

# Charles M. Balch, M.D. PhD (h.c.) FACS

Interview 97

## Interview Navigation Materials

**Date submitted: 25 July 2019**

### Interview Information:

Four sessions: 22 October 2018, 12 November 2018, 17 December 2018, 26 March 2019

Total approximate duration: 4 hours 30 min.

Interviewer: Tacey A. Rosolowski, Ph.D.

**To request the interview subject's CV and other supporting materials, please contact:**

Javier Garza, MSIS, [jjgarza@mdanderson.org](mailto:jjgarza@mdanderson.org)

### Interview Subject Snapshot:

Name: Charles Balch, MD

Interviewed: 2018

Primary appt: Surgery and Anesthesiology, Surgical Oncology

Research: tumor immunology, melanoma, breast surgery, T-lymphocyte differentiation

Admin: Head, Division of Surgery and Chair Surgical Oncology [1985 – 1993]; VP Hospitals and Clinics ('93-'94); Executive VP for Health Affairs ('94 – '96)

Other:

Interview link:

### About the Interview Subject

Charles Balch (b. 24 August 1942, Toledo, OH) was recruited to MD Anderson in 1985 to serve as Head of the Division of Surgery and Anesthesiology and Chair of the Department of Surgical Oncology (1985-1993). He went on to serve several administrative roles, including VP for Hospitals and Clinics ('93-'94) and Executive VP for Health Affairs ('94 – '96). Dr. Balch was instrumental in reorganizing breast cancer care as the first multi-disciplinary organ site clinic in the institution and the US. He left the institution in 1997 to serve in executive leadership roles in other institutions, then returned in 2016, when he focused on mentoring. Dr. Balch is also founding Editor-in-Chief of the *Annals of Surgical Oncology*.

**Major Topics Covered:**

Personal background and education

Research: tumor immunology, melanoma, breast surgery, T-lymphocyte differentiation

Surgery at MD Anderson: history of; key figures in early years; shifting focus to subspecialization, surgical oncology perspective, and evidence-based practice; recruitments; training programs; and evolving strength of Division

Division of Surgery, creation and evolution

Department of Surgical Oncology: evolution of, development of research mission within

Disease-site reorganization

Prevention: creation of Division

Charles LeMaistre: vision for MD Anderson; strategic plan; working with Texas Legislature; legacy

Fiscal crises: managed care, changing healthcare environment; role of Texas laws and regulations; institutional responses to

Leadership: traditions of at MD Anderson; personal experience of; executive roles beyond the institution

**About transcription, the transcript, and the views expressed**

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [ ].

The Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

*The views expressed in this interview are solely the perspective of the interview subject. They do not represent the official views of any other individual or of The University of Texas MD Anderson Cancer Center.*

# **Charles M. Balch, M.D. PhD (h.c.) FACS**

Interview 97

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## **Charles M. Balch, M.D. PhD (h.c.) FACS**

Interview 97

### **Chapter Summaries**

**Interview Session One:** 22 October 2018

#### **Chapter 00A**

*Interview Identifier*

#### **Chapter 01**

*How a Son's Career Can Parallel a Father's*

**A: Personal Background;**

Codes

C: Leadership; D: On Leadership;

A: Personal Background;

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

B: Institutional Mission and Values;

B: MD Anderson History; B: MD Anderson Snapshot;

C: Portraits;

In this chapter, Dr. Balch talks the choices his father made while developing a career as a chemist. He observes that his own career path paralleled his father's track: entrepreneurial, research based, and academic. Dr. Balch keys on the fact that his father's entrepreneurial initiatives involved vision, a key leadership quality. Dr. Balch then talks about the leadership qualities that have been important in his own career.

Next, Dr. Balch talks about R. Lee Clark's vision for MD Anderson. He describes how he met Dr. Clark.

#### **Chapter 02**

*Creativity, Leadership, and Choosing Medicine*

**A: Personal Background;**

Codes

C: Leadership; D: On Leadership;  
A: Inspirations to Practice Science/Medicine;  
A: Character, Values, Beliefs, Talents;  
A: Personal Background;  
D: On Research and Researchers;  
A: The Researcher;  
A: Influences from People and Life Experiences;

In this chapter, Dr. Balch notes that he played jazz trumpet and focused on music during high school, then reflects on the importance of creativity to both leadership and research. He describes the mental process of playing jazz.

Next he explains that an experience working with a physician on his first aid merit badge while in the Boy Scouts convinced him to go into medicine. He attended the University of Toledo [Toledo, OH: BS conferred in 1963], where he was able to work as a surgical assistant in the Toledo Hospital. He explains he was particularly intrigued by the heart surgeons and the challenge of “making irreversible decisions quickly.”

## **Chapter 03**

### ***Medical School and Other Training: Breaking into Opportunity***

#### **A: Professional Path;**

Codes

A: The Researcher;  
A: Professional Path; C: Evolution of Career;  
A: Military Experience;  
C: Mentoring; D: On Mentoring;  
A: Inspirations to Practice Science/Medicine;  
A: Influences from People and Life Experiences;  
D: The History of Health Care, Patient Care;  
D: Understanding Cancer, the History of Science, Cancer Research;

Dr. Balch begins this chapter on his medical training by noting that the process of applying to medical school was a “breakout moment” when he was encouraged to apply to top schools rather than setting his sights on a regional medical school. He talks about the culture shock he experienced going to New York City to attend the Columbia College of Physicians & Surgeons (MD conferred, 1967). He explains that he focused on cardiac physiology and was able to begin conducting research. Dr. Balch notes that he wanted to be in an academic medical center and explains his motivations: to focus on creating new knowledge and teaching.

Next, he talks about the prominent physicians who mentored him and his ambition to become a cardiac surgeon. He mentions his internship in surgery at Duke University Medical Center

(1967-1968) and his clinical residency in surgery at the University of Alabama in Birmingham (1970-1975).

## **Chapter 04**

### ***Work in the Emerging Fields of Immunology and Surgical Oncology***

#### **A: Professional Path;**

Codes

A: The Researcher;

A: Professional Path; C: Evolution of Career;

A: Overview;

A: Definitions, Explanations, Translations;

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

C: Discovery and Success;

C: Mentoring; D: On Mentoring;

C: Leadership; D: On Leadership;

In this chapter, Dr. Balch talks about how his involvement in two evolving fields, immunology and surgical oncology, influenced his career path. He notes that based on his strong record during his residency and his fellowship [1971-1973 Research Fellowship, Immunology, Scripps Clinic and Research Foundation, La Jolla, CA], Drs. Durrant and Cooper hired him into the faculty at the University of Alabama, where his work in surgical oncology evolved. Dr. Balch describes his growing experience working on clinical trials and his research on adjuvant therapies and monoclonal antibodies.

Next he speaks about his role as Associate Director of Clinical Studies and then interim Director of the Cancer Center at the University of Alabama. He also describes the unique characteristics of surgical oncology as oncology management and comments on why it succeeded as a field.

## **Chapter 05**

### ***Melanoma Research and Comments on Research Disappointments***

#### **A: The Researcher;**

Codes

A: The Researcher; C: Discovery and Success;

A: Definitions, Explanations, Translations;

A: Overview;

In this chapter, Dr. Balch talks about his research. He begins with comments about the balance he had to find between his surgical interests and research and administrative commitments. He notes that general surgery training enabled him to take on a project of being one of the first to insert chemo infusion pumps via abdominal surgery, and that his later research led him to focus on melanoma and breast cancer.



Dr. Balch talks about his work on melanoma staging. He describes how the project came about through a desire to create a database and then evolved into new criteria for staging melanoma because of the involvement of statistician Sing Jaw Son, PhD. He talks about his sabbatical year in Australia (1983) at the Sydney Melanoma Institute, a collaborator in the melanoma project and where he wrote a book on melanoma.

Next Dr. Balch talks about lessons learned from two studies that did not yield real results.

## **Chapter 06**

### ***Surgical Oncology at MD Anderson, Part I: Changing Surgical Tradition***

#### **B: Building the Institution;**

Codes

A: The Researcher;

A: Professional Path; C: Evolution of Career;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: Institutional Politics;

B: Controversy;

A: Definitions, Explanations, Translations;

B: MD Anderson Culture;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

Dr. Balch begins this chapter by explaining how his research on melanoma raised his visibility and brought him to the attention of other institutions. Eventually he received a call from Bob Hickey at MD Anderson, and Dr. Balch explains that he developed a vision and plan for the evolution of surgical oncology. He describes the situation in surgery at that time (mid-eighties): excellent clinical surgery, but no academic programs, no research, no clinical trials, and a traditionalist approach that created a gap between the “MD Anderson way of surgery” and advances being adopted at other institutions.

Dr. Balch explains that he presented a plan for super-specialization (to also guide recruiting), for database development, management, and biostatistics to support clinical trials, for multi-disciplinary care, and active competition for grant dollars. He also observes that he and his plan were not well-received in the Department of Surgery, explaining why. He give examples of the traditionalist approach in the department and the generalist focus.

Next, Dr. Balch outlines his first steps in implementing his vision, first reorganizing the Department of Surgery as the Department of Surgical Oncology and tracking patient outcomes to set in place a system where “outcomes should be the same regardless of who did the surgery.” He talks about individuals he recruited.

## Chapter 07

### *Surgical Oncology at MD Anderson, Part II: The First Multi-Disciplinary Breast Center and the Success of a Surgical Oncology Approach*

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

A: Professional Path; C: Evolution of Career;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Working Environment;

B: Institutional Mission and Values;

B: Survivors, Survivorship; C: Patients, Treatment, Survivors;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: Institutional Politics;

B: Controversy;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

B: MD Anderson Impact; C: MD Anderson Impact;

In this chapter, Dr. Balch explains his move to organize sections around organ based leadership, highlighting multi-disciplinary care as a guiding philosophy. He talks about starting the first multi-disciplinary breast center in the U.S.<sup>1</sup>, noting that MD Anderson faculty in urology and head and neck were also using this approach.

Dr. Balch explains that he used patient outcomes as evidence to advocate for the value of this system. He also explains that the multi-disciplinary approach saved the institution money.

He notes that younger faculty supported the changes, as did Dr. LeMaistre. He notes that Dr. LeMaistre was a visionary and supporter of patient-centered care.

## Chapter 08

### *Surgical Oncology at MD Anderson, Part III: Creating a Fellowship Program*

#### **B: Building the Institution;**

Codes

C: Education at MD Anderson;

B: Education; D: On Education;

C: Leadership; D: On Leadership;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

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<sup>1</sup> In an interview conducted for the interview project, "The First Fifty Years of Surgery at MD Anderson," Dr. David Winchester mentions that the first multi-disciplinary breast center was established at another institution.

In this chapter, Dr. Balch talks about the academic dimension of his vision for the Department of Surgical Oncology: to create an education and research focused center to enhance patient care and train leaders for MD Anderson and other institutions. He sketches how the training program evolved, discusses the T32 training grant from the NIH, and notes that around 90% of the Department's trainees went on to positions at academic medical centers. Dr. Balch talks about how training was delivered in each content area and notes his own commitment to providing Saturday sessions on the qualities of leadership as well as good writing and presentation skills. He tells the story of Dr. Michael Henderson, an Australian surgeon and former trainee, to demonstrate the success of the program and the evolution of surgical oncology as a field.

## **Interview Session Two: 12 November 2018**

### **Chapter 00B**

#### ***Interview Identifier***

### **Chapter 09**

#### ***Transforming the Division of Surgery, an Overview***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
B: Working Environment;  
B: Growth and/or Change;  
B: Obstacles, Challenges;  
B: MD Anderson Culture;  
C: Professional Practice; C: The Professional at Work;  
C: Understanding the Institution;  
C: Education at MD Anderson;  
B: Education; D: On Education;  
B: MD Anderson Impact; C: MD Anderson Impact;

In this chapter, Dr. Balch provides an overview of how he went about transforming the Division of Surgery when he arrived at MD Anderson in 1985. He explains the scope of his responsibility, which included the entire Division, its core resources, its clinical trials office, and the database management.

Next Dr. Balch explains the rationale for the division system that had been set in place by then president Dr. Charles LeMaistre [oral history interview]. He notes that his mandate was to unify disparate surgical departments into a single division with strong academic grounding and a research purpose. He acknowledges the challenges in demonstrating the value of this

administrative restructuring. He notes the role of Donna Sollenberger [oral history interview], his administrative assistant, in helping him achieve this goal. Dr. Balch explains how the current administrative state was preventing the institution from recruiting quality individuals. He discusses his key recruits (Jack Roth and Elizabeth Grimm) in his attempt to build both surgical excellence as well as research.

Next Dr. Balch discusses how the Division developed a training program in support of a new Department of Thoracic Surgery, with the assistance of Dr. Denton Cooley of The Texas Heart Institute, and chief of Cardiovascular Surgery at clinical partner Baylor St. Luke's Medical Center. He mentions some other new departments created as well as his role in creating the first ambulatory surgery space.

## **Chapter 10**

### ***Transforming the Division of Surgery, Part of the Institution's Strategic Plan***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Research;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

C: Understanding the Institution;

C: Education at MD Anderson;

B: Education; D: On Education;

B: The Business of MD Anderson; C: The Institution and Finances;

B: MD Anderson History; B: MD Anderson Snapshot;

In this chapter, Dr. Balch explains that Dr. Charles LeMaistre allowed the Division heads to drive the institution's strategic plan and touches on the range of institutional goals that were to be addressed by transforming the Division of Surgery. (Dr. Balch was a member of the Executive Committee for the Strategic Plan from 1988 to 1996). He explains that Dr. LeMaistre's vision built on decisions made by R. Lee Clark to eliminate economic competition among specialties and reduce economic silos. He notes that the Division heads prioritized doing prospective clinical trials.

Next, Dr. Balch explains why he wanted to build subspecialization in the Division of Surgery as a support for both patient care and research. He discusses how developing new training programs in surgery for fellows supported these goals.

## **Chapter 11**

***Subspecialization: The Key to Building a New Division of Surgery***  
**B: Building the Institution;**

Codes

A: Personal Background;  
D: Technology and R&D;  
B: Research;  
B: Growth and/or Change;  
B: MD Anderson Culture;  
C: Professional Practice; C: The Professional at Work;  
C: Understanding the Institution;  
B: MD Anderson Impact; C: MD Anderson Impact;

In this chapter Dr. Balch explains why his desire to subspecialize surgery at MD Anderson was key to his mission of developing the Division. He comments on the challenges of getting tradition oriented departments of surgery and notes that his mission to change traditional thinking was controversial. To demonstrate how he was holding traditional practice up to scrutiny for quality outcomes, he tells a story about suspending limb perfusion until consistency of the practice could be demonstrated.

Next, Dr. Balch talks about how the division went about establishing practice guidelines, noting that this was precursor of the current system of linking quality and safety to evidence.

Next, Dr. Balch comments on the complexity of the change process he had set in motion and its success as measured by the number of faculty and trainees who have risen to leadership in their specialties.

He makes comments on his participation at national meetings then discusses how his own laboratory became involved in sending experiments into space.

**Interview Session Three: 18 December 2018**

**Chapter 00C**

***Interview Identifier***

**Chapter 12**

***Building the Division of Surgery: One Precursor to Disease-Site Reorganization***

**B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;  
B: Research;  
B: Growth and/or Change;  
B: MD Anderson Culture;  
C: Professional Practice; C: The Professional at Work;  
C: Understanding the Institution;  
B: The Business of MD Anderson; C: The Institution and Finances;  
B: MD Anderson History; B: MD Anderson Snapshot;  
B: MD Anderson Impact; C: MD Anderson Impact;

In this chapter Dr. Balch provides an overview of what he accomplished after five years of service as Head of the Division of Surgery. He explain that his division focused on developing multi-disciplinary collaborations in treatment, a mindset evolving in parallel with the Divisions of Medicine and Radiation Oncology. This positioned the institution to reorganize patient care delivery around disease sites, becoming the first institution in the US so organized. He also emphasizes how R. Lee Clark's decision to pay all MD Anderson faculty on one practice plan laid the groundwork for this.

## **Chapter 13**

### ***Head of Hospitals and Clinics: Managed Care and the Origin of the National Comprehensive Cancer Network; The MD Anderson Outreach Corporation***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
A: Professional Path; C: Evolution of Career;  
B: Beyond the Institution;  
B: Growth and/or Change;  
B: MD Anderson Culture;  
C: Professional Practice; C: The Professional at Work;  
B: The Business of MD Anderson; C: The Institution and Finances;

In this chapter, Dr. Balch focuses on two main challenges he faced as Vice President of Hospitals and Clinics: the impending managed care crisis and the institution's initiative to develop a network of affiliates. He begins by explaining how he was asked by Dr. Charles LeMaistre to serve in this new leadership role. He discusses the context in 1993 and explains the measures taken to ensure that the institution worked more efficiently with better margins.

Next, Dr. Balch tells the story of secret discussions with leaders at Memorial Sloan Kettering to join efforts in negotiating aggressively with managed care and how these conversations led to the creation of the National Comprehensive Cancer Network, a body that still establishes guidelines for standards of care in cancer treatment.

Next, Dr. Balch talks about Charles LeMaistre's vision for a national and international network of institutions delivering MD Anderson care. He discusses the creation of the Tex Moncrief Cancer Center –one of the first affiliates, located in Fort Worth, Texas.

## **Chapter 14**

### ***Comments on Leadership***

#### **A: Overview;**

Codes

C: Leadership; D: On Leadership;

Dr. Balch begins by talking about his scope of responsibilities while he was VP of Hospitals and Clinics and then EVP of Medical Affairs. He then explains that he took on these roles out of loyalty to Charles LeMaistre and to MD Anderson, though his “core values” lie in teaching and clinical work, not in administration. He talks about the need for physicians to have leadership training and the perspective they bring to administration. He also comments that leadership training can prepare researchers to lead team scientific efforts.

## **Chapter 15**

### ***Disease-Site Reorganization; Building Rotary House***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

B: The Business of MD Anderson; C: The Institution and Finances;

B: MD Anderson Impact; C: MD Anderson Impact;

In this chapter, Dr. Balch focuses on the reorganization of patient care around disease sites and the creation of Rotary House, also an addition to patient care.

He first sketches how Eva Singletary, MD and Gabriel Hortobagyi, MD [oral history interview] in Breast Medical Oncology asked patients to wear pedometers and discovered how far they were required to walk to circulate among the various specialists involved on their teams. He explains how this led to the decision to reorganize Breast Medical Oncology as the first multi-disciplinary breast center.

He then talks about the building of Rotary House from funds from the Rotary Club and explains how it fit into Charles LeMaistre's vision of using hospital services for intensive and intermediate care.

Next, he returns to the disease-site reorganization and explains how it led to specialization of the staff, cost-savings, and reduction in staff. Dr. Balch also notes that MD Anderson ran the largest pharmacy in the world, which could generate income that could be put back into clinical research for innovative therapy.

## **Chapter 16**

### ***Creating the First Prevention Program***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
B: Growth and/or Change;  
B: Research;  
B: Prevention;  
B: Institutional Politics;  
B: Controversy;

In this chapter, Dr. Balch talks about Dr. LeMaistre's desire to establish a Division of Cancer Prevention. He then sketches the difficulty of building a new division by taking faculty from other established divisions. He explains that conducting clinical trials to provide an evidence base to justify reimbursement for preventative therapies. He cites a study Bernard Levin, MD [oral history interview] conducted on COX-2 inhibitors and explains why no drug prevention study has been done since that time.

At the end of the session, Dr. Balch previews a topic to discuss in the next session: Dr. LeMaistre's strategy of encouraging the Texas legislature to change MD Anderson's status as a not-for-profit.

## **Interview Session Four: 26 March 2019**

### **Chapter 00D**

#### ***Interview Identifier***

## **Chapter 17**



## ***Addressing the Managed Care Crisis (mid 90s) with HR 192 and Other Legislation***

### **B: Building the Institution;**

Codes

D: The History of Health Care, Patient Care;

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

B: The Business of MD Anderson; C: The Institution and Finances;

C: Portraits;

B: MD Anderson History; B: MD Anderson Snapshot;

B: Beyond the Institution;

B: MD Anderson and Government;

In this chapter, Dr. Balch talks about factors contributing to MD Anderson's financial instability in the mid-nineties: the impending managed care crisis, requirements that MD Anderson care for all patients even though they could not pay (when Harris County could take some of that burden), regulations governing how MD Anderson—as a state institution—could bid for services, and regulations preventing patients from self-referring. He explains that Dr. Charles LeMaistre ordered an analysis to determine how to address these challenges. He says that MD Anderson's major competitors were private institutions and needed to function more like them to create possibilities for success. He discusses Dr. LeMaistre's approach to working with the Texas legislature, and tells the story of a key reception and the day in 1995 when the self-referral legislation was speedily passed and signed by George W. Bush.

Next, Dr. Balch explains how he and other administrators prepared for the impact of self-referral and the rapid increase in patients seen as a result. He talks about a new administrative layer of executive vice presidents were created to coordinate budgets and other efforts across the institution to increase revenue and reduce costs. He talks about an innovative practice of closing inpatient floors that were underutilized to save money.

Dr. Balch then sketches the organization of the Executive Council in the newly formed Executive Vice Presidents' Office, specifically devoted to financial discipline and strategic planning. He notes that when the Office began, MD Anderson had no managed care contracts. The office was able to secure 90 contracts in the first twelve months.

Dr. Balch next describes efforts to expand MD Anderson beyond Houston into other areas in Texas, materializing Charles LeMaistre's vision to create something new multi-disciplinary cancer care, an area where MD Anderson adds particular value for patients.

Dr. Balch then explains that these measures decreased costs prepared the way for the growth generated under Dr. John Mendelsohn.

## **Chapter 18**

### ***A New Chapter as CEO at City of Hope and Other Roles***

#### **A: Professional Path;**

Codes

A: Personal Background;

A: Professional Path; C: Evolution of Career;

C: Leadership; D: On Leadership;

A: The Researcher;

Dr. Balch begins this chapter by briefly touching on his candidacy for president when Charles LeMaistre stepped down and reflects on why John Mendelsohn was successful. He explains that the other candidates went on to high level positions at other institutions.

Next, Dr. Balch talks about his move to the position of CEO of City of Hope in California, an institution in financial difficulty. He sketches what he accomplished in five years and notes that the job “took a piece of me.” He talks about moving next to be EVP and CEO of the American Society of Clinical Oncology, concurrent with an academic appointment at Johns Hopkins Medical School so he could continue his clinical practice. He explains how and why he wanted to develop ASCO’s reach.

Dr. Balch then explains why he shifted out of administration into a full time role at Johns Hopkins to continue clinical practice, direct research, and create a clinical trials network.

## **Chapter 19**

### ***A Return to MD Anderson in 2016 and Reflections on a Career***

#### **A: Contributions;**

Codes

A: Personal Background;

A: Professional Values, Ethics, Purpose;

C: Leadership; D: On Leadership;

C: Mentoring; D: On Mentoring;

A: Contributions;

A: Activities Outside Institution;

A: Career and Accomplishments;

A: Professional Path; C: Evolution of Career;

D: The History of Health Care, Patient Care;

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

Dr. Balch begins this chapter by explaining why he returned to Texas and then to MD Anderson in 2016, retiring from clinical practice and devoting energy to mentoring young faculty’s careers.

Dr. Balch next reflects on his contributions to MD Anderson then on the changes to the healthcare environment he has seen over the course of his career. He explains that he had an impact on the field through his efforts to shift the practice of surgery from a reactive intervention to surgical oncology and a treatment development mindset implemented in a collaborative team environment.

Dr. Balch then talks about changes to how surgeons develop their careers as researchers and as leaders. He explains that they need special support to develop research careers and this has an impact on how fellows are trained and how surgeons manage their working environments to encompass research.

In the final minutes of the interview, Dr. Balch reflects on his legacy and what his long career has done for him.

## **Charles M. Balch, M.D. PhD (h.c.) FACS**

Interview 97

**Interview Session One: October 22, 2018**

### **Chapter 00A**

#### ***Interview Identifier***

***T.A. Rosolowski, PhD***

[00:00:01]

And I want to say for the record that today is October 22nd, 2018, and I'm in the Historical Resources Center Reading Room on the 21st floor of Pickