[00:31:56]

Raymond Alexanian, MD

[00:31:56]

Well, good.

[00:31:57]

Tacey Ann Rosolowski, PhD

[00:31:58]

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And that was from 1962 to 1963, the Christie Hospital and Holt Radium Institute in Manchester, England.

[00:32:05]

Raymond Alexanian, MD

[00:32:05]

Yes. He had been based at Oxford, and I thought when I applied for the program that I would be at Oxford, I thought that was really neat, and then after I was accepted in his program, he made it clear that he was moving to what was considered a better position for him in Manchester. And so therefore, I trailed along to Manchester.

[00:32:37]

Tacey Ann Rosolowski, PhD

[00:32:37]

So how did these residencies develop your interests in hematology? And, you know, because, of course, the question is coming, when did you become very interested in cancer.

[00:32:48]

Raymond Alexanian, MD

[00:32:48]

A lot of that are byproducts of the opportunities for academic positions. When one is embarking on a hematology training program, you really don't know where you're going to end up, whether you're going to be in some group practice in hematology or you might get an appointment at some medical school or move on to another training or research program, so that the opportunities were not clear, and so you progressed from year to year hoping for the best, you might say.

[00:33:53]

Tacey Ann Rosolowski, PhD

[00:33:54]

Interesting. Now, am I correct in assuming that you were directing yourself more toward an academic career than private practice?

[00:34:01]

Raymond Alexanian, MD

[00:34:01]

Yes. Well, it seemed that whatever exposure I had in my education in a way sort of appealed to me as a potential career, and I never knew what was going to happen. So in high school, I thought, "Well, it might be nice to be a teacher," and then in college I said, "Well, maybe I could

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learn to become a professor of something.” Then in medical school I said, “Well, I’m going to become a doctor. I’ll become a general practitioner somewhere and see what happens.”

[00:34:46]

Tacey Ann Rosolowski, PhD

[00:34:46]

Yeah, you’re a bring-it-on kind of guy. (laughs)

[00:34:48]

Raymond Alexanian, MD

[00:34:48]

Bring it on. (laughs) Then as you go on and on, and you say, “Well, I like the people, so maybe I’ll become a professor in a medical school,” after you see all the—I said, “Well, how are you going to do that unless you make yourself known somehow?” So I said, “Well, maybe I’ll do some research and maybe I’ll find a way to do that.” So from year to year, as you can imagine, I was always packing my suitcase going somewhere.

[00:35:24]

Tacey Ann Rosolowski, PhD

[00:35:26]

I’m starting to feel sorry for Lois. (laughs)

[00:35:27]

Raymond Alexanian, MD

[00:35:28]

Well, and I’m sure you’ve interviewed others, so that between the ages of sixteen and thirty-two, I was packing my suitcase every year or two, going from one thing, place, to another. And I wasn’t very good at packing, my wife will tell you. She said, “How did you manage to pack?” One of her favorite questions. And I said, “I don’t know how to pack.” So I always had many of my personal things stashed with my mother somewhere, wherever she was with my father, so I never regained my boyhood things until I settled into some place, like my stamp collection or my baseball cards or all this stuff.

[00:36:34]

Tacey Ann Rosolowski, PhD

[00:36:34]

Well, you kind of made up for it when you came to Houston, because you stayed here for—

[00:36:38]

Raymond Alexanian, MD

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[00:36:38]
Comic books.
[00:36:39]

Tacey Ann Rosolowski, PhD
[00:36:39]
Your comic books. (laughs)
[00:36:39]

Raymond Alexanian, MD
[00:36:40]
You can't do without those.
[00:36:42]

Tacey Ann Rosolowski, PhD
[00:36:42]
Oh, you had a big collection of comic books?
[00:36:43]

Raymond Alexanian, MD
[00:36:44]
Not big, but my mother was very fast to get rid of them.
[00:36:47]

Tacey Ann Rosolowski, PhD
[00:36:47]
What was your favorite comic, or did you have a bunch of them?
[00:36:49]

Raymond Alexanian, MD
[00:36:50]
I had some of the first *Batman* and *Superman* comics.
[00:36:53]

Tacey Ann Rosolowski, PhD
[00:36:53]
Oh, my gosh.
[00:36:53]

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Raymond Alexanian, MD

[00:36:53]

I never knew that they were going to be useful or valuable. (laughter)

[00:36:56]

Tacey Ann Rosolowski, PhD

[00:37:02]

That's funny.

[00:37:03]

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Chapter 04

A: The Researcher

Early Research on Stem Cells and Erythropoietin

Story Codes

A: The Researcher

C: Discovery and Success

A: Definitions, Explanations, Translations

A: Influences from People and Life Experiences

A: Professional Path

A: Career and Accomplishments

A: Joining MD Anderson

Raymond Alexanian, MD

[00:37:03]

So can I ask, I'm sure many of these itineraries are similar to what—you've heard others like this?

[00:37:11]

Tacey Ann Rosolowski, PhD

[00:37:11]

You know, it's amazing, some people are incredibly focused, "I'm going to do this. This is what—."

[00:37:17]

Raymond Alexanian, MD

[00:37:17]

Do this in one place.

[00:37:17]

Tacey Ann Rosolowski, PhD

[00:37:17]

And others are more, you know, open to opportunities and things that fall very organically. It's all about what opportunities and mentors come your way.

[00:37:27]

Raymond Alexanian, MD

[00:37:27]

Right. That's right.

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[00:37:27]

Tacey Ann Rosolowski, PhD

[00:37:28]

So the stories can be very, very different.

[00:37:29]

Raymond Alexanian, MD

[00:37:29]

I'm sort of in the latter category.

[00:37:30]

Tacey Ann Rosolowski, PhD

[00:37:30]

Yeah. Well, it's very interesting. So tell me how did the cancer focus start. Tell me about that.

[00:37:39]

Raymond Alexanian, MD

[00:37:40]

When I was in Manchester, it's obvious that I had no job after that, so my previous mentor, Dr. Finch, F-i-n-c-h, in Seattle said, "When you're finished in Manchester, you're welcome to come back here, and we'll get started on a program for you."

So that was my intention until Dr. Lajtha, my Manchester mentor, who was often a visiting lecturer throughout the world and had given a lecture and was invited at a program at MD Anderson Hospital in 1963, came back and said, "Ray, I've got a job for you."

I said, "What do you mean, Dr. Lajtha?"

He said, "Well, they're looking for somebody like you down at Houston."

I said, "Well, that's interesting, because I don't have a job unless I go back to Seattle." So I sent in my résumé, which was virtually nonexistent, just my school program, and I had a couple of papers in Manchester, but it was very—and so had an interview here in transit back to Seattle.
[00:39:24]

Tacey Ann Rosolowski, PhD

[00:39:25]

Who did you interview with?

[00:39:25]

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Raymond Alexanian, MD

[00:39:26]

In transit back, my wife and daughter went on to Seattle, and I detoured for an interview with Dr.—

[00:39:39]

[interruption]

Raymond Alexanian, MD

[00:39:53]

So, Dr. Bergsagel, B-e-r-g-s-a-g-e-l, Bergsagel, I had an interview here, and that was followed by—let's see. That was in July of 196—

[00:40:16]

Tacey Ann Rosolowski, PhD

[00:40:16]

Let's see. It must have been 1963?

[00:40:18]

Raymond Alexanian, MD

[00:40:19]

Sixty-three. Followed by a second interview in December of 1963 at a hematology meeting where I presented a paper and—

[00:40:31]

Tacey Ann Rosolowski, PhD

[00:40:35]

Now, when Dr. Lajtha said, "They're looking for somebody like you," what did he mean? I mean, what were you doing at the time?

[00:40:42]

Raymond Alexanian, MD

[00:40:42]

I had finished the two years in hematology and was finishing—no, two years in hematology, one more year of research in Seattle and one more year with him.

[00:40:56]

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Tacey Ann Rosolowski, PhD

[00:40:57]

What was the research that you were doing?

[00:40:58]

Raymond Alexanian, MD

[00:40:59]

With Dr. Lajtha?

[00:41:00]

Tacey Ann Rosolowski, PhD

[00:41:00]

Mm-hmm.

[00:41:00]

Raymond Alexanian, MD

[00:41:01]

Well, it's an area called stem cell kinetics. It has to do with the primordial cells in the bone marrow that lead to other cells, normal cells. What are the normal—is there some grandfather cell that accounts for all the different red cells, white cells, and platelets? It's called the stem cell, and it had to do with that primordial cell that he had an interest in and that if they could understand that cell, that might eventually lead to an understanding of leukemia and other diseases like that.

[00:41:43]

Tacey Ann Rosolowski, PhD

[00:41:47]

What did you find most intriguing about that research? Because you stuck with it.

[00:41:59]

Raymond Alexanian, MD

[00:42:02]

Well, first of all, with Dr. Finch, who was also a research scientist of some renown in red-cell disorders, like anemias and conditions like that, had been a very good teacher in terms of approaching research problems related to red cells and how to understand anemias and the processes and causes and diagnoses and so on. All of these areas were in their different phases of evolution. So he was a very good person to teach his students how to approach these diseases from not only a clinical way but a research way.

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Then with my time in Manchester, this was a similar process of where one can—I worked with hundreds of experimental mice, literally hundreds of mice, and where one could apply techniques of transfusion into mice, believe it or not, exposing them to low oxygen and injecting animals and radiating mice and work out answers to certain questions related to stem cells.

So with those two consecutive years added to the clinical hematology, I was prepared to work this out and also have the qualifications, with help from Dr. Finch, to apply for a research grant so that I would be developing my own projects, at first with his supervision and then with my own. And that's, as you can imagine, a fairly intense one-on-one, "What are you doing this week?" And, "Report to me what's the progress, and are you writing this up? Are you presenting this, or what are you doing?"

[00:45:03]

Tacey Ann Rosolowski, PhD

[00:45:03]

It's like really intense mentoring.

[00:45:04]

Raymond Alexanian, MD

[00:45:05]

And then when you write something, he said, "Well, send me a draft of what you're writing." So I would write something, which I thought I was good at writing, but I was not really as good as he was, of course, and so he would edit everything I wrote in great detail. He was a terrific, superb editor of science-writing. He says, "Are you saying something that's clear here? That's not clear to me."

[00:45:37]

Tacey Ann Rosolowski, PhD

[00:45:38]

Is this Dr. Lajtha?

[00:45:39]

Raymond Alexanian, MD

[00:45:39]

Dr. Finch first, and then Dr. Lajtha, the same thing, a double-barreled sequence. And he said, "Well, if you can't write clearly, then you can't think clearly." So I didn't quite agree with that, but still you can think up to a point but maybe expressing it is different, so I was drilled heavily for two years on this.

[00:46:13]

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Tacey Ann Rosolowski, PhD

[00:46:14]

So with both problem solving and kind of basic knowledge and—yeah.

[00:46:18]

Raymond Alexanian, MD

[00:46:19]

So I was in a good position to come here, and so I had my own research project here.

[00:46:27]

Tacey Ann Rosolowski, PhD

[00:46:27]

And what was that?

[00:46:27]

Raymond Alexanian, MD

[00:46:28]

Well, at that time, I carried the program I had begun in Seattle. You see, there was another year in Seattle in '63, as I was—

[00:46:44]

Tacey Ann Rosolowski, PhD

[00:46:45]

So you began your own research project during that year?

[00:46:48]

Raymond Alexanian, MD

[00:46:48]

During that year with Dr.—that dealt with the hormone called erythropoietin. It's sort of spelled out in the writing. And this substance is, as you know, widely used now for treating anemia and—

[00:47:07]

Tacey Ann Rosolowski, PhD

[00:47:08]

And what was the project? What were you working on with it?

[00:47:10]

Raymond Alexanian, MD

[00:47:10]

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Well, it's hard to believe, but I was the first one to detect or measure normal levels in human beings, which everyone knew that it was there, but no one could quantify it, so I was able to quantify it in human urine. So my project dealt with large twenty-four-hour collections of urine from patients and normal people, and we would take the urine and concentrate it into a tiny amount by essentially drying it up, dry up the urine by allowing the water to flow through a cellophane filter over a period of time, and you're left with a small amount, say a cupful, that represents a twenty-four-hour collection, or even less. And you can take those small amounts and inject it into mice and measure their erythropoietin. There's more to it than that, but that's essentially the process.

[00:48:43]

Tacey Ann Rosolowski, PhD

[00:48:44]

Now, what does erythropoietin do in the body?

[00:48:47]

Raymond Alexanian, MD

[00:48:48]

As human beings become more anemic due to blood loss or due to disease, they build up a normal response with high levels of erythropoietin, which is a hormone, to make more red cells. It's a compensating feature for anemia, and it's also a compensating feature for people at high altitude, so as you get low in oxygen, it helps you adjust. It's part of a normal adaptation, I guess similar to many other hormones like insulin. When the sugar levels are high, we make more of our insulin to bring it down. And other hormones.

[00:49:38]

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Chapter **05**
B: MD Anderson Past
MD Anderson in the mid-Sixties

Story Codes

B: MD Anderson History
B: Multi-disciplinary Approaches
C: Research, Care, and Education
C: Portraits

Tacey Ann Rosolowski, PhD

[00:49:40]

Interesting. So, coming to MD Anderson.

[00:49:45]

Raymond Alexanian, MD

[00:49:47]

So I began with this project, but also began to see patients and—

[00:49:53]

Tacey Ann Rosolowski, PhD

[00:49:54]

So when you were hired here, what was your—

[00:49:57]

Raymond Alexanian, MD

[00:49:57]

I had very limited experience, very limited in oncology. I had my two-year training in hematology, the fundamental two years, the first two years. So I did see some patients, a few patients, with leukemia or lymphoma or myeloma, very few, but I did see some. Dr. Finch was a teacher in all of these areas, and so I had some—and, of course, I had studied the textbooks and articles of these different diseases, but I had not seen a large number of patients.

[00:50:40]

Tacey Ann Rosolowski, PhD

[00:50:41]

So why did they bring you here? What was your [unclear]?

[00:50:44]

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Raymond Alexanian, MD

[00:50:44]

Well, the goal was to—at that time Dr. Bergsagel’s ambition was to develop a department that combined basic with clinical research, so that in those days, Dr. Clark, who was the president, felt that it was important to shorten the time between the laboratory and the bedside. That was part of the philosophy of research in those days and still is now. So if one could shorten the time, one could help more patients.

But as soon as I arrived, Dr. Bergsagel, who was then going to be my mentor, my new mentor—you remember I’ve had a number of mentors along—

[00:51:45]

Tacey Ann Rosolowski, PhD

[00:51:45]

Yeah, very lucky too.

[00:51:46]

Raymond Alexanian, MD

[00:51:47]

—said that he was moving to Toronto and that I’m more or less on my own. But I also had other colleagues here, Dr. Schullenberger, who was head of hematology then, Dr. Gamble, who was head of medicine then, but they had less focus on research than Dr. Bergsagel.

So Dr. Bergsagel invited me to join him in Toronto, and so I did go for an interview, and I and my wife said, “Hell, no, I’m not going up to Canada.” (laughter) I just came from Seattle. We just had moved after a series of moves, and I was not ready. So here I am.

[00:52:44]

Tacey Ann Rosolowski, PhD

[00:52:44]

So here you are. Right. So that meant, wow, suddenly you’re here at MD Anderson having research going without a mentor for the first time, really.

[00:52:54]

Raymond Alexanian, MD

[00:52:55]

Without a mentor, but that was quickly partially resolved in different ways. First of all, as soon as I arrived, there was a Southwest Oncology Group that MD Anderson was part of with other

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academic centers in the Southwest, and I inherited Dr. Bergsagel's myeloma program that he had begun here. This is clinical trials in myeloma.

However, there were also programs in lymphoma and leukemia, and Dr. Clark very rapidly then hired other leaders in these fields, like Dr. Frei and Dr. Freireich, who began their own department, who had a major influence on my research, because even though I was not physically in their department, they were major mentors in the area of clinical trials and studying disease and so on.

[00:54:30]

Tacey Ann Rosolowski, PhD

[00:54:31]

And just for the record, the department that Dr. Frei and Freireich were part of was Developmental Therapeutics.

[00:54:36]

Raymond Alexanian, MD

[00:54:36]

Developmental Therapeutics. And since I was hired in hematology, I chose to stay in hematology since I felt it improper to change departments so soon after I had—

[00:54:58]

Tacey Ann Rosolowski, PhD

[00:54:59]

But you considered it?

[00:55:00]

Raymond Alexanian, MD

[00:55:00]

No, I didn't.

[00:55:01]

Tacey Ann Rosolowski, PhD

[00:55:01]

Oh, you didn't consider it. Okay.

[00:55:02]

Raymond Alexanian, MD

[00:55:02]

I was invited to, and I made it clear that it was just too fast, too quick for me, and I'd just as soon

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learn from Dr. Frei and Freireich, who were very helpful and constructive, teaching me a lot. I went to all of their conferences and so on. So I had a new set of mentors, you might say.
[00:55:36]

Tacey Ann Rosolowski, PhD

[00:55:37]

We have just a few minutes remaining today because I know you have something else to do after this.

[00:55:41]

Raymond Alexanian, MD

[00:55:41]

[unclear].

[00:55:41]

Tacey Ann Rosolowski, PhD

[00:55:42]

Yes, we have. It's almost quarter of.

[00:55:43]

Raymond Alexanian, MD

[00:55:44]

Well, I can do eleven—until twelve.

[00:55:50]

Tacey Ann Rosolowski, PhD

[00:55:51]

Oh, you can?

[00:55:51]

Raymond Alexanian, MD

[00:55:52]

You want to keep going?

[00:55:53]

Tacey Ann Rosolowski, PhD

[00:55:53]

Oh, great. Sure. That would be fine.

[00:55:54]

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Raymond Alexanian, MD

[00:55:55]

Let's keep going.

[00:55:53]

Tacey Ann Rosolowski, PhD

[00:55:55]

Okay. Terrific.

[00:55:55]

Raymond Alexanian, MD

[00:55:55]

Because the more we can do today, the better.

[00:55:57]

Tacey Ann Rosolowski, PhD

[00:55:57]

Yeah, that's great.

[00:55:58]

Raymond Alexanian, MD

[00:55:58]

Are you tired yet?

[00:55:58]

Tacey Ann Rosolowski, PhD

[00:55:59]

No, I'm good. (laughter) I just didn't want to make you late if you had something you had to do.

[00:56:05]

Raymond Alexanian, MD

[00:56:05]

Am I covering the kind of ground you're looking for?

[00:56:07]

Tacey Ann Rosolowski, PhD

[00:56:07]

Yeah, and I'll certainly ask a question to direct focus if we need to do that.

[00:56:12] O

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One thing I wanted to ask you about is kind of your impressions of MD Anderson at the time when you arrived. I mean, it's a very different institution than it was by the time you left.
[00:56:24]

Raymond Alexanian, MD

[00:56:25]

Yes. Well, by then, as you can imagine, I had already been at so many institutions, both in my education, including army hospitals and centers in England, because even in my training, it was customary in those days of more difficult travel that if you're going on a trip, by the way, stop off at this center and give a little talk or see what they're doing. So there was a kind of a custom to visit different centers in transit.

So, going to England back, I must have visited ten different centers in transit to give talks and learn from them in different areas like Salt Lake City and Brookhaven and places at Cambridge and Paris, different places all over, who were doing research similar to my area of study, so that I would present my data and they would critique it, which is good, and say, "Maybe you could do this better this way," or that way, and they would tell me their project. As a younger person, I wasn't as competent as they were in helping me as suggesting to them. So it was a very good experience. I don't know, I don't think that's done anymore in that way. It was more of a family of people in your field whom you engaged with.

So where were we?

[00:58:41]

Tacey Ann Rosolowski, PhD

[00:58:42]

You were contrasting—

[00:58:43]

Raymond Alexanian, MD

[00:58:43]

Oh, my impressions of MD Anderson.

[00:58:44]

Tacey Ann Rosolowski, PhD

[00:58:44]

Yeah, mm-hmm.

[00:58:44]

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Raymond Alexanian, MD

[00:58:44]

Well, first of all, I was kind of happy that I had a job that I could say was my permanent job at least for a period and that I had a direction and project. I had my erythropoietin project and also clinical trials projects and myeloma or any other related cancers that would be of interest, and I was part of a team that was focusing on these different areas related to cancer so that there was more of a cancer-focus orientation.

It was apparent very early that MD Anderson was a leading center for cancer research. There were only three at the time: there was Sloan-Kettering, MD Anderson, and Roswell Park. So I was at one of the three leading cancer centers. At this center, there was also a clear desire to develop in the field, to expand and move up, to build more, become bigger, more people, and so on, so that I was part of an ambitious program.

Dr. Clark was a very, in a way, inspiring type of person. Even though he was a surgeon, he had kind of grand view of the future that was interesting. Of course, many of the people you hear in my training, college presidents and medical school deans, they all have a grand view for their own future, and so he was in that vogue of future. So it was different from what I had been exposed to before because it was cancer-focused and it was an institution-focused.

[01:01:26]

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Chapter 06

A: The Researcher

Focusing on Myeloma and Perspectives on Myeloma Research and Treatment

Story Codes

A: The Researcher

C: Discovery and Success

C: Evolution of Career

B: Controversy

B: MD Anderson History

C: Professional Practice

C: The Professional at Work

D: Understanding Cancer, the History of Science, Cancer Research

D: The History of Health Care, Patient Care

C: Collaborations

A: Overview

A: Definitions, Explanations, Translations

Tacey Ann Rosolowski, PhD

[01:01:27]

So tell me about how your research evolved once you came here, because you obviously had expanded the array of research you had done.

[01:01:35]

Raymond Alexanian, MD

[01:01:36]

I felt I was successful in my erythropoietin program for a number of years. I can't remember when my last paper in that field was written. It probably ran for maybe eight or ten years, something like that. And then as—

[01:02:02]

Tacey Ann Rosolowski, PhD

[01:02:02]

Can I ask you, what was the significance of that research vis-à-vis cancer?

[01:02:07]

Raymond Alexanian, MD

[01:02:08]

Well, at the time, patients with hematologic cancers usually had developed anemia, and anemia

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was due to bone marrow failure, usually, or infiltration of some sort. So there was the idea that maybe one could learn to help the anemia in some way. And as it turned out, some of my research both in Seattle and here was incorporated into the later development of commercially produced erythropoietin by Amgen Company, and they were based in Seattle [unclear], because that was an anemia red-cell center. As I say, Dr Finch was interested in that. So that evolved. I think that's the connection. There could have been another reason why they're based in Seattle.

So they developed commercial erythropoietin for treating patients with anemia, at first with kidney failure, where they cannot make erythropoietin, so they have an inability to make any erythropoietin. Then it was applied to other causes of anemia, including cancer-related anemia. There was not a direct, thoughtful plan in that on my part. It just happened to evolve that way, and I was kind of pleased to see that some of my earlier work sort of contributed to this later therapeutic process.

So by then, though, after a number of years, it was evident that myeloma as a clinical problem was becoming more important to me, and there were many more patients, and it was evident that with the resources available with the number of patients and the variety and the clinical trials, that there was a major potential for research and understanding what the disease was and how it developed and what could be done to control it and whether one could reach a point where one could cure it eventually.

[01:05:18]

Tacey Ann Rosolowski, PhD

[01:05:19]

Now, when I was doing some background work on this, it seemed as though myeloma was actually a pretty—I mean, there wasn't a huge incidence of it. Is that correct?

[01:05:28]

Raymond Alexanian, MD

[01:05:29]

That's correct. However, it's all in proportion. Compared to the three common diseases, leukemia, lymphoma, myeloma, each of these, leukemia has a dozen varieties or more, maybe, lymphoma the same dozen varieties, myeloma has just myeloma. There are attempts to break down varieties. And the number of patients in the country with myeloma who are diagnosed are more common than, say, from Hodgkin's Disease, which is a common lymphoma, but only one of a variety of lymphomas, and it's more common than the most common acute leukemia, but there are a whole bunch of varieties. So leukemia has a variety of diseases. So—

[01:06:44]

Tacey Ann Rosolowski, PhD

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[01:06:45]

I guess the reason I said that was because it sounds as though MD Anderson, since it saw so many patients, gave you an opportunity to see more cases of this relatively rare condition.

[01:06:56]

Raymond Alexanian, MD

[01:06:56]

More cases, but it's not about the cases. You want to—I look on each patient as not only a project to do the best for that patient, but to learn the most from that patient for future patients. So every patient is—I don't want to use the word “experiment.” Maybe that's something I should seal for fifteen years. (laughs) Each patient is a model, is a sample of what dozens of future patients will become with time, who have not been diagnosed yet, but will develop. You and I could develop. So it was important to document each patient as best as possible, the nature of his disease, how he fits into the spectrum of myeloma, what features he had that were different from others, how one could control it, which drugs, which combinations, and so on and so on and so on, so that every patient became a research subject. Every patient I saw was a research subject.

[01:08:19]

Tacey Ann Rosolowski, PhD

[01:08:24]

Why did myeloma become so important rather than you focusing on lymphoma or [unclear] leukemia?

[01:08:33]

Raymond Alexanian, MD

[01:08:34]

Well, as this center evolved, as you heard, when Dr. Frei and Dr. Freireich came, the division of patients was a controversial area. I'm sure others have spoken to this. And there was a de facto scheme that evolved with time over a period of several years that leukemias would be primarily with developmental therapeutics. Myeloma would be with Dr. Alexanian. Since it was an uncommon disease, let him take care of it. And lymphomas became kind of a battleground, you might say. As time developed, I don't think the lymphoma issue was ever finally settled. The leukemias and myeloma were settled, and lymphoma's remained a battleground for many years, in part—well, I'm not sure of some of this, but my understanding was in part because the radiation therapy was an important part of the lymphoma treatment and radiation therapy such as with Dr. Fuller—have you interviewed her?

[01:10:30]

Tacey Ann Rosolowski, PhD

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[01:10:30]

No.

[01:10:31]

Raymond Alexanian, MD

[01:10:31]

She would be interesting to interview.

[01:10:33]

Tacey Ann Rosolowski, PhD

[01:10:34]

Her first name?

[01:10:35]

Raymond Alexanian, MD

[01:10:35]

Lillian Fuller. She's getting older, but I think she's clear. Sort of sided with hematology on that issue. I tried to stay out of this battle. It was sometimes acrimonious and—

[01:11:04]

Tacey Ann Rosolowski, PhD

[01:11:07]

I get the picture of some pretty intense personalities at the time.

[01:11:10]

Raymond Alexanian, MD

[01:11:11]

Yeah, intense personalities, but, you know, the referral pattern automatically, in a way, neutralized some of the tension, because when patients are referred to an individual doctor or a group, that is the pathway that patient would follow. So the control of the referral pattern was there was no specific control. Dr. Clark made it clear that the referral pattern was a referral pattern, that if a doctor outside wanted to send a patient to a doctor here, there's nothing anyone's going to do to change that. So after a number of years, this conflict became more settled. Maybe it took ten years, though.

[01:12:18]

Tacey Ann Rosolowski, PhD

[01:12:18]

Wow.

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Raymond Alexanian, MD

[01:12:21]

I think I'd be interested in hearing what Dr. Freireich says to this, because he was a major factor in this tension.

[01:12:32]

Tacey Ann Rosolowski, PhD

[01:12:34]

Interesting. Wow. Well, I kind of derailed you on this from talking about the progress of your research on myeloma, so let's [unclear].

[01:12:44]

CLIP Research Innovations

Raymond Alexanian, MD

[01:12:45]

Well, when I first came here for an interview, there was no effective treatment for myeloma. None. Dr. Bergsagel was one of the very first to discover a drug that was effective in controlling myeloma. In 1962, he wrote his paper. So at that time, there was only one effective drug, and there were clinical trials in the Southwest Oncology Group with that drug that led to this discovery.

Then when Dr. Frei influenced me as my mentor in clinical trials, along with Dr. Bergsagel, there was the effort to evaluate combinations of drugs. So combinations of drugs were developed for treating leukemia, lymphoma, myeloma, and so combinations of drugs were developed for myeloma that were better than the single drug. Then as the years elapsed, other techniques such as high-dose therapy supported by bone marrow transplant, were developed—that's some years later—as another modality.

[01:14:33]

Tacey Ann Rosolowski, PhD

[01:14:33]

Now, is the first kind of big landmark—because I have 1969 as the date when you were able to show that Melphalan with Prednisone—

[01:14:43]

Raymond Alexanian, MD

[01:14:43]

Melphalan with Prednisone. Yes, that was an important study that showed that, the first combination, and that was then the worldwide standard of care for many years, and you can say

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that was my first major discovery, but that was developed by a number of many people in the Southwest Group with Dr. Frei and Dr. Bergsagel's influence.

[01:15:20]

Tacey Ann Rosolowski, PhD

[01:15:22]

So what was the reasoning to combine those particular drugs? What's the logic of trying the combinations?

[01:15:30]

Raymond Alexanian, MD

[01:15:31]

You know, it's very empiric. Dr. Frei, when I met with him, says, "Ray, what drugs are useful in myeloma? What might be useful?"

And I said, "Well, we have Melphalan."

"Okay. Well, what else is there? Is there anything out there?"

So I said, "Well, we use Prednisone to treat high blood calcium in myeloma, and when we give Prednisone, it makes people feel better when they're taking it, and it seems to alleviate nausea sometimes, but I don't know if it will kill myeloma."

So he said, "What else?"

I said, "Well, the bones are soft in myeloma, and there's some people that think that fluoride," fluoride like for your teeth, fluoride, "might help myeloma, help with the bones."

"Okay. Let's put that down. Fluoride. What else?"

I said, "Well, in patients with anemia, I'm giving a male hormone to boost up erythropoietin levels to help with anemia in some patients." And at that time, male hormone injections were a common treatment for anemia. And I worked out that it was through erythropoietin, the improvement, but that's a different story, but still.

So he said, "Let's put that on the list. Anything else?"

So I said, "Well, that's all I can think of. Maybe something will come to me."

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So he said, “Well, let’s put together a cocktail and let’s give it some people.” You know, in those days, research protocols did not have to go through the scrutiny they do now. I’m sure we couldn’t have done any of these trials with our current standards requirements.

[01:17:45]

Tacey Ann Rosolowski, PhD

[01:17:45]

Right.

[01:17:46]

Raymond Alexanian, MD

[01:17:47]

So we put this combination together and brought it to the Southwest Group as a proposal. At that time, MD Anderson registered maybe half the patients with myeloma. The other half came from all the others together, so we could double the pace of it. And we found that the combination of the four drugs worked better in inducing remissions and building up the hemoglobin and maybe helping the bones and so on.

Then as time went on, it became evident, well, maybe we don’t need the fluoride and the male hormone. Maybe we just do the Prednisone and so on. That’s why we focused on that. Then with the Prednisone, as you can imagine, there are side effects from a drug like that. If you take it daily for a long period, you get bloated and irritable and so on. So I worked it out so that the Prednisone would only be given for a short burst in high dose with the Melphalan, so that the side effects would be markedly reduced, although for a few days you might have insomnia that you could also neutralize with some, in those days, barbiturate. Now there are other sedatives now.

So a lot of this was trial and error and working out the details, and then from then there were long gaps in our progress, but then every so often new drugs and new programs—and the two main programs would be the transplant-supported program, which we began here with Dr.—get my bibliography. (laughter)

[01:20:38]

Tacey Ann Rosolowski, PhD

[01:20:39]

I don’t know if I have a complete one. This is the advantage of being able to go back and correct.

[01:20:50]

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Raymond Alexanian, MD

[01:20:49]

[unclear].

[01:20:49]

Tacey Ann Rosolowski, PhD

[01:20:50]

No, no, it's quite all right. Also, as you'll notice, I'm taking a lot of notes, and I can send you the notes and you'll probably be able to supply the name at a later date.

[01:21:01]

Raymond Alexanian, MD

[01:21:05]

These only have the recent papers.

[01:21:07]

Tacey Ann Rosolowski, PhD

[01:21:07]

That's okay. We can fill it in later. Not to worry.

[01:21:09]

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Chapter 07

A: The Researcher

Myeloma: Breakthroughs with Transplant-Supported Chemotherapy

Story Codes

A: The Researcher
A: The Clinician
C: Discovery and Success
C: Patients
C: Patients, Treatment, Survivors
C: Professional Practice
C: The Professional at Work
C: Collaborations
B: Multi-disciplinary Approaches
D: Fiscal Realities in Healthcare

CLIP Research Innovations

Raymond Alexanian, MD

[01:21:10]

Anyway, but also that doctor—the major influence then, the next thing was when Dr. Barlogie joined me. Dr. Barlogie was a very important scientist who worked in Dr. Freireich's department in the laboratory, but he was also interested in clinical matters and was a very inspiring person to work with, who thought of a number of imaginative things and felt that if we could exploit a—there was an Englishman named McElvain, M-c-E-l-v-a-i-n, who presented a paper that showed that if you gave Melphalan in very high dose, very high toxic dose, severely toxic doses, you could recontrol the myeloma in patients who would otherwise be dying of myeloma, but with a high mortality of about 25, 30 percent.

So Dr. Barlogie said, “There's something there that we need to look into.”

And I said, “Great.”

So he said, “Why don't we just see if we can use the high doses and rescue the patient with a transplant so they would survive the procedure.” So he then persuaded our transplant service. The gentleman's name I'm thinking is from Holland. Why can't I think of his name?

So we decided, “Okay, let's find some patients who would otherwise be dead in a few months, and let's do the same procedure on them.”

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So I said, “Well, you can’t do it on them, because their marrow is filled with tumor, and how are you going to get your stem cells?” Remember stem cells, that’s my old field. (laughs)
[01:24:10]

Tacey Ann Rosolowski, PhD

[01:24:11]

Mm-hmm.

[01:24:11]

Raymond Alexanian, MD

[01:24:12]

“How are you going to get your stem cells?” So I said, “Well, maybe there are enough in there that we can use, or maybe we can work out a way of purifying it or something like that.”

Well, to make a long story short, there were enough even in patients—enough stem cells.

[01:24:28]

Tacey Ann Rosolowski, PhD

[01:24:28]

Oh, really?

[01:24:29]

Raymond Alexanian, MD

[01:24:29]

But at the time you drew the marrow, then there weren’t enough in everybody. In other words, you couldn’t tell who had enough stem cells to save them and who didn’t. So we could collect the marrow, calculate if we had enough, give them the high-dose therapy, give them their marrow back, and hope for the best.

[01:24:54]

Tacey Ann Rosolowski, PhD

[01:24:55]

My god.

[01:24:56]

Raymond Alexanian, MD

[01:24:57]

They’re otherwise dying, though, so they sign consents.

[01:25:01]

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Tacey Ann Rosolowski, PhD

[01:25:01]

Sure.

[01:25:01]

Raymond Alexanian, MD

[01:25:03]

So it turned out that more than 90 percent had enough stem cells, but in the early phases, we did lose a small number because what we thought were sufficient were not, and it turned out to be effective in half of the 90, half of those. In other words, we were able to do what McElvain had done without the transplant with the transplant and pull 90 percent of them through it successfully.

So then it was apparent pretty early on that even though it worked, it only worked for a few months, six months. So I said, "Well, this doesn't make sense. We've got to do this earlier in the disease, before they relapse." So then we said we have to take patients who are in remission, who are healthy and not relapsing, and who could be healthy for five years, and then take their stem cells, hope we had enough, and hit them hard then. Of course, no one had done these things before. (laughs)

[01:25:03]

Tacey Ann Rosolowski, PhD

[01:26:46]

Right, right.

[01:26:48]

Raymond Alexanian, MD

[01:26:48]

So then we started to do that, and it turned out that we began to see instead of what we call partial remissions, which is where you have remission but you still have residual disease left, from the tests that we do, we began to see a higher number of so-called complete remissions, there was no sign of disease, that we rarely ever saw with just Melphalan and Prednisone. Melphalan and Prednisone may have a 5 percent complete remission rate, but with the transplant-supportive therapy, it had become 25 percent or 30 percent. So I said, "Something's happening here, and maybe that'll last longer." Well, it does last. Complete remissions do last a lot longer, but then there was, again, recurrence.

[01:27:47]

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Tacey Ann Rosolowski, PhD

[01:27:48]

How long did those remissions last?

[01:27:50]

Raymond Alexanian, MD

[01:27:51]

Partial remissions lasted, on the average, two years, and complete remissions lasted, on the average, four years.

[01:27:58]

Tacey Ann Rosolowski, PhD

[01:28:02]

Now, let me ask a question. Here you have a patient who's in remission, they've gone through, you know, a very arduous treatment process. Was it difficult to convince patients to undertake another trial, to go through this kind of thing again?

[01:28:24]

Raymond Alexanian, PhD

[01:28:25]

Well, one of the things about a center like this, which, even before the patient comes here, has a big, strong reputation, and when they've come to see a specialist in that center such as myself, who has probably a lot more experience than their oncologist does in this disease, and I explain to them that, "This is where we are in our knowledge of your disease and that your likelihood of relapse is such-and-such after so many years, based on previous natural history." As I mentioned, every patient I see is a study, so I'm collecting all of this, hundreds and hundreds of patients in my database, that I can tell them with some accuracy, "This is what's going to happen if we don't do this with certain ranges, you know. And we're developing this new program, which involves this, this, and so on, and I can tell you, sir, that if it were me or my family, I would do it, because we have maybe done it ten and you may be the eleventh, and so far it's working out and they're getting through it. It's not easy, and you don't have to do this if you don't want to, but I think it's worth it. Plus it's going to cost you a lot," because insurance had not approved these procedures, "but we can cover some of it at a center like ours." It's curious, we can cover the indigents, but we can't cover those with money. You know that.

[01:30:37]

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Tacey Ann Rosolowski, PhD

[01:30:37]

Mm-hmm, mm-hmm.

[01:30:38]

Raymond Alexanian, MD

[01:30:39]

So the indigents who come here get more—in those times, got more expert professional attention than those with resources, because they couldn't afford it, which is a sort of, I guess, kind of an irony, you might say. However, very quickly on, we lobbied hard to get Medicare approval, and then once they got Medicare approval, we got insurance approval, and this took a couple of years.

[01:31:19]

Tacey Ann Rosolowski, PhD

[01:31:22]

What years are we talking about here for this process?

[01:31:24]

Raymond Alexanian, MD

[01:31:25]

Oh, gosh, I'd have to look at my—can I see this?

[01:31:29]

Tacey Ann Rosolowski, PhD

[01:31:30]

Yeah, sure. Let's see. I didn't have a date for those bone marrow transplants. I hadn't done a complete review of your—

[01:31:41]

Raymond Alexanian, MD

[01:31:42]

I would say in the 1980s, somewhere in there. And Dr. Barlogie was very instrumental in working this out too.

[01:31:54]

Tacey Ann Rosolowski, PhD

[01:31:54]

Oh, really.

[01:31:55]

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Raymond Alexanian, MD

[01:31:57]

So then it's become the standard of treatment now so that—

[01:32:07]

Tacey Ann Rosolowski, PhD

[01:32:08]

And it's still the standard treatment?

[01:32:09]

Raymond Alexanian, MD

[01:32:09]

Standard treatment.

[01:32:09]

Tacey Ann Rosolowski, PhD

[01:32:09]

Wow.

[01:32:10]

Raymond Alexanian, MD

[01:32:10]

However, only about 80 percent of patients qualify for it. There are certain physical health requirements. You can't have severe heart disease or emphysema, and the transplant service likes to have people who are fit-looking. By that they mean if they can at least walk to the bathroom. And there are some patients who come from abroad who are unable to stay or you have to be physically here. So about 20 percent who might qualify don't receive that for various reasons, but almost all of them do, 80 percent.

Then there were more complexities. [unclear] says, "Well, if one transplant is good, maybe two transplants are better." And that's what Dr. Barlogie developed when he moved to Arkansas. So the people who I work with always move on somewhere else, right?

[01:33:21]

Tacey Ann Rosolowski, PhD

[01:33:21]

Why did Dr. Barlogie leave?

[01:33:22]

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Raymond Alexanian, MD

[01:33:23]

He wanted to set up a Myeloma Center, which—I think he could have stayed here, and I begged him to stay and try to do it here, but I don't know the full—are you going to interview him some day?

[01:33:46]

Tacey Ann Rosolowski, PhD

[01:33:46]

I don't know. I haven't heard his name before, so I don't know.

[01:33:49]

Raymond Alexanian, MD

[01:33:50]

Well, the University of Arkansas were willing to commit huge resources, a whole building, staff, money, multimillions, to develop a Myeloma Center in Arkansas. So it is called the Myeloma Cancer Center, and you could look up his résumé. It's very impressive.

[01:34:20]

Tacey Ann Rosolowski, PhD

[01:34:24]

Interesting.

[01:34:25]

Raymond Alexanian, MD

[01:34:26]

And it turns out that his Center was so successful that he had some conflict with his Division of Medicine head, who wanted some of the money drained to his services that were coming into the Myeloma Center.

[01:34:54]

Tacey Ann Rosolowski, PhD

[01:34:55]

Very interesting.

[01:34:55]

Raymond Alexanian, MD

[01:34:56]

So that's the reason he moved.

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Chapter 08

A: The Researcher

A Breakthrough Myeloma Treatment with Thalidomide

Story Codes

A: The Researcher

A: The Clinician

C: Discovery and Success

C: Collaborations

B: Multi-disciplinary Approaches

B: MD Anderson and Government

B: Critical Perspectives on MD Anderson

Raymond Alexanian, MD

[01:34:56]+

So anyway, but still we carried on here. It turns out that the double transplants were not any better than the single transplant. Then the notion was, well, how about giving a double transplant with the first transplant your own cells and the second transplant from a matched sibling donor, so you can get a graft versus tumor effect. There are all kinds of variations on that, and that didn't turn out to be successful.

CLIP Research Successes

The next big breakthrough came with the two drugs, the Thalidomide group of drugs and the Velcade or Bortezomib group. Now, you should probably read a little bit on how Thalidomide became discovered. Have you heard of that?

[01:36:00]

Tacey Ann Rosolowski, PhD

[01:36:01]

Tell the story for the record. (laughs)

[01:36:03]

Raymond Alexanian, MD

[01:36:05]

Dr. Barlogie had a patient who was otherwise dying and wanted to offer a new drug to try something on him, so he asked a specialist in—let's see. What is the research area? And I can't remember his name either. Oh, my memory. Anyway, a specialist at Harvard who was doing

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work related to small-capillary development around tumors, and he found that Thalidomide, which is a drug that caused birth defects, could inhibit the development of this vascular network, and why don't you give it a try? Of course, Thalidomide had become an orphan drug, but it was still available through sources in Europe and other places, and it was available because it was effective in treating a group of patients with HIV who got various skin ulcers, and I cannot recall the details of that, but it was an effective drug in healing.

So Dr. Barlogie gave a patient Thalidomide. It didn't work in the first one, and he gave it to a next one. One of these first two patients had—there was an article in *New York Times* about the evolution. I should bring that clipping to you, because it was such an interesting journalistic story. The wife of the patient begged him to try anything on her husband, and so he found the Thalidomide and gave it, and I don't know if it was to her husband or the next patient, it was effective in controlling the myeloma—
[01:38:37]

Tacey Ann Rosolowski, PhD
[01:38:38]
Wow.
[01:38:38]

Raymond Alexanian, MD
[01:38:38]
—just out of the blue. And a whole new development of Thalidomide and analogs of Thalidomide developed, and there were very rigorous controls in terms of avoiding pregnancy and so on. So the Celgene company, that was virtually nonexistent and operating out of a closet, you might say, sort of had manufactured this for the HIV patients and became a huge profit-making company because of this single drug and other drugs to follow and then—
[01:39:47]

Tacey Ann Rosolowski, PhD
[01:39:48]
So were there difficulties with dosage? I mean, how—were you involved in this as well?
[01:39:53]

Raymond Alexanian, MD
[01:39:53]
So once it was effective, I said, “Well, what do we do next?” We put it in combinations, right?
[01:39:58]

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Tacey Ann Rosolowski, PhD
[01:39:58]
Yeah, yeah. Right. Mm-hmm.
[01:39:59]

Raymond Alexanian, MD
[01:39:59]

So, therefore, we were first to do a combination of—I forget the first combination, Thalidomide with Dexamethasone, and somewhere in here Dr. Weber has a paper on that.

Then the next drug that came was Velcade that Dr. Orlowski was instrumental, who is now head of myeloma, developed when he was at North Carolina, and this drug was also, as it was being evaluated in Phase 1 trials in cancer, different cancers, found to be effective in myeloma, one patient or two patients, and says, “Oop, we got another one.” So, the next round of combinations.

So the current standard of care is a combination of Velcade first with Thalidomide and Dexamethasone, and then with its analog, R_____ and Dexamethasone, followed by transplant. So that over a period of forty years we have evolved from no remissions and an average survival of a year and a half in myeloma to a combination of drugs that can control and transplant that induces remission in 95 percent of patients, of whom 40 percent are complete remissions and where the average survival is six years, median survival, with about 3 percent probably being cured. I have a paper on curability in here, the last paper—
[01:41:55]

Tacey Ann Rosolowski, PhD
[01:41:56]
Mm-hmm. That’s the most recent one.
[01:41:57]

Raymond Alexanian, MD
[01:41:58]

—where we followed patients for up to twenty years. This is from the old file, carried on, that about 3 percent of patients have not relapsed. They’re in complete remission beyond twelve years. In other words, between twelve and twenty years, still in complete remission.

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Chapter 09

B: Overview

The Challenge of Defining “Cure” in Oncology; Views of Research Approval Processes

Story Codes

A: The Researcher

A: The Clinician

D: Understanding Cancer, the History of Science, Cancer Research

D: The History of Health Care, Patient Care

B: Critical Perspectives on MD Anderson

C: Offering Care, Compassion, Help

C: Patients

C: Cancer and Disease

Raymond Alexanian, MD

[01:41:58]+

So I say, well, someone’s got to come up with a definition of cure. What will it be? So I says, “I think I’ll do it. So let’s call ‘cure’ someone who has not relapsed after twelve years,” and that’s the definition. It may change.

[01:42:41]

Tacey Ann Rosolowski, PhD

[01:42:45]

Interesting. Yeah, I mean, I hadn’t really thought about that question, but it is a question. How do you know when you cure somebody?

[01:42:51]

Raymond Alexanian, MD

[01:42:51]

How do you know when you’re cured of any disease?

[01:42:52]

Tacey Ann Rosolowski, PhD

[01:42:53]

Yeah, yeah.

[01:42:53]

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Raymond Alexanian, MD

[01:42:56]

And I think, now, you can quibble. What do you call somebody who's in, like, complete remission for twelve years and dies of something else? Is he cured? How about if he's in complete remission for five years and dies of something else? Okay. So you can get into little word games and semantics. So I say if you've gone in complete remission twelve years and die of something else, then you're cured, because no one else has died of myeloma after twelve years. But at five years, the prospect of dying from myeloma is higher because you haven't reached that milestone.

[01:43:50]

Tacey Ann Rosolowski, PhD

[01:43:50]

That milestone, yeah.

[01:43:51]

Raymond Alexanian, MD

[01:43:52]

And I think the same thought processes have gone for leukemia and lymphoma and other conditions.

[01:44:01]

Tacey Ann Rosolowski, PhD

[01:44:02]

Right.

[01:44:03]

Raymond Alexanian, MD

[01:44:07]

I'm going to stretch for a minute.

[01:44:08]

Tacey Ann Rosolowski, PhD

[01:44:09]

Sure.

[01:44:09]

Raymond Alexanian, MD

[01:44:09]

How are we doing?

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[01:44:09]

Tacey Ann Rosolowski, PhD

[01:44:09]

We're doing fine. I'll pause the recorder. It is exactly 11:30.

[recorder is paused] (end of first audio file)

Raymond Alexanian, MD

[00:00:00]

—is that there's no design. You've got to get away from that, and I think you've seen that with others.

[00:00:07]

Tacey Ann Rosolowski, PhD

[00:00:08]

Yeah, yeah.

[00:00:08]

Raymond Alexanian, MD

[00:00:09]

All of this is just by chance, and the individuals have to have a certain minimum of ambition for their own careers and also kind of commitment to humanity to some extent—to a big extent, I think. You can't just say, "I'll do it and maybe it'll help somebody." You have to have some commitment to humanity.

[00:00:45]

Tacey Ann Rosolowski, PhD

[00:00:46]

Well, just the way that you've told the stories, you know, that the patient need drives—

[00:00:51]

Raymond Alexanian, MD

[00:00:52]

It drives, right.

[00:00:52]

Tacey Ann Rosolowski, PhD

[00:00:52]

—drives what the researcher's is doing.

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[00:00:54]

Raymond Alexanian, MD

[00:00:56]

There are many circumstances I faced where there's a—and this is what troubles me even now. There are effective programs that could be applied to a difficult patient, but, “Well, we don't have the approvals, we don't the protocols, we don't have the drugs. We can get all these if you wanted to work on it right now.”

And I say, “Look. This man's in the room here,” or woman. “We've got to deal with this now. We can't wait for a year.” So I'm a little bit of a rebel in the sense that I will bypass, deliberately bypass requirements I think I can get away with if I'm going to help a patient, that if I can get a drug somewhere, somehow, and I have this drug, “Sir, I'm putting this on the table here.”

And the nurse said, “Look. You haven't heard anything here.”

“I'm leaving the room. If you want to steal this, I don't know anything about it. But take it in this way. Watch for this side effect.”

So that's why I've broken a lot of rules here. Do you like to hear that? I mean, you can—
[00:02:30]

Tacey Ann Rosolowski, PhD

[00:02:30]

Yeah.

[00:02:30]

Raymond Alexanian, MD

[00:02:31]

You can put it in now and you don't have to save it for fifteen years.

[00:02:34]

Tacey Ann Rosolowski, PhD

[00:02:35]

You can decide. You can decide.

[00:02:36]

Raymond Alexanian, MD

[00:02:36]

No, no.

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[00:02:36]

Tacey Ann Rosolowski, PhD

[00:02:36]

You want to stretch your legs a little bit or do you—

[00:02:38]

Raymond Alexanian, MD

[00:02:38]

I tell you what. I think I'd better go, because I have to get some copies done. Do you know how to make copies here of anything in the library? I have an office, a secretary who can do it.

[00:02:49]

Tacey Ann Rosolowski, PhD

[00:02:49]

I'll turn off the recorder. So we're finishing up with our interview session now, and the time is 11:36. Thank you, Dr. Alexanian.

[00:02:58]

Raymond Alexanian, MD

[00:02:58]

Yes, thank you.

[00:02:59] (end of session one)

Raymond Alexanian, PhD

Interview Session 2 – June 5, 2014

Chapter 00B **Interview Identifier**

Tacey Ann Rosolowski, PhD

[00:00:00]

There we go. Okay. So we are now officially recording, and the time is 9:45, and I'm in the Historical Resources Center Reading Room this morning with Dr. Raymond Alexanian. Today is the fifth of June, 2014.

So thank you very much, Dr. Alexanian, for coming in again this morning.

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Chapter 10

B: Critical Evaluation

Threats to MD Anderson's Status: Losing Focus on Innovative Research and Problems with Regulatory Procedures

Story Codes

A: The Researcher
A: The Clinician
A: Professional Values, Ethics, Purpose
A: Critical Perspectives
B: MD Anderson History
B: Institutional Processes
B: Obstacles, Challenges
B: Beyond the Institution
B: MD Anderson and Government
B: Critical Perspectives on MD Anderson
C: Professional Practice
C: The Professional at Work

Tacey Ann Rosolowski, PhD

[00:00:00]+

And before we turned on the recorder, you mentioned an issue that you wanted to address, an observation you'd made, and I wondered if you would kind of continue making that point for the record.

[00:00:34]

Raymond Alexanian, MD

[00:00:34]

Yes. You invited comments on any areas that might be of interest and might be different from those normally explored, and one issue has been over the years that there are many sections that have a cadre of scientists and clinical leaders who are exploring new research opportunities either in basic research or in clinical trials or in new therapies such as transplant or immunotherapy, and are making progress in their areas, but are often not recognized for their work and either not promoted in a timely manner or attracted elsewhere as other centers recognize the competence of these individuals, and therefore we lose on our own standing. And this is not across the board. Many of our department, since we're dealing with more than a hundred different types of cancer, there are many areas of focus.

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So some areas are holding their own in terms of national standing and competition for new knowledge, where others steadily fall behind because of perhaps resources or patients or personnel or, in some cases, the inclination of the department heads not to embark on certain research programs that might deflect from the clinical missions, and therefore staff is required to spend more time on patient care, and often the patient care is no better than what's in the community, whereas others embark on newer things that have a chance of improving welfare at the same time as maintaining the best possible care and opportunities for patients and programs.
[00:03:35]

Tacey Ann Rosolowski, PhD

[00:03:35]

Are you able to share basically some divisions that you feel are making enormous headway in new knowledge versus others that have been more entrenched?

[00:03:47]

Raymond Alexanian, MD

[00:03:47]

Well, in my particular area, I have felt that in myeloma we have made progress, and leukemia is one of our star departments in terms of transplant department, has melded their technique and technology and resources with those of other departments so that there are strong cooperative links with the other departments that use transplant opportunities. Certain clinical departments such as medical [unclear] are leaders in the field or recognized, and the departments that are recognized are pretty well known to the staff because there is national recognition and awards and so on. So my comments suggest primarily those in hematology, and these comments change, so that's from decade to decade, obviously. So some—

[00:05:15]

Tacey Ann Rosolowski, PhD

[00:05:15]

Right. I was going to ask you that, yeah.

[00:05:16]

Raymond Alexanian, MD

[00:05:16]

—become leaders and some fall behind, and a lot depends on the personnel, the resources in terms of grants and patients and other things, so that this is not a consistent opinion, so there's variability.

[00:05:40]

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Tacey Ann Rosolowski, PhD

[00:05:41]

I mean, I was curious because you came to the institution in 1964 and obviously were very involved in developing a research focus at that time and were working very actively with people who were busy pushing the envelope with treatment. So as you're thinking decade to decade, I mean, what was this problem like in the mid-sixties, you know, and did you see changes in that balance? Did the institution, in your view, have a better record, you know, a greater percentage over time of faculty who were involved in that kind of pioneering research or has it remained the same? I mean, what's your diagnosis over time?

[00:06:22]

Raymond Alexanian, MD

[00:06:22]

My view of it is maybe different from that of others, but in the 1960s when I was recruited, Dr. Clark recognized that there was a potential for important breakthroughs in cancer that were stimulated by the National Cancer Institute and their funding outlets that became more generous, so that he attempted to instill in departments the research mission, even though he himself was not that directly involved, although he may have been in his earlier years. But he felt that since the funding resources became more generous and expansion of the hospital in terms of physical stability and patient referrals were rising, that here was an opportunity to build up the research cadre, and there were also new technologies like CAT scans and MRI scans, transplant, new drugs, new combinations of new and old drugs, and so on, so that he was able to craft this thrust into these new areas. So I think that's what I recognize, although I was very junior here, and I had the sense that this was the reason that I was hired here, you might say.

[00:08:26]

Tacey Ann Rosolowski, PhD

[00:08:27]

But it sounds like it was also a little bit of a cultural shift, that maybe the people who were already hired here, there were a good number of them who hadn't anticipated that their careers would be required to take this kind of a turn.

[00:08:39]

Raymond Alexanian, MD

[00:08:39]

Well, those who were here, already here, were those staffed initially by Dr. Clark as clinical staff, and they were expert clinicians in their field. Many of them did not have an interest in research or the capacity for it, had no training in that area, and so there was, depending on department, by department, some resistance to that notion. "Why should my patients go into this program when he's doing okay this way?" and so on.

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So in order to create something new, you have to clash in some ways, educate, you might call it, and so there were often a series of mini confrontations in this sense, and usually these were resolved very amicably because of the family nature of the hospital that was kind of in a—that the team sense tended to balance the righteous new research push sense, you might say. There was a melding of interests so that as time went on, it was clear that the new ways were successful, and therefore they were pursued with different intensities or vigors.

And, of course, we're talking about not just one disease or area. We're talking about differences in different areas so that as with progress in many places, the advances came in, little steps in each different area at different times, so that sometimes there would be steps forward in one disease and then another disease and so on and so on.

Like one of the first controversies I remember was the treatment for Hodgkin's disease. Hodgkin's disease was a disease that was usually untreatable and incurable, and with the development of combined therapy such as chemotherapy, radiation therapy, staging, so that one could determine who would be potentially curable with radiation alone, who required combination therapy, and so on, this type of approach where medical and radiation therapy and possibly transplant-supported therapies were integrated could be done more easily at a center like MD Anderson, where all of these resources were available and where there was equivalent motivation by individuals in these different areas.

But it wasn't easy. There was a period of steps and years of education, although it became accomplished here so that we were one of the first centers to apply such combined therapies, so that we now look on Hodgkin's disease as cured in a large fraction of patients. And similar approaches were applied to lymphoma and leukemias and so on that were combined therapies and new therapies such as treatment of or prevention of meningeal leukemia, such as in children, so that children's leukemia, which was once incurable, is now cured. I'm not saying that we were the pioneers in that particular area, but we certainly—our group followed up on advances elsewhere. So each area had its own pace of progress.

[00:13:42]

Tacey Ann Rosolowski, PhD

[00:13:43]

Now, obviously a key player in bringing—or key group of players in bringing this research focus to the fore at MD Anderson were all of the personalities involved with Developmental Therapeutics. And I guess, you know, one of the reasons I'm so glad you brought this up is that I have assumed that once developmental therapeutics came in and there was a period of adjustment to this new perception and there were certain administrative changes, that basically

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the commonly held mission of the institution to do pioneering work filtered out through the entire faculty. And I guess what you're telling me is that is not necessarily the case.

[00:14:27]

Raymond Alexanian, MD

[00:14:27]

No, I think Developmental Therapeutics were the leaders in the program I just mentioned.

[00:14:36]

Tacey Ann Rosolowski, PhD

[00:14:36]

Right.

[00:14:37]

Raymond Alexanian, MD

[00:14:38]

With Dr. Frei and Dr. Freireich, the combined therapy was carried by them from the NIH, where they had originally done this work, and therefore applied here. Hodgkin's disease is one of the examples I mentioned, and leukemia the second. These were developed through Developmental Therapeutics, so they were the leaders in the field, but the other aspects such as radiation therapy—and here is where you might want to interview Dr. Fuller, Lillian Fuller, because she was one of the leaders in combined therapy.

The other parts of hematology, like myself, learned from developmental therapeutics and tried to apply those principles in myeloma and other diseases related to myeloma, and I think the same principles were then also applied to breast cancer and other solid tumors where chemotherapy is often given first in order to reduce the bulk of cancer, so that resection may be more complete and then followed with radiation therapy. So the combined modality approach was pioneered by the Developmental Therapeutics here, but the application was done through each department separately so that while they were the leaders, I think it's a mistake to say that they were the only group who were pursuing this.

[00:16:49]

Tacey Ann Rosolowski, PhD

[00:16:50]

Right. I didn't mean to imply that, if that's what you thought I said. I guess what I was thinking, more of a shifting, shifting the focus of the institution, that there became more and more individuals at MD Anderson who were doing that kind of work—

[00:17:04]

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Raymond Alexanian, MD

[00:17:04]

Yes, that's right.

[00:17:05]

Tacey Ann Rosolowski, PhD

[00:17:05]

—rather than focusing strictly on clinical care, as you said the original staff did.

[00:17:12]

Raymond Alexanian, MD

[00:17:13]

Yes. And also, as travel became easier, we were also influenced by other centers' work and so that we were more aware of what might be useful elsewhere, although we considered ourselves the leaders. Of course, that may be an ego expression. So there was more interchange and we became more aware of other people's work as we not only heard their presentations but also reviewed their papers before they were published. So we learned rapidly what was happening.

But we also—it's not just learning, but you have to then say, well, we have to then apply it ourselves and push it through our own system.

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Chapter 11

B: Critical Evaluation

Regulatory Procedures: A Critical View

Story Codes

A: The Researcher
A: The Clinician
A: Critical Perspectives
D: Ethics
B: MD Anderson History
B: Institutional Processes
B: Obstacles, Challenges
B: Beyond the Institution
B: MD Anderson and Government
B: Critical Perspectives on MD Anderson
C: Professional Practice
C: The Professional at Work
C: Understanding the Institution;
C: The Institution and Finances;
C: Research, Care, and Education;

Raymond Alexanian, MD
[00:17:13]+

And one of the second peeve—well, not peeve—second issue that you may wish to bring up with others is that as the years have developed, the regulatory climate has become more oppressive so that it has become much more difficult to develop new programs or new treatments or new techniques, and there is a sense that the regulatory machinery is maintained more to follow the process of review rather than attempting to expedite the research. It used to be the original period, the regulatory review was, say, well, how can we improve that research, how can we add more resources, and how can we add more departments to your combined therapy project? That was the internal review.

Now the review is more focused on are we following the rules so we don't make any mistakes, so that we don't approve drugs that shouldn't be approved, or we're focusing on if we make a mistake and we're audited by the FDA, are we going to be disciplined. There's more of a self-protective emphasis rather than an original emphasis.

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Of course, I'm speaking as an old-timer here, so that I recognize that we need the regulatory review because there are throughout the country a small percentage, perhaps less than 5 percent, of scientists who abuse the rules, who do improper things, avoid getting consent, and cut corners and this. It's like police work, when we have police mainly to protect 95 percent of the people from the 5 percent who speed or rob or steal or do other mischievous things. That's why we have police. So now we have a regulatory group to protect us from the 5 percent, but then we, in a way, impede the other 95 percent. You have not heard that before?

[00:21:37]

Tacey Ann Rosolowski, PhD

[00:21:37]

Oh, I have heard that before. I mean, there are a number of individuals who've talked about the regulation processes and some—I mean, I interviewed Ralph Freedman [Oral History Interview], who obviously was very involved in institutional review boards and very concerned about these ethical issues. And there have been a number of people who've spoken about, you know, the poisonous things that can happen when people do cut corners and what can happen to the individual who's found out.

[00:22:04]

Raymond Alexanian, MD

[00:22:05]

Do they mention poisonous things happening here?

[00:22:07]

Tacey Ann Rosolowski, PhD

[00:22:08]

Yes, they have mentioned some things. I mean, never by name, but issues that have arisen.

[00:22:13]

Raymond Alexanian, MD

[00:22:13]

Well, there's always a small—there's always a thief among you when there's so many people. And the question is—you might look into the history of—like, for instance, you've heard of the drug Thalidomide.

[00:22:38]

Tacey Ann Rosolowski, PhD

[00:22:39]

Oh, yes.

[00:22:39]

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Raymond Alexanian MD

[00:22:40]

Thalidomide used to cause birth defects. But then when Dr. Barlogie was here with me, and then had since moved to Arkansas, he was faced with a patient who was dying from multiple myeloma, and he looked for an opportunity to treat this patient. And I have enormous respect for him because he is one of the more adventurous scientists who has led us forward in this area. So he had heard from another scientist in Boston that this old drug, Thalidomide, would do certain things in the test tube that might help patients with myeloma because of its particular features.

So it happened that Thalidomide had already been commercially approved to treat some rare skin problems that patients with HIV had, so he could then give it to patients with myeloma, which he did. And I won't go into whether he had regulatory approval or not. I suspect he didn't, as I would not have. And he found that it was successful and it was effective. Then that class of drugs became one of the major classes of drugs that were used as effective treatment for myeloma. And although one could have followed a regulatory pathway which might have taken several years to develop in terms of approvals and grants and money and drug and so on and so on, here this was given empirically and found to be effective. So I'm not saying this is what you trade off for in terms of the regulatory things.

[00:24:56]

Tacey Ann Rosolowski, PhD

[00:24:58]

Well, there's no doubt that very complicated and increasingly complicated ethical dilemmas and research dilemmas arise as you're investigating novel treatments.

[00:25:09]

Raymond Alexanian, MD

[00:25:09]

Well, you know, the ethical dilemma, there was a man called Hippocrates who said, "Do no harm." Let's say, as an example, you have something that might be useful but has no harm, no side effects that you know of, [unclear] others, and has not been tested in such a process. The ethical dicta was do no harm, not don't try anything because it might do some unknown harm we hadn't seen.

So I have tremendous respect for Dr. Freedman, but the "do no harm" thesis when applied across the board means "do not try" or "try only after we have had exhaustive reviews and approvals and delays." It probably shouldn't surprise you that when there are clinical trials that are multi-center trials, that in these multi-center approvals that we are usually the last institution to get our

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approvals through the mill, that many times a trial has been completed by the time we even enter it.

[00:26:50]

Tacey Ann Rosolowski, PhD

[00:26:50]

Why is that?

[00:26:51]

Raymond Alexanian, MD

[00:26:54]

I think it's because our regulatory—unless it's changed in the last couple of years, our regulatory apparatus is so oppressive that, first of all, many of our scientists know that and don't even bother joining, saying, "Well, don't wait for us. We have all this and that to do." Or, "Okay, we've started," and by the time the trials are moving on, the trial needs fifty patients in the trial and they have already enrolled forty-five, says, "Okay, we'll enroll one or two at the end." So it's very oppressive, so it's not worth—and it might be useful for somebody to get a poll on how many multi-center trials we are participating in—

[00:27:58]

Tacey Ann Rosolowski, PhD

[00:27:58]

Interesting.

[00:27:59]

Raymond Alexanian, MD

[00:27:59]

—and how late they—from the time it was approved and from the time to when we were allowed to enter, that time frame is the longest; has been.

[00:28:13]

Tacey Ann Rosolowski, PhD

[00:28:14]

Interesting, yeah. I wasn't aware of that. You're the first person who's mentioned that lag.

[00:28:19]

Raymond Alexanian, MD

[00:28:19]

In contrast, when the trial is initiated here and, therefore, we have the, let's say, resources of drug support or grant support and begun here and we are asking others to join us, at those trials we're

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the first. So I'm talking about—so there's some variability. Certain trials, if they're initiated here, we're the first. If they're initiated elsewhere, we're often the last. So there's a mixed—
[00:28:58]

Tacey Ann Rosolowski, PhD

[00:29:00]

Right. Interesting. Very interesting.

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Chapter 12
B: Building the Institution
Chief of the Myeloma Section, 1998 – 2004: Leveraging Resources and Mentoring Young Faculty

Story Codes

A: The Researcher
A: The Clinician
A: The Administrator
B: Multi-disciplinary Approaches
B: MD Anderson Culture
C: Mentoring

Tacey Ann Rosolowski, PhD

[00:29:00]+

Would you like to talk now about some of the administrative roles that you served?

[00:29:10]

Raymond Alexanian, MD

[00:29:10]

Oh, sure. Well, I don't think I've done much administration here. I've been on lots of committees.

[00:29:14]

Tacey Ann Rosolowski, PhD

[00:29:15]

Yeah, and I was interested in those committees, actually, because, I mean, for when they were and what they focused on, but I guess I wanted to start with your role as deputy head and head of section, just to kind of get a handle on what you did there. From 1980 to 1983, you were deputy head of the Division of Cancer Medicine, as I understand.

[00:29:39]

Raymond Alexanian, MD

[00:29:40]

Well, that was, I think, an administrative appointment, where deputy means when the chairman cannot attend a meeting, you attend in his place. So I would say that was more of a title.

[00:29:58]

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Tacey Ann Rosolowski, PhD

[00:29:58]

More of a title. And was that the same situation from '95 to '98 with deputy head of hematology as well?

[00:30:06]

Raymond Alexanian, MD

[00:30:06]

Yes.

[00:30:06]

Tacey Ann Rosolowski, PhD

[00:30:07]

Okay. But from 1998 to 2004, you were head of the section of lymphoma and myeloma, correct?

[00:30:15]

Raymond Alexanian, MD

[00:30:16]

No, I don't think that's right. Well, was I? 1998 to—

[00:30:22]

Tacey Ann Rosolowski, PhD

[00:30:22]

2004.

[00:30:23]

Raymond Alexanian, MD

[00:30:32]

I would say my primarily administrative would be the head of myeloma.

[00:30:37]

Tacey Ann Rosolowski, PhD

[00:30:37]

Okay. And that would—maybe that's the [unclear].

[00:30:41]

Raymond Alexanian, MD

[00:30:41]

I don't even think it was a title.

[00:30:42]

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Tacey Ann Rosolowski, PhD

[00:30:42]

Yeah, it says section chief, myeloma.

[00:30:44]

Raymond Alexanian, MD

[00:30:44]

When I began here, I was the only one doing myeloma for quite a number of years, maybe twenty years, and therefore I was the head of myself. (laughter) I shouldn't say that, because when patients were sick and had to be hospitalized, we had our whole department, small department, rotated in caring for patients who needed hospitalization. But in the clinic I was the only one to see these patients for twenty years, and then Dr. Barlogie joined me, and I'm trying to remember the year. Must be in the 1980s sometime.

[00:31:39]

Tacey Ann Rosolowski, PhD

[00:31:40]

Yeah, if that was twenty years, then it's around '84 or something like that.

[00:31:43]

Raymond Alexanian, MD

[00:31:43]

Something like that.

[00:31:43]

Tacey Ann Rosolowski, PhD

[00:31:44]

Yeah. Okay.

[00:31:44]

Raymond Alexanian, MD

[00:31:44]

Then he and I worked together as partners, and he was the inspiration for many of the new things. However, I continued also building on many of the things I had begun so that the publication record speaks for itself on who did what, I think, and so we were a very good team. Then the transplant service joined our team somewhere in there, and the papers reflect the timing of that, and so that—

[00:32:32]

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Tacey Ann Rosolowski, PhD

[00:32:33]

What was the transplant service attached to before joining [unclear]?

[00:32:37]

Raymond Alexanian, MD

[00:32:38]

No, no, they didn't join. They were independent.

[00:32:40]

Tacey Ann Rosolowski, PhD

[00:32:40]

Okay.

[00:32:41]

Raymond Alexanian, MD

[00:32:41]

Dr. Dicke, Karl Dicke, D-i-c-k-e, developed that section, and he had a small cadre of people that worked with him, and then this expanded as the successes became evident in a number of areas. Then Dr. Champlin came to replace Dr. Dicke, and the dates of that I'm not clear on, and I think the papers would reflect that.

[00:33:24]

Tacey Ann Rosolowski, PhD

[00:33:25]

Now, so was the transplant group, was that—

[00:33:27]

Raymond Alexanian, MD

[00:33:27]

Separate.

[00:33:28]

Tacey Ann Rosolowski, PhD

—formally called the Transplant Group?

[00:33:30]

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Raymond Alexanian, MD

[00:33:30]

Yes, it's a transplant department.

[00:33:32]

Tacey Ann Rosolowski, PhD

[00:33:32]

Transplant department. Okay.

[00:33:32]

Raymond Alexanian, MD

[00:33:33]

Yes. As you know from in the transplant—we're talking about bone marrow transplant and then stem cell transplant, so not organ transplant.

[00:33:50]

Tacey Ann Rosolowski, PhD

[00:33:50]

Mm-hmm. Yeah, you talked about your transplant work last time.

[00:33:54]

Raymond Alexanian, MD

[00:33:54]

Yeah. So that's one of the advantages of a center like ours, is the sense that there was an easy melding of departments where there was shared opportunities and shared credits in terms of papers and grants and so on, so whereas this was easier for us than for many other outside centers.

[00:34:33]

Tacey Ann Rosolowski, PhD

[00:34:34]

Mm-hmm. Mm-hmm. And this was also prior to the period of enormous growth so [unclear].

[00:34:42]

Raymond Alexanian, MD

[00:34:43]

This was at the time during the—now I'm talking—the first combined was with radiation and then transplant, so that there were different techniques. And now we're talking about immunotherapy, different newer techniques that are showing promise.

[00:35:03]

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Tacey Ann Rosolowski, PhD

[00:35:04]

Mm-hmm. So as head of section, when you kind of took on that role formally, were there any specific changes in the power that you were given to make decisions, the resources that you were given to develop the areas? What happened with that?

[00:35:25]

Raymond Alexanian, MD

[00:35:26]

Well, you try to exploit the opportunities you have in terms of personnel, patients, techniques, financial support, and so you decide, first of all, what is the most promising area of research and advance in your field, and then see how you can apply what you have to make those advances, and then show in terms of papers and studies and larger numbers of patients—see, one of the advantages here, the major advantage of MD Anderson is a large numbers of patients with diversity, with diverse features, combined with the resources in terms of diverse technologies and techniques, and so that one can apply these so that one can—just a small number of people, like myself and Dr. Barlogie, with the numbers of patients we see and applying the new methods quickly, we can develop better treatments and better ways of understanding. And Dr. Barlogie also provided a special laboratory support in terms of—I was going to say DNA, RNA, and typing facilities that he was able to apply to patients with myeloma.

[00:37:26]

Tacey Ann Rosolowski, PhD

[00:37:26]

So in 1998, when you were given the title of section chief, did you have resources from the administration that enabled you act on some of those strategic pathways?

[00:37:40]

Raymond Alexanian, MD

[00:37:44]

As I mentioned, resources are the number of patients—when we're dealing with drugs and laboratory, we have samples and bone marrow studies, and the laboratory—see, the laboratory was able to do cytogenetics, and we could do special technology procedures with some of the staff in laboratory medicine. Laboratory medicine is a crucial part of the work in myeloma, in terms of special tests, one test called electrophoresis, and that's very important in myeloma studies.

So our work with the clinical special chemistry and bone marrow, the facilities were already there, the application of certain programs to the patients who were also already there, and one

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thing that I always felt, which I commented on before, is that for every new patient that I saw, there was a database. His data was recorded in a database in terms of his clinical and laboratory features and so on, so that the follow-up could be done more easily. So there was no special providing of—that's one of the great advantages of a place like this, you have the resources.
[00:39:50]

Tacey Ann Rosolowski, PhD

[00:39:51]

Mm-hmm. They're already available.

[00:39:51]

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Chapter 13

A: The Educator

Mentoring Young Faculty in Research Flexibility and Writing Skills

Story Codes

A: The Mentor
C: Mentoring
D: On Research and Researchers

Raymond Alexanian, MD

[00:39:53]

And one of the issues, somebody can say, “Well, I can’t do any research because we can’t do this special test here.”

And I’d say, “How can you say that? You don’t have to do *that* particular new thing. How about these other things as a young person you could develop that’s already here? Don’t look for something that might not come here for five years. You have your own career to develop. You need to get some papers written. Why don’t you do with what you have first as you simultaneously work on getting the other things for five years?” So there’s a kind of a—you have to in some ways inspire people to look to your career, make your discoveries with what you have as rapidly as you can, get a name for yourself gradually, and then if you have some—I guess what I’m saying is get your singles and doubles in as a young person and then get the home run when you’re a little bit on more secure ground and have everything.

[00:41:16]

Tacey Ann Rosolowski, PhD

[00:41:17]

Interesting, yeah, a strategic plan for a career.

[00:41:20]

Raymond Alexanian, MD

[00:41:21]

Yeah. That’s why many people get discouraged too easily because they’re not—I don’t think some of them may not be led in the way that I would do. And also another painful thing is that many people, when they have a finding, made an observation, I say, “You’ve got to have this presented at a meeting and have a paper, write it up,” they’ll say, “Oh, I don’t know how to write. I’m too lazy to write. I can’t do this and that and so on.”

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I say, “Never mind. I want to see a draft next month summarize this, this, this,” and next month comes and very little is done. “Look, I’m serious. I want something in writing. This is your job,” and blah, blah, blah, blah. You have to work with young people in terms of writing. Writing comes hard. Even Ernest Hemingway took weeks to write; it didn’t come in an hour. You have to work at things. So writing is one of the important aspects that I have a focus on. I think it’s important to get it right, get the draft written, get it accepted, and even then when you submit a paper, it’s not the end of it. You get critiques. You have to do some things over again and so on. You have to work hard with the system. And too little of that is done now. There’s a certain laziness, I call it, to writing, even though the observations are there, and very little happens. Then what do you find? You open the journal, then you find, oh, Mayo Clinic just wrote the same thing that you had all the data on for two or three years, and there it is.

[00:43:31]

Tacey Ann Rosolowski, PhD

[00:43:32]

Yeah, the missed opportunity.

[00:43:32]

Raymond Alexanian, MD

[00:43:33]

And it’s gone.

[00:43:39]

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Chapter 14

B: An Institutional Unit

The Research Committee; The Surveillance Committee

Story Codes

B: Institutional Processes
B: MD Anderson History
B: MD Anderson Snapshot
B: MD Anderson Impact
B: Devices, Drugs, Procedures
B: MD Anderson Culture
B: Institutional Mission and Values
C: This is MD Anderson
B: Building/Transforming the Institution
B: Multi-disciplinary Approaches

Tacey Ann Rosolowski, PhD

[00:43:46]

Would you like to tell me a bit about some of these committees that you were working on? Because they kind of came at interesting times. One of them was, that you were on pretty early, 1971, various times over the course of your career into the mid-eighties was the Research Committee. What exactly was that?

[00:44:07]

Raymond Alexanian, MD

[00:44:07]

Yes. In those days, the Research Committee, that was first established by Dr. Clark so that representatives from different disciplines, surgery, radiation, so on, could advise a doctor on his research project to see if they could participate, they could make some suggestions. This was not like the Regulatory Committee now. It was, as I mentioned earlier, to offer improvements and suggestions.

Part of it was developed so that—part of the rationale was that if there were some research in an area, that it wouldn't offend or step on the toes of another department that was also—instead of operating, they were radiating or something like that. So it was a way of keeping peace among departments. He transformed the wording in terms of contributing to the work, but in the background it was not muscling in on my territory. If I don't want to give radiation and I just

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want to operate, I just want to operate. Or if I want to give radiation, I just want to radiate, so, blah, blah, blah, blah. So it was meant to meld the group, and this was a very healthy process.
[00:45:49]

Tacey Ann Rosolowski, PhD

[00:45:49]

Interesting.

[00:45:49]

Raymond Alexanian, MD

[00:45:49]

There was some heads clashed and so—

[00:45:52]

Tacey Ann Rosolowski, PhD

[00:45:52]

Do you remember some incidences, some specific incidences where—I mean. (laughs)

[00:45:57]

Raymond Alexanian, MD

[00:45:58]

Yeah. It's so long ago. I guess as the chairman I was considered the peacemaker since I—in those days, the forces of the clashing was surgery and radiation. Chemotherapy was kind of new, but then as chemotherapy became more and more successful, as I mentioned with the combined therapy, you see the combined therapy led to cures, whereas before, the individual therapies did not. So it was a transforming model, Hodgkin's disease. So then as much as possible, this was incorporated, and then—

[00:46:51]

Tacey Ann Rosolowski, PhD

[00:46:51]

So then how did it work? I mean, so someone would come—

[00:46:54]

Raymond Alexanian, MD

[00:46:54]

Submit a project in writing, and this would be reviewed by two people, and that would be presented to the committee with the sponsoring person present. He would hear the clash of—I think that's the way it went. And as a moderator, I would devote certain time, and also since

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you'd have the written opinions of the critiques, you'd try to see how much common ground could be covered.

Sometimes it was something like, oh, what's a good way of getting funding for this, or who's the funding agency, or could we work with some other centers or cooperative center. So it was a way of—or there may have been some need for another hospital nearby who had a procedure that we couldn't do, like kidney biopsies. This is something we didn't do here but could be done at other centers. So we would discuss these. I'm not saying that [unclear]. So at least it was meant to be a scientific clinical discussion of what would be the best way of moving this forward, and then at the same time we would try to give the investigator newer, maybe go a little further, go a little faster, go a little in this direction. So it was a resource.

Then as the years went by and the regulatory apparatus from the NIH required what we called patient protection, evidence of patient protection, and so we had what we called a Surveillance Committee.

[00:48:56]

Tacey Ann Rosolowski, PhD

[00:48:58]

I noticed that too, right.

[00:48:59]

Raymond Alexanian, MD

[00:48:59]

I was on that too.

[00:48:59]

Tacey Ann Rosolowski, PhD

[00:49:00]

Yeah. That was [unclear].

[00:49:02]

Raymond Alexanian, MD

[00:49:03]

Those were two different committees at the time. So in some ways we've continued that. We call it something—another name.

So the project that you'd submitted would pass the Research Committee, then would come to this other committee to make sure that the requirements that we had—each center makes a contract with the NIH in terms of how they are going to protect patients. It's called—the document is

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called something. It's a contract, and I don't know what you call it. So you work out—in other words, you say you have to meet the criteria that are set up by the NIH, and each center has these. So there are about several thousand of these throughout the country, and each center is unique. It doesn't have the same one. So it indicates that you're going to have a written consent for any new procedure, and then you have the consent forms. You have consent forms for each of the procedures. So it goes through all the requirements. So that was the second committee, the Surveillance Committee.

[00:50:27]

Chapter 15

B: Building the Institution

***“The Research Report”*: an Innovative Communication Device for MD Anderson**

Story Codes

B: MD Anderson History

B: MD Anderson Snapshot

B: MD Anderson Impact

B: Institutional Processes

B: Devices, Drugs, Procedures

B: MD Anderson Culture

B: Institutional Mission and Values

C: This is MD Anderson

B: Devices, Drugs, Procedures

C: On Texas and Texans

C: Portraits

B: MD Anderson and Government

Tacey Ann Rosolowski, PhD

[00:50:29]

So when you first came on, were you—the committee was formed in 1970—well, that's—

[00:50:37]

Raymond Alexanian, MD

[00:50:37]

That's when I was appointed [unclear] proceeded, yeah.

[00:50:39]

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Tacey Ann Rosolowski, PhD

[00:50:39]

That's when you were on it, 1971. Okay. So what were some of the activities that you took part—that the committee was addressing when you came on? Were they still working out the details of this contract or—

[00:50:50]

Raymond Alexanian, MD

[00:50:51]

No, no. I guess—I'm curious to know whether we saved minutes from those committees.

[00:50:56]

Tacey Ann Rosolowski, PhD

[00:50:56]

Oh, I'm sure they must be someplace in the archives, yeah.

[00:50:59]

Raymond Alexanian, MD

[00:51:00]

You could look back on a couple of the minutes. I forget what some of the details—but it was really many of the projects were—and there was a roster of projects that were approved, and then there's more to it than that. The projects that were approved as research projects had to every two years submit a report of what was accomplished, and these were put into a book called the *Research Report*.

[00:51:32]

Tacey Ann Rosolowski, PhD

[00:51:32]

The *Research Report*. Yeah, those are still being published. (laughs) So that was part of the—that came under the Research Committee?

[00:51:41]

Raymond Alexanian, MD

[00:51:40]

That came under that, right, so it was under the research part. Then this required the investigator either to—well, he had to make a research report if he wanted to keep the project going, and if he didn't, he could remove it or delete it. So in a way, the person's record of accomplishment, even if he didn't have publications in outside journals, you had this record of what he was doing, and

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so I'm sure this was useful to the department heads and the administrator as to what is this man doing here, you know, what is he working on, so he could look it up and see what he's doing and who was he doing it with. Then the other departments could see, "Well, he's doing this. Why don't I do work with him on this," and so on and so on.

So the attempt was made to get a more cooperative—that's why, as the years went by, it was easy for some departments who wished to, to make these co-op arrangements with other departments because you knew what everyone else was doing in a way or what they were interested in. You attended the meetings or saw the *Research Report* or saw all these things.
[00:53:02]

Tacey Ann Rosolowski, PhD

[00:53:02]

Interesting.

[00:53:02]

Raymond Alexanian, MD

[00:53:03]

Whereas other centers didn't have this process as well oiled. In fact, I remember some years ago, I think I was on the Research Committee, and as the chairman, I think I was called to a national meeting of cancer centers in terms of their research procedures. And I sort of vaguely remember that when I described how we were doing it—and I was a very young person, and this had already been established before I became chairman. I mean, I didn't develop this. But when I described our process, they were amazed at the interdepartmental connections and discussions and processes that we had already established here.

And it turns out that Dr. Clark asked me, "Well, how did the meeting go?"

And I said, "Dr. Clark, they were all praising the way we were doing things here."

And he just beamed with pride. He says, "Well, that's great. I'm glad to hear it."

And I was just a young fellow, and said, "Well, I'm really proud to be part of this."

He says, "That's great news." (laughs)

[00:54:52]

Tacey Ann Rosolowski, PhD

[00:54:52]

And you got to bring him the good news. (laughter)

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[00:54:53]

Raymond Alexanian, MD

[00:54:54]

So maybe that's why he appointed me to so many committees. (laughter)

[00:54:57]

Tacey Ann Rosolowski, PhD

[00:55:01]

Yeah. Well, it's really interesting. What do you think made—you said that Dr. Clark had actually established, founded the Research Committee.

[00:55:11]

Raymond Alexanian, MD

[00:55:12]

Well, he must have.

[00:55:13]

Tacey Ann Rosolowski, PhD

[00:55:13]

He must have.

[00:55:14]

Raymond Alexanian, MD

[00:55:14]

I mean, I can't imagine, and I don't know the beginning. You'd have to look at the very first minutes, which go to the sixties or fifties.

[00:55:21]

Tacey Ann Rosolowski, PhD

[00:55:21]

Yeah, because it really is pretty amazing to keep getting these bits of evidence that from the very beginning the institution was created with the goal in mind of creating these interdepartmental linkages, collaborations [unclear].

[00:55:36]

Clip

Raymond Alexanian, MD

[00:55:37]

You have to also be sensitive to his motivations. As a state-funded institution, at that time all the

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support or dominant part of the support came from the state, and so that he would have to go to the state legislature and show some evidence that we were not just doing what everyone else was doing, that we were a leader in the field and that, therefore, more funding and more resources, more building that he would have to show some evidence of that. And because the MD Anderson was founded because of unmet needs in cancer in the state, as you know, the history evolved from the fact that many women were dying of cervical cancer, and MD Anderson himself, as a gynecologist—not MD Anderson, Dr.—
[00:56:44]

Tacey Ann Rosolowski, PhD

[00:56:47]

Ernst Bertner?

[00:56:47]

Raymond Alexanian, MD

[00:56:48]

—Bertner. Thank you. (laughs) Dr. Bertner was sensitive to—you've heard all this before.

[00:56:54]

Tacey Ann Rosolowski, PhD

[00:56:54]

Oh, no, go ahead.

[00:56:54]

Raymond Alexanian, MD

[00:56:55]

Well, my understanding and my recollection was that he was sensitive to the fact that cervical cancer could not be detected with smears and that many of these women, especially poor women in the valley, could be cured if they were recognized early and so on. So this was one of the leads to the development of MD Anderson. I'm sure there's more to the story than that.

[00:57:22]

Tacey Ann Rosolowski, PhD

[00:57:22]

But clearly it is very much tied to the state.

[00:57:26]

Raymond Alexanian, MD

[00:57:27]

The state. Right. And this was new, because, as I understand it, the only other facility of its type

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was at Sloan-Kettering in New York, which was not state, which was developed by private philanthropy. So he was the first to do it from the state, and therefore, by showing the state evidence of progress—and you can imagine every two years he has to show that this is the progress we've made, and he has this *Research Report* book—I'm sure he brought it with him—and for distribution. So it was all in writing, all of these things. And the *Research Report* had all the grants, awards, and papers that were published. The whole thing was laid out there. So I would imagine he found this useful.

[00:58:31]

Tacey Ann Rosolowski, PhD

[00:58:32]

Interesting. Yeah, very interesting. I hadn't heard the story in quite that way.

[00:58:36]

Raymond Alexanian, MD

[00:58:36]

It may not be exactly that way. That's the way I—

[00:58:38]

Tacey Ann Rosolowski, PhD

[00:58:39]

No, but it's your perspective, absolutely.

[00:58:40]

Raymond Alexanian, MD

[00:58:41]

My perspective, yeah.

[00:58:41]

Tacey Ann Rosolowski, PhD

[00:58:41]

Yeah, and I think it's interesting, because nobody else has mentioned the *Research Report* playing that kind of role as an internal communication device and as a communication device with the legislature.

[00:58:52]

Raymond Alexanian, MD

[00:58:53]

Well, the *Research Report* was also distributed and sent to clinicians throughout the state and saying, "Look, this is what we're doing with these cancers. Send us your patients if you have

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problems.” This was meant to be a vehicle for patient management and potential advance. There were many uses of all of it. And that’s not the only doc. I’m sure there are many other documents, I mean newsletters and all this stuff.

[00:59:28]

Tacey Ann Rosolowski, PhD

[00:59:28]

Right. Very interesting.

[00:59:29]

Raymond Alexanian, MD

[00:59:30]

And also he was very aware of the press, a person of that position.

[00:59:36]

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Chapter 16

B: Building the Institution

The Faculty Classification Committee and Related Issues with Tenure and Promotion

Story Codes

B: MD Anderson Culture
B: Building/Transforming the Institution
B: Institutional Processes

Tacey Ann Rosolowski, PhD

[00:59:37]

Let's see. There's also this—I didn't know what this committee was—Faculty Classification. What was that about?

[00:59:50]

Raymond Alexanian, MD

[00:59:51]

In order to have promotions, it used to be that if a department head wanted to promote a staff person, he could just promote him if the head administrator agreed and there was funding to support that new rank. Then it was decided—and I don't know who it is, probably Dr. Clark or somebody like that said that we needed a committee for this review because why should such-and-such and his department promotes such-and-such a person who has done nothing, whereas this person who has done so much is overlooked. So there was a standardization by having a committee that would apply or attempt to apply consistent standards for promotion and appointments of people who come from elsewhere, who were appointed or promoted within the ranks, and that included tenure.

Now, the tenure is a whole different area of controversy we could talk about if you wanted to. It's a whole historical story in itself. But the promotion required certain criteria for promotion, and this committee—and I think I was one of the first chairmen, I'm not sure, to have set certain standards for promotion. This included recommendations from your department head, but also a certain requirement for publications, sometimes grants, and national and international recognition somehow, by being appointed to committees or giving talks in Paris or something like that, so there's some record, and so that this committee reviewed that and made a recommendation to the president that such-and-such be promoted or not promoted.

[01:02:17]

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Tacey Ann Rosolowski, PhD

[01:02:17]

How controversial was this?

[01:02:19]

Raymond Alexanian, MD

[01:02:19]

It could be very controversial. As time went on, most submissions were approved because department heads knew, were familiar with the criteria and says, “Oh, you could get by. You have this.” So, however, there were some who, since the committee was constituted by other senior people who also had their own junior staff who desired promotion, everyone was very anxious to apply the same standards across the board, said, “Don’t promote him if you don’t promote him.” So there was this general level of consistency. However, every so often, maybe once or two people every meeting, there was controversy and that person was not approved. That doesn’t mean he was forever—this is not approved at this year, but let’s wait for next year or the next year. So it was not approved for that at that time. So as time went on, most people were easily approved.

[01:03:49]

Tacey Ann Rosolowski, PhD

[01:03:50]

Were the guidelines themselves or the criteria [unclear]?

[01:03:52]

Raymond Alexanian, MD

[01:03:52]

They were written down.

[01:03:52]

Tacey Ann Rosolowski, PhD

[01:03:53]

But were they themselves controversial?

[01:03:54]

Raymond Alexanian, MD

[01:03:55]

I don’t think so. I would say, in general, our criteria were less stringent for sure than Harvard or Yale or the most distinguished medical schools, so that promotion at this center was clearly easier than at a leading medical school. However, it had to be that way, because if you didn’t, then your staff would depart for another place. So, many times people were proposed for

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promotion and the department says, “This man has had offers from here, here, here, and here,” and say, “Look, if he’s not promoted, I’m going to lose him.” So that wasn’t the sole criteria. We still tried to be consistent, because you couldn’t allow or permit somebody to be promoted just because the department head says he thinks he’s going to lose him. He may not be. Who knows what the facts are.

[01:05:25]

Tacey Ann Rosolowski, PhD

[01:05:26]

Right.

[01:05:26]

Raymond Alexanian, MD

[01:05:27]

And says, “Well, how could you lose him? He hasn’t written anything. Harvard’s not going to appoint him, so where’s he going?”

So he says, “Well, he may go into private practice.” So, well, maybe that’s where he belongs.

[01:05:41]

Tacey Ann Rosolowski, PhD

[01:05:41]

Now, you mentioned the tenure issue.

[01:05:46]

Raymond Alexanian, MD

[01:05:47]

The tenure issue was a very controversial issue for a number of years, and it may still be. I don’t know.

[01:05:53]

Tacey Ann Rosolowski, PhD

[01:05:53]

When was that, about?

[01:05:54]

Raymond Alexanian, MD

[01:05:54]

Along the way, the title of the hospital became, instead of the MD Anderson Hospital, became the University of Texas MD Anderson Hospital. When you use the term “University,” then

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there's a standardization of that term across all the universities in the State of Texas and perhaps around the country, that a university, if you're going to call it a university, has to fulfill certain functions that include both research and education.

The research part was easy to fulfill. The education was a little more difficult because we did not have medical students, we had primarily postgraduate trainees, and so that the focus of education was on postgraduate trainees. And that didn't mean you couldn't get promoted just from the research, you could, certainly, as many Harvard professors don't do any teaching, they just write books and write something like—so you could do the research and you didn't have to do education. But let's say if you were weak in research and you did a large amount of rounding with the residents, going to the medical school for lectures and all that, that counted as a balance for your research.

But then another requirement came, and this came somewhat suddenly—at least it seemed suddenly to me—the question of tenure. Tenure at most universities in the country is lifetime tenure for a faculty professor, and so therefore the State of Texas had to decide among the universities whether this would be a standard. The University of Texas at Austin and the major centers said, “Of course it has to be lifetime. We could not attract anyone here if it weren't that.” So the major universities had lifetime tenure.

However, Dr. Clark objected to this. I think that's public information. I don't think that's a secret. Dr. Clark and, I think, one other place in Texas—it could have been a place in West Texas, Permian Basin, something like that, I don't know, one other place objected. So they appealed this decision, and they compromised on, “All right. Well, you're a special case. We will permit seven-year tenure.” And Dr. Clark didn't want any tenure.

[01:09:22]

Tacey Ann Rosolowski, PhD

[01:09:23]

Interesting.

[01:09:24]

Raymond Alexanian, MD

[01:09:25]

Of course, as the founder and somewhat dominant figure, if you have tenure, then you lose control, right?

[01:09:37]

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Tacey Ann Rosolowski, PhD

[01:09:37]

Right.

[01:09:37]

Raymond Alexanian, MD

[01:09:38]

I may have it wrong. He accepted seven-year tenure. And the reasoning, there are lots of critics of lifetime tenure as people just have it and don't do anything for years, right?

[01:09:59]

Tacey Ann Rosolowski, PhD

[01:09:59]

Mm-hmm.

[01:09:59]

Raymond Alexanian, MD

[01:09:59]

You could have that, and in your career you've probably run into it more than I have. But the professors, I haven't known any like that.

[01:10:08]

Tacey Ann Rosolowski, PhD

[01:10:08]

I've known remarkably few, actually. I've known remarkably few who do that.

[01:10:13]

Raymond Alexanian, MD

[01:10:13]

There are a few.

[01:10:14]

Tacey Ann Rosolowski, PhD

[01:10:15]

There are a few, but not as many, I think, as people imagine.

[01:10:17]

Raymond Alexanian, MD

[01:10:18]

Imagine, yes.

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[01:10:18]

Tacey Ann Rosolowski, PhD

[01:10:18]

And particularly at an institution like this where people come here because they're driven.

[01:10:22]

Raymond Alexanian, MD

[01:10:22]

Yeah, they're driven. But in some universities, they must have. They said they call it the woodwork?

[01:10:28]

Tacey Ann Rosolowski, PhD

[01:10:28]

Yeah, deadwood.

[01:10:28]

Raymond Alexanian, MD

[01:10:28]

The deadwood. Okay. So every university must have one or two like that, right?

[01:10:34]

Tacey Ann Rosolowski, PhD

[01:10:34]

Yeah.

[01:10:34]

Raymond Alexanian, MD

[01:10:34]

Okay. So Dr. Clark didn't want any of that, so he accepted seven-year tenure, and therefore the Faculty Classification would approve that feature, and that usually went automatically with a rank of associate professor or higher, the seven-year tenure. However, there were controversies even on that, because the—let me think if I remember. There was a loyalty component to tenure that as the Promotions Committee chairman, that was new to me, the loyalty factor.

[01:11:47]

Tacey Ann Rosolowski, PhD

[01:11:47]

Tell me more about that. I'm not sure what you mean.

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[01:11:51]

Raymond Alexanian, MD

[01:11:51]

I wasn't sure either, so I said, "What do you mean? What is a loyalty factor?"

Well, the loyalty factor is here's a person in a person's department who has the criteria for associate professor, he's written a lot, but he is in a constant state of dispute with his chairman. He's a rival. And the chairman refuses, he wants to dismiss him if he can, but he can't. He's very productive, he has grants, he's a big-shot in his own way. He could be a department head anywhere. This didn't come up very much. It did come up, though. He says, "Well, I'm not going to do it."

So I says, "Why?"

So he says, "Oh, well, it's going to be a mess here."

So we couldn't resolve that, of course. What the faculty chairman had to understand that that was a factor he had to deal with.

[01:13:01]

Tacey Ann Rosolowski, PhD

[01:13:02]

Was that something that people actually called it, they called it the loyalty factor, or is that your term for it?

[01:13:06]

Raymond Alexanian, MD

[01:13:07]

There was someone on our committee who used that. I mean, that's an extreme example. There are other things like that. Let's say somebody who's doing work but is not working as a team person, he's doing his own thing but would not cooperate fully. He wants to do his own way and is not working in the cooperative way I mentioned. So it's really the department head's choice. He's faced with the challenge more than the Faculty Classification, but we would hear as these recommendations would come, recommendation for promotion but not tenure. See, there's two parts to it.

[01:14:08]

Tacey Ann Rosolowski, PhD

[01:14:08]

So you didn't hear the tenure cases.

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[01:14:08]

Raymond Alexanian, MD

[01:14:09]

We didn't hear the tenure.

[01:14:10]

Tacey Ann Rosolowski, PhD

[01:14:10]

Okay.

[01:14:10]

Raymond Alexanian, MD

[01:14:11]

Well, no, we would. We would just hear the recommendation. Then, however, there's also a timeframe. If a person is on the staff and doesn't have tenure by a certain time period, by the sixth year, they will never get the tenure. So there's a clock.

[01:14:40]

Tacey Ann Rosolowski, PhD

[01:14:40]

A tenure clock. Right.

[01:14:41]

Raymond Alexanian, MD

[01:14:41]

Clock. So we are aware of this clock, and so you have to make the judgment on these difficult cases. "Look, the clock is running out here." So in many cases, the department head is not aware as much as our committee is aware, and so he's informed that there's a clock ticking.

[01:15:03]

Tacey Ann Rosolowski, PhD

[01:15:03]

Okay. So you kind of were [unclear].

[01:15:04]

Raymond Alexanian, MD

[01:15:04]

Well, let's say it's a newly appointed department head who doesn't bother with all these, newly appointed. He has to learn quickly as the staff is coming to promotion time what each person's

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clock is. They learn this fairly quickly, and they also realize that you can do the promotion without the tenure or you can do them together. You can't do the tenure without the promotion, because unless you're at associate grade—so you can't do—then there are curious things. There are assistant professors who are always assistant professors. They don't do any research, because you have to have a professorial rank here [unclear], and that was also a requirement for the university title, all the semantics. I may have it garbled, but that's essentially what I had to learn.

So there are people who are permanent assistant professors, and then the question is tenure. And the response is, well, if he's only an assistant professor, we don't usually give tenure if he doesn't qualify for promotion. And these are people who are just doing only clinical work in the different departments, only, and they don't write, they don't teach, they don't do anything else but see patients. And I don't have to—it's not any great secret that I don't think these people belong here, but they are hired to do the work, and I think they're hired because the department head doesn't exert enough effort to get some young person who's motivated and ambitious to replace these people. And there's a certain inertia on personnel dealing that department heads have, as you may know. They just don't want to fuss with it.

[01:17:41]

Tacey Ann Rosolowski, PhD

[01:17:41]

Mm-hmm, mm-hmm. What were some of the effects that tenure had? I mean, when this new tenure [unclear].

[01:17:50]

Raymond Alexanian, MD

[01:17:50]

It's for seven-year blocks. Then you're renewed.

[01:17:53]

Tacey Ann Rosolowski, PhD

[01:17:54]

Right. But once that happened and the faculty understood that that was the new environment they were working in, did it stimulate people to do research? Did people leave? I mean, what [unclear]?

[01:18:05]

Raymond Alexanian, MD

[01:18:04]

No, I don't think it made—I think it satisfied. Those who met the tenure standard, who were tenured, didn't care. They'd just get automatically renewed after seven years. They were usually

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the people working anyway. Now, sometimes a person, you reach a point—well, like for myself. I knew I was going to retire in, let's say, at a certain time, and my time, the clock ran out two years before. I said, "Oh, don't bother applying. Don't send the paperwork in. It's not worth it. Just let it go."

[01:18:50]

Tacey Ann Rosolowski, PhD

[01:18:51]

It is a cumbersome process.

[01:18:52]

Raymond Alexanian, MD

[01:18:52]

Yes.

[01:18:53]

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Chapter 17

B: Building the Institution

The Patent Committee

Story Codes

B: MD Anderson Culture
B: Building/Transforming the Institution
B: Institutional Processes
B: Discovery and Success

Tacey Ann Rosolowski, PhD

[01:18:55]

I'm looking at some of the other committees you were on. Wow. You were on the Surveillance Committee for a while. Then there was the Patent Committee. Was that interesting [unclear]?

[01:19:05]

Raymond Alexanian, MD

[01:19:06]

No, it wasn't.

[01:19:06]

Tacey Ann Rosolowski, PhD

[01:19:06]

Poor you. (laughs)

[01:19:08]

Raymond Alexanian, MD

[01:19:08]

Well, it was, at the time—I'm trying to remember what we did. Now, the Patent Committee, it was kind of—at first I thought it would be very boring, but occasionally there was an interesting problem would come up because if somebody felt that there was the potential for a patent, that person wanted to have some institutional protection that was evident in writing or something, so that the institution couldn't really protect you too much legally, I guess, but at least it would be registered as an idea that was in writing, that was recorded, so that as that person is sometimes working with a drug company or other equipment company, to negotiate the terms for this patent. There was a lawyer on our committee, too, as you can imagine, so that this staff person could negotiate with some legal backing that was provided by the Patent Committee and its lawyer to work with you.

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Otherwise, this person would run to the lawyer and work out something, and the lawyer would say, “I don’t know what you had. How do I know?” So they’d come to this committee, and the committee would substantiate that this was worthwhile and, therefore, had the stamp of our committee, and now you can set up some work with them.

[01:21:41]

Tacey Ann Rosolowski, PhD

[01:21:42]

Did that paper trail also help establish, you know, the date or origin? Because I can imagine that, you know, in a complicated—

[01:21:51]

Raymond Alexanian, MD

[01:21:51]

Yes, I’m sure it did. I don’t know how much of that, something—it wasn’t so much—it doesn’t even have to be a medical [unclear]. I remember that the Nursing Service came to our committee, and I said, “Well, that’s unusual.” Well, they had a device. When you’re giving chemotherapy, you have these multipronged accesses. Now everyone sees it, but in those days, that was new. So they had something that would give three or four inputs to an IV line in a different sequence, but which also partly depended on the drugs going through. So there was a device that someone in their department devised, and there was an apparatus company that was interested in it, and so they said, “Well, what do we do now?”

They were told to come to the Patent Committee and we’ll say, “Here’s your patent.” Something like that developed. This was years ago, and I just don’t have the details and I don’t even know what happened to it. But you can see that something can develop like that.

[01:23:27]

Tacey Ann Rosolowski, PhD

[01:23:27]

Sure. And just for the record, you were on that committee from ’83 to ’86, so I imagine those processes must be very, very different now, I mean [unclear].

[01:23:38]

Raymond Alexanian, MD

[01:23:38]

Probably. I don’t think we met every month, either. Maybe every two months.

[01:23:42]

Tacey Ann Rosolowski, PhD

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[01:23:42]

Oh, really? Wow. Wow. I can just imagine that's incredibly active now.

[01:23:45]

Raymond Alexanian, MD

[01:23:45]

Yeah, probably.

[01:23:46]

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Chapter 18

B: An Institutional Unit

The Transfusion Task Force and National Transfusion Standards

Story Codes

B: Institutional Processes
B: MD Anderson Culture
B: Education
B: Growth and/or Change
A: Critical Perspectives

Tacey Ann Rosolowski, PhD

[01:23:46]
What about the Transfusion Task Force?
[01:23:50]

Raymond Alexanian, MD

[01:23:50]
Transfusion Committee, that was an interesting committee. There's a committee after this, wasn't there?
[01:23:54]

Tacey Ann Rosolowski, PhD

[01:23:55]
[unclear].
[01:23:55]

Raymond Alexanian, MD

[01:23:55]
They called it Task Force, yeah. That was of interest because as the years evolved, in order to provide a transfusion to a patient, you had to provide some sort of written justification. There was a box, a kind of a checkbox. In the old days, you could just order it and pay no attention to anyone, just say transfusion of red cell, platelets, whatever. But then the national transfusion bodies—there must be a body; I don't know what it's called—required all centers who are approved by them to set up criteria for transfusion. So this body, we set up criteria for transfusing red cells, platelets, so on and so on.

But it got to be sort of complicated because it wasn't just transfusion for a certain number. It was sometimes transfusion in preparation for an operation or to get platelets up to a level that you

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could avoid bleeding during a procedure or biopsy or things like that. So there were yet a set criteria, but we didn't want the criteria—I was trying to reduce the requirements for the staff to explain themselves in this area because our department gave lots of transfusions. So I focused on making it as simple as possible so that there would be a checkbox, and that the checkbox could be one that was eventually either by a physician assistant or Nursing Service checkbox, that the doctor didn't have to do everything, because a lot of it was pretty automatic unless there was some very special thing.

So I was trying to—and the Transfusion Department wanted a very firm high standard to meet their standards nationally. They wanted to show that they were doing a complete job. And, of course, they didn't do the transfusion. They just did the cross matching and all that, but they wanted to make sure that the requirements were met. So a small amount had to do with donating your own blood, for example, in preparation, and some of it had to do with whose—let's see.
[01:27:29]

Tacey Ann Rosolowski, PhD

[01:27:35]

Yeah, because this was in the eighties and into the—or, I'm sorry, in the nineties. I mean, AIDS had already become an issue and there's a lot of discussion, yeah.

[01:27:44]

Raymond Alexanian, MD

[01:27:44]

Yes, that's right. So, yeah, AIDS and hepatitis, and, of course, we were dealing with the indications for transfusion more than—the transfusion laboratory dealt with the “who doesn't qualify” part. But we also tried to help on rallies for blood donations from the staff, in other words, that we have a big family here. Well, how many employees? Ten thousand. So surely there are a lot of donors here. So I think we organized the first employee donor groups.

I'm trying to remember what else. Also the consent, that every patient—so this was a real stick. They wanted that every patient who came to the hospital had to sign a waiver for transfusions. I said, “Every patient? Suppose he's just coming to see us once and is not going to have an operation, nothing.” So I kind of resisted. I said, “Which patient?”

“Every patient.”

Okay. So it turned out that it was easier to have every patient sign a waiver for transfusion, because if you make it selective, then it doesn't work. That's why when you come to register, you sign the waiver for transfusion.

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[01:29:32]

Tacey Ann Rosolowski, PhD

[01:29:32]

Interesting. Huh.

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Chapter 19

B: An Institutional Unit

The Summer Students Program

Story Codes

B: Institutional Processes
B: MD Anderson Culture
B: Education
B: Growth and/or Change
A: Critical Perspectives

Tacey Ann Rosolowski, PhD

[01:29:32]+

Let's see. I'm looking at were there any others that stick in your mind? Because we have just a few other committees, but do you think we've hit the big ones?

[01:29:44]

Raymond Alexanian, MD

[01:29:44]

Yes. May I see the list?

[01:29:47]

Tacey Ann Rosolowski, PhD

[01:29:47]

Sure.

[01:29:48]

Raymond Alexanian, MD

[01:29:55]

Well, the summer students, I was active. I always had a summer student working with me. These were high school seniors—

[01:30:02]

Tacey Ann Rosolowski, PhD

[01:30:02]

Oh, really? Huh.

[01:30:03]

Raymond Alexanian, MD

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[01:30:03]

—who were going to college. Applications were submitted throughout the state, they came from everywhere, and we selected about—I think about fifteen or twenty in those days. I don't what it is now. So in the summertime when you see a young person with a blue thing, they're usually a volunteer, and they're assigned. In those days, we had to match up the laboratory with the student. Each student was assigned a laboratory. So I, as the chairman, or a member would try to identify doctors who were willing to take a student. I said, "Not just to help you. They have to have a project, they have to submit an outline of the project, and they have to work on the project, and this project has to come up with something maybe a little bit at the end of the summer, so that they can say, 'I've done this. I've done that.'"

[01:31:04]

Tacey Ann Rosolowski, PhD

[01:31:05]

So it's a research-focused—

[01:31:06]

Raymond Alexanian, MD

[01:31:06]

It's a research-focused project.

[01:31:07]

Tacey Ann Rosolowski, PhD

[01:31:07]

Now, how did that project—how did that summer program get started then, and what was the purpose of it?

[01:31:12]

Raymond Alexanian, MD

[01:31:12]

This began before I got there. The purpose was— (laughs) It's one of Dr. Clark's ideas, I'm sure, is to get young people interested in—he's full of these ideas to the legislature. I always think he's trying to get money for it.

[01:31:31]

Tacey Ann Rosolowski, PhD

[01:31:31]

Yeah, yeah.

[01:31:31]

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Raymond Alexanian, MD

[01:31:31]

Maybe this is—of course, there was no money. I think there was a stipend, maybe \$100 a month, something like that. And they had to provide their own housing here too.

[01:31:45]

Tacey Ann Rosolowski, PhD

[01:31:45]

Oh, wow.

[01:31:45]

Raymond Alexanian, MD

[01:31:46]

So they had to have a facility to stay here, whether it was an aunt or an uncle. And they're still doing that.

[01:31:53]

Tacey Ann Rosolowski, PhD

[01:31:54]

Let me just say for the record that the years we're talking about, this is the Curriculum Committee for Summer Students, and that was 1970 to 1974.

[01:32:02]

Raymond Alexanian, MD

[01:32:03]

Yeah, for four years.

[01:32:04]

Tacey Ann Rosolowski, PhD

[01:32:04]

And from '72 to '74, you were chairman of that committee, yeah.

[01:32:09]

Raymond Alexanian, MD

[01:32:10]

So you recruit labs and stuff, and then you go through and you get about one hundred applications for fifteen positions or twenty. So you go through them. And many of these students went on graduate school, medical school. Some of them are now on our staff.

[01:32:31]

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Tacey Ann Rosolowski, PhD

[01:32:32]

Oh, wow.

[01:32:32]

Raymond Alexanian, MD

[01:32:33]

(laughs) So, in fact, sometimes someone would run into me, says, “You remember me?”

And I says, “Yes, I remember.” So I had that difficulty; I didn’t remember.

[01:32:33]

Tacey Ann Rosolowski, PhD

[01:32:47]

That’s very interesting.

[01:32:48]

Raymond Alexanian, MD

[01:32:49]

[reading list, whispering].

[01:33:08]

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Chapter 20

B: Critical Evaluation

The Value of Committee Work; Changes in MD Anderson Culture and the Need for Mentoring

Story Codes

B: Institutional Processes
B: MD Anderson Culture
B: Education
B: Growth and/or Change
A: Critical Perspectives
C: Mentoring
A: The Mentor

Tacey Ann Rosolowski, PhD

[01:33:08]

Any other observations you want to make on committees at this point?

[01:33:10]

Raymond Alexanian, MD

[01:33:27]

I think one thing that it's important for committees to do is to—first of all, most of the faculty doesn't want to do committees. They feel it's a waste of their time. And that's unfortunate, because they can learn a lot on committees. On the face of it, it may seem uninteresting, and hours can be spent on boring things, but I think that committees have a useful purpose, especially when there's a clash of divergent views. And the stronger the clash, the better it is and the better the outcome, because if there's a clash, there's something important that someone's clashing about, and if you can resolve it in a way that satisfies both parties, then only good can come from it. So I like to see clashes. I participate in clashes if I can.

I think that too much of our work is pro forma work. Fortunately, the committees are now more streamlined, so that I think—I'm not sure—that many times certain modest amendments or adjustments on a protocol can be just cleared by the chairman without going through a committee, and I think that's good. In the old days, everything would have to go through the committee. And committee work should be streamlined. Unfortunately, as I mentioned, too much of our internal review board committees are meant to protect the hospital rather than to expedite research.

[01:35:47]

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Tacey Ann Rosolowski, PhD

[01:35:55]

It seems to be a common view.

[01:35:57]

Raymond Alexanian, MD

[01:35:57]

Also, there are even, I'm told—I don't know if it's true—that even some departments don't have—well, that's not true. They probably do have. Do you know, for example, do all departments now have departmental meetings of their staff?

[01:36:25]

Tacey Ann Rosolowski, PhD

[01:36:25]

I believe so, yeah. I think that's pretty much standard process.

[01:36:29]

Raymond Alexanian, MD

[01:36:29]

Is that standard process?

[01:36:29]

Tacey Ann Rosolowski, PhD

[01:36:29]

Yeah, pretty much standard practice, yeah. I think a lot of those kind of things have evolved as the institution has become larger and more complicated, because I think when it was smaller, you could rely on people having face-to-face contact in situations and passing information, but now the institution is so large that you have to have a formal meeting in order to get basic communication done.

[01:36:57]

Raymond Alexanian, MD

[01:36:57]

How many of those meetings do you suppose people present their research work to each other?

[01:37:02]

Tacey Ann Rosolowski, PhD

[01:37:02]

Well, that's a different issue. That's a completely different issue.

[01:37:02]

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Raymond Alexanian, MD

[01:37:02]

See, in those days, in the old—we used to expect that—

[01:37:02]

Tacey Ann Rosolowski, PhD

[01:37:02]

Wow.

[01:37:02]

Raymond Alexanian, MD

[01:37:02]

—for each meeting, have a short presentation of some something interesting. Could be an interesting patient or an interesting idea or a result of your own work, just for ten minutes. I have a feeling none of that is done.

[01:37:25]

Tacey Ann Rosolowski, PhD

[01:37:25]

Right. I think other venues have to be created to do that, because people do talk a lot about how the institution has changed. And actually, that's a question I wanted to ask you, because you left, you retired in 2004, so you were here during the huge expansion.

[01:37:40]

Raymond Alexanian, MD

[01:37:40]

Yeah. Well, who knows more about a particular department's research? Don't you think other people in the department would be more familiar, should be more familiar?

[01:37:50]

Tacey Ann Rosolowski, PhD

[01:37:51]

Mm-hmm.

[01:37:51]

Raymond Alexanian, MD

[01:37:51]

Well, I think that work is being done in departments that are not even known about by other department members. They don't even know about it.

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[01:37:58]

Tacey Ann Rosolowski, PhD

[01:37:58]

When did you start seeing that happening in the history of the institution?

[01:37:58]

Raymond Alexanian, MD

[01:37:58]

Oh, I think I can't—it's hard to pinpoint it. Maybe twenty years ago. Some departments do make a point of having—because all of the doctors are included on a project, for example. They're all colleagues. But somebody may be working on a project, say, in his laboratory or on a few patients on his own protocol that other people in the department aren't aware of. Then what's even more is that after a year of progress, the person is working, no one knows where he is in the project. Maybe it's successful and no one knows about it, and he's published. The world knows about it. The people in the department don't know about it. Can you imagine that?

[01:38:59]

Tacey Ann Rosolowski, PhD

[01:38:59]

Yeah, I can. I can, actually. I can. [unclear]. (laughter)

[01:39:01]

Raymond Alexanian, MD

[01:39:02]

So I say, why is that?

[01:39:07]

Tacey Ann Rosolowski, PhD

[01:39:08]

Well, that's really a measure of growth, you know, and just how large the institution has become.

[01:39:14]

Raymond Alexanian, MD

[01:39:15]

Well, I mean, all right, that's an excuse, and I think—

[01:39:17]

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Tacey Ann Rosolowski, PhD

[01:39:17]

Oh, really? So what's your view?

[01:39:18]

Raymond Alexanian, MD

[01:39:18]

I think it's the department head is so busy, probably with personnel and other things or his own work, that he doesn't clash heads or inform, have this exchange, and doesn't many times look after the progress of the younger staff or the new fellows, say, "What are you working on? Tell me about your work."

You know, in the old days in medical schools, I would be in some departments when, let's say, the student and the department head would ask you to come to his office, and, of course, we knew it would be our turn. And the student would meet with the department head. These are busy department heads, and these are students, medical students, third-year students. And he would meet with you for ten or fifteen minutes and ask you, "What did you see that was interesting in my department, and what did you learn from it? Tell me what you read about it," one-on-one with the department head to a medical student. It's probably not that anymore.

[01:40:57]

Tacey Ann Rosolowski, PhD

[01:40:57]

Yeah. I mean, those days are long gone.

[01:40:58]

Raymond Alexanian, MD

[01:40:58]

And I know that it's not done very much here, but I think that it doesn't take that much time to require each member of a department, let's say, every three to four months to make a presentation for ten minutes, fifteen minutes. I don't think that's hard. Then it's amazing how many new things, things that can be done to—why don't you do it this way? Why don't you ask such-and-such to do it? [unclear].

[01:41:33]

Tacey Ann Rosolowski, PhD

[01:41:35]

Mm-hmm, fostering that collegiality and [unclear].

[01:41:37]

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Raymond Alexanian, MD

[01:41:37]

Yeah. And look, if you [unclear], maybe I'm happy to—"If you're having trouble writing, well, send me a draft, I'll just edit it and don't give me any credit. I'll be happy to work it over for you." We don't hear that.

[01:41:49]

Tacey Ann Rosolowski, PhD

[01:41:50]

Have there been some other big cultural changes that you've noticed that concerned you and are concerning you?

[01:41:59]

Raymond Alexanian, MD

[01:42:01]

Well, not anymore since I'm retired. (laughs)

[01:42:02]

Tacey Ann Rosolowski, PhD

[01:42:03]

You're retired. Right.

[01:42:03]

Raymond Alexanian, MD

[01:42:04]

In my final years, I would comment on many of these things. I said, "Look, why don't you do this or do that."

Of course, no one pays any attention, and then say, "Well, that's the old-fashioned way. We don't do that anymore."

[01:42:21]

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Chapter 21

A: View on Career and Accomplishments

Retirement and Contributions

Story Codes

- A: Career and Accomplishments
- A: Post Retirement Activities
- A: Critical Perspectives
- A: Character, Values, Beliefs, Talents
- A: Personal Background

Tacey Ann Rosolowski, PhD

[01:42:25]

Why did you decide to retire when you did in 2004?

[01:42:28]

Raymond Alexanian, MD

[01:42:32]

Let's see. First of all, my wife was after me for the previous five years to say, "Why are you continuing to work so hard?" So I don't really work that hard. I never brought work home, except for writing, but I never brought any special work home. Then she pointed out, "You know, you're working for nothing, because your retirement package gives you the same salary as if you worked."

So I said, "I know that, but it keeps me busy."

She said, "Oh, okay, well."

Of course, I was periodically invited abroad and she would come with me to different places, and she liked that, and she was supportive of what I was doing. But then I think—let's see. 2004?

[01:43:36]

Raymond Alexanian, MD

[01:43:37]

I think I had a minor illness. I had a retinal hole that required surgery, successful, and that sort of set me back for maybe a month or so. Then I continued to write papers, as you saw my bibliography from '04 to last year, and so I wanted—I felt that I still had something to contribute that I wanted to keep writing about, and I was seeing a large number of patients, and my patients, many of them, were terrified I was going to retire. I tried to prepare them every year, "It could

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be.” Oh, they were terrified. Some of them even wrote to the president saying, “Please discourage him.” And so I just kept on going, writing the papers, coming in. I didn’t come in at eight o’clock. I took my time. I came in when I wanted to and went home when I wanted to.
[01:44:57]

Tacey Ann Rosolowski, PhD

[01:44:58]

Was this before 2004?

[01:44:59]

Raymond Alexanian, MD

[01:44:58]

2004.

[01:45:00]

Raymond Alexanian, MD

[01:45:01]

That was when I was part-time.

[01:45:02]

Tacey Ann Rosolowski, PhD

[01:45:02]

When you were part-time, okay. So in 2004, you went to part-time?

[01:45:06]

Raymond Alexanian, MD

[01:45:07]

Part-time. Two days a week.

[01:45:08]

Tacey Ann Rosolowski, PhD

[01:45:08]

Okay, two days a week. And then how long did you stay on that schedule before you—

[01:45:12]

Raymond Alexanian, MD

[01:45:13]

Well, I retired last year.

[01:45:15]

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Tacey Ann Rosolowski, PhD

[01:45:15]

Oh, I didn't know.

[01:45:16]

Raymond Alexanian, MD

[01:45:16]

It was about seven, eight years of two days.

[01:45:18]

Tacey Ann Rosolowski, PhD

[01:45:19]

Oh, okay.

[01:45:19]

Raymond Alexanian, MD

[01:45:19]

Isn't there somewhere recorded?

[01:45:19]

Tacey Ann Rosolowski, PhD

[01:45:20]

Maybe. Maybe it is. Okay. I'm sorry I missed that.

[01:45:22]

Raymond Alexanian, MD

[01:45:22]

Maybe it was 2005.

[01:45:23]

Tacey Ann Rosolowski, PhD

[01:45:23]

Okay. So 2004, you kind of went to like 20 percent time?

[01:45:26]

Raymond Alexanian, MD

[01:45:26]

There were about seven, eight years of that, of the two days a week.

[01:45:29]

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Tacey Ann Rosolowski, PhD

[01:45:30]

Okay, and seven, eight years. Okay. So last year, you retired definitively.

[01:45:35]

Raymond Alexanian, MD

[01:45:36]

Yeah, last—this is all I got. In fact, this is a story about it. Dr. Weber, who works with me, said, “We have a gift to give you.” So she handed me, at my ceremony, a computer.

I says, “I don’t need a computer, Donna.”

She says, “Well, the other choice was to have a watch.”

This was back in September. I says, “Well, I’d rather have the watch, because the one I have is wearing out.”

[01:46:02]

Tacey Ann Rosolowski, PhD

[01:46:03]

Lovely watch.

[01:46:04]

Raymond Alexanian, MD

[01:46:05]

So then she said, “Well, there’s a watch I can’t give you now, because it has to be returned within seven days if you don’t like it.”

I says, “Okay.” So I said, “And I don’t know if I’m going to be here to see you exactly seven days, whether you have enough, because I’m here two days a week.”

So she put it off a long time. Finally, last week she gave me the watch.

[01:46:35]

Tacey Ann Rosolowski, PhD

[01:46:35]

That’s so funny. It’s a beautiful brushed-steel watch. Yeah.

[01:46:43]

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Raymond Alexanian, MD

[01:46:43]

It's a beautiful watch. Yeah, yeah.

[01:46:44]

Raymond Alexanian, MD

[01:46:46]

So I have to show it to her for the first time. [unclear] in a box, so I'm wearing it today.

[01:46:50]

Tacey Ann Rosolowski, PhD

[01:46:50]

Yes, very nice.

[01:46:51]

Raymond Alexanian, MD

[01:46:51]

So I said, "I want a watch with a date, that keeps the right date." And I don't even know if it keeps—is it the right date, or is it off?

[01:46:59]

Tacey Ann Rosolowski, PhD

[01:46:59]

It's the fifth. Nope, one day off.

[01:47:01]

Raymond Alexanian, MD

[01:47:01]

One day off, okay. So I'll figure out how to fix this. Maybe there's—

[01:47:08]

Tacey Ann Rosolowski, PhD

[01:47:09]

Nice gift.

[01:47:10]

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Raymond Alexanian, MD

[01:47:11]

So do I have it right?

[01:47:19]

Tacey Ann Rosolowski, PhD

[01:47:19]

Let's see.

[01:47:20]

Raymond Alexanian, MD

[01:47:21]

I don't have my glasses on.

[01:47:24]

Tacey Ann Rosolowski, PhD

[01:47:25]

Let's see. Oh, that turns that one. Usually if you push it partway in, it turns. Oh, there it goes.

There it goes. Oh, god.

[01:47:33]

Raymond Alexanian, MD

[01:47:33]

You got it?

[01:47:33]

Tacey Ann Rosolowski, PhD

[01:47:34]

Almost. There it goes.

[01:47:35]

Raymond Alexanian, MD

[01:47:35]

I'm told you can only do it in the morning if you—

[01:47:38]

Tacey Ann Rosolowski, PhD

[01:47:39]

Oh, okay. (laughs) So it'll probably turn it.

[01:47:41]

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Raymond Alexanian, MD

[01:47:41]

We'll see what happens.

[01:47:42]

Tacey Ann Rosolowski, PhD

[01:47:42]

We'll see what happens, yeah.

[01:47:42]

Raymond Alexanian, MD

[01:47:43]

So that's my little gift.

[01:47:47]

Tacey Ann Rosolowski, PhD

[01:47:48]

So for those seven, eight years—

[01:47:49]

Raymond Alexanian, MD

[01:47:50]

That was two days a week. I saw patients, wrote papers, went to conferences. I wasn't on any committees.

[01:47:58]

Tacey Ann Rosolowski, PhD

[01:48:04]

What do you feel you accomplished during those seven or eight years?

[01:48:06]

Raymond Alexanian, MD

[01:48:07]

I think that I helped the younger staff, especially Dr. Wang and Dr. Weber. She was already more established. I helped them in their work. And then I wrote a number of papers. I gave talks. I helped at conferences the management of lots of patients. That's what I'm going to now. There's six patients to be presented at noon.

[01:48:38]

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Tacey Ann Rosolowski, PhD

[01:48:38]

Wow. And this is at Grand Rounds or—

[01:48:41]

Raymond Alexanian, MD

[01:48:41]

This is a myeloma patient presentation. You can come if you like.

[01:48:46]

Tacey Ann Rosolowski, PhD

[01:48:47]

Oh, I can't. (laughter) I would have been interested, but I can't. (laughs)

[01:48:52]

Raymond Alexanian, MD

[01:48:53]

They just present difficult cases that they're getting. So I find this fulfilling. I also enjoy my hobby, which I play a lot of tournament bridge.

[01:49:09]

Tacey Ann Rosolowski, PhD

[01:49:09]

Oh, interesting.

[01:49:10]

Raymond Alexanian, MD

[01:49:10]

As you saw on my résumé, I'm what's called a Silver Life Master, which is kind of moving up in the ranking.

[01:49:22]

Tacey Ann Rosolowski, PhD

[01:49:22]

And is that related to bridge?

[01:49:23]

Raymond Alexanian, MD

[01:49:24]

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Yeah, bridge, in bridge. And I play in tournaments three times a week here in Houston, and this weekend is a big, big tournament, and I find that interesting.

[01:49:38]

Tacey Ann Rosolowski, PhD

[01:49:40]

How did you get interested in bridge? What's that about?

[01:49:43]

Raymond Alexanian, MD

[01:49:43]

I played a little bit in college and sort of enjoyed it. My mother taught me, and I never played much of it until the last, say, fifteen years with my wife, who then learned to play bridge, and she was my partner for many years. She's also a Life Master.

[01:50:05]

Tacey Ann Rosolowski, PhD

[01:50:11]

What else are you doing with your retirement time?

[01:50:13]

Raymond Alexanian, MD

[01:50:14]

Well, I go to the gym every day. I like to do lap swims, and I swim every day almost. Let's see. I used to travel periodically several times a year. Sort of kind of cut that down to taking cruises several times a year, sort of the lazy way of traveling.

[01:50:40]

Raymond Alexanian, MD

[01:50:44]

I like to go out to dinner. Let's see. We have neighbors we visit with a lot. Come in here today.

[01:50:57]

Tacey Ann Rosolowski, PhD

[01:51:01]

Well, just on a slightly different tack, as you look back on the work that you did here at MD Anderson and are still doing, what do you feel you've left behind that you're satisfied with, very content with?

[01:51:19]

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Raymond Alexanian, MD

[01:51:20]

I feel very fulfilled. I think I've made some important contributions to medicine and especially to my field. I have helped educate many young doctors. I've helped the institution evolve in several ways on committees and processing, and I feel comfortable that my role has contributed to this hospital to being a leading cancer center in the world. That's why I want to keep it that way if I can, which I can't, but if it happens that way, because it's very competitive and nothing comes easy. You have to work hard. You have to study hard, work hard, put the energy in, put the thought in, educate younger people, get a team to work together, have them clash and work it out, fight it out, and then get things done.

Idleness—by “idleness” I mean just doing standard things—is easy to drift to, very easy to drift to, that you have to make a concerted effort to overcome that. I see less and less of that, not markedly less, but just a slow easing less. You don't hear that, though?

[01:53:26]

Tacey Ann Rosolowski, PhD

[01:53:27]

Well, I guess it may be people are very caught up. I mean, I was just going to ask you your impression, for example of the Moon Shots Program, which is extremely ambitious.

[01:53:27]

Raymond Alexanian, MD

[01:53:40]

Ambitious.

[01:53:40]

Tacey Ann Rosolowski, PhD

[01:53:41]

So to me, the message I'm getting is that there are ambitious things, but I don't—what is your view of that particular approach to—

[01:53:50]

Raymond Alexanian, MD

[01:53:50]

Well, I think that it's better to try something than not to try it, so I certainly endorse the concept. And if the resources are there, which I understand there are, from a benefactor or two, well, then, go for it.

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Now, when it comes down to the choice of the Moon Shots, which has a more promising avenue to making—because when you use the term “Moon Shot,” you’re talking about a homerun, and homeruns don’t come out of the blue. They come out of little steps. I mean, Thomas Edison didn’t have the light bulb just [demonstrates]. I mean, there’s all kinds of, you know, physics and electricity and all those things. That took a long time.

So I guess the term “Moon Shot” is meant to be dramatic. Certainly the press likes it. And so I’m not familiar enough with the components of the Moon Shot and how they are evaluated competitively. I don’t know. I assume if it were a true Moon Shot, that this would be completely evaluated externally, that no one from here would be part of the evaluation. I don’t know how it’s being done. So if it’s being done only here, then I’m sure there’s a lot of politics, and you’ll get yours and I’ll get mine and all that stuff, which will happen all the time. It happens on our Research Committee and all that.

[01:55:44]

Tacey Ann Rosolowski, PhD

[01:55:45]

Right.

[01:55:46]

Raymond Alexanian, MD

[01:55:48]

And if it all comes out to work—yet if I were doing it, I’d have the Moon Shots, I’d have them evaluated by an external group who are sufficiently motivated to do it for nothing if they can, and I think they’d be happy to. I mean, I’d be happy to review someone else’s projects just to read it over and come up with an evaluation and critique it. Maybe you could help the Moon Shot the next time. Nothing helps a project so much as criticism. Criticism is the life of science. All the great discoveries, even after they were made, were heavily criticized. If you want to look at the—read the life of Pasteur on his germ theory, they thought he was nuts to imagine these invisible things causing fermentation or whatever. “It can’t be. I don’t see them.” You know, those kind of things.

So I don’t think we have enough. I don’t know how—so I like the Moon Shot concept. If it’s heavily critiqued, it’s great, and if the successful ones go up, but the unsuccessful ones should be strengthened for the next time, because who knows whose turn it is.

[01:55:48]

Tacey Ann Rosolowski, PhD

[01:57:24]

Right. Exactly. Exactly. Is there anything else that you’d like to add?

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[01:57:29]

Raymond Alexanian, MD

[01:57:30]

You've been so kind and so good. I don't know how you do this. You have to sit with some people like me for two hours at a time.

[01:57:38]

Tacey Ann Rosolowski, PhD

[01:57:38]

(laughs) It's a pleasure.

[01:57:38]

Raymond Alexanian, MD

[01:57:39]

Is it fun to you?

[01:57:40]

Tacey Ann Rosolowski, PhD

[01:57:40]

Oh, yes, absolutely.

[01:57:40]

Raymond Alexanian, MD

[01:57:42]

Is it fun?

[01:57:42]

Tacey Ann Rosolowski, PhD

[01:57:43]

(laughs) Absolutely. If you had to do it, you'd say, "Kill me now"? (laughs)

[01:57:47]

Raymond Alexanian, MD

[01:57:47]

Kill me. You have amazing patience and you're so kind.

[01:57:51]

Tacey Ann Rosolowski, PhD

[01:57:52]

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Oh, well, thank you. But I'm serious. Do you have anything else you'd like to add? We have a few minutes left, I mean, if there's—

[01:57:57]

Raymond Alexanian, MD

[01:57:58]

Oh, I just can't—

[01:57:58]

Tacey Ann Rosolowski, PhD

[01:58:00]

And that's fine. If you don't, you can say no.

[01:58:02]

Raymond Alexanian, MD

[01:58:02]

Well, I can't think of anything. Anything I've said, you can include.

[01:58:05]

Tacey Ann Rosolowski, PhD

[01:58:06]

Sure. Well, thank you.

[01:58:06]

Raymond Alexanian, MD

[01:58:07]

I have no secrets. No secrets.

[01:58:08]

Tacey Ann Rosolowski, PhD

[01:58:09]

Thank you. Well, you'll get a copy of your transcript for review.

[01:58:11]

Raymond Alexanian, MD

[01:58:11]

How will you possibly—will you meld the different—sometimes we talked about something in different timeframes, so you'll try to meld it together?

[01:58:21]

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Tacey Ann Rosolowski, PhD

[01:58:22]

Yeah. Well, let me turn off the recorder, and then I can tell you a bit about that.

[01:58:24]

Raymond Alexanian, MD

[01:58:25]

Yeah, okay.

[01:58:25]

Tacey Ann Rosolowski, PhD

[01:58:26]

So we're closing out the interview, and I want to thank you very much for participating in the project.

[01:58:30]

Raymond Alexanian, MD

[01:58:30]

Yes, you're welcome.

[01:58:31]

Tacey Ann Rosolowski, PhD

[01:58:31]

And I'm turning off the recorder at 11:45.

[01:58:34] (end of session two)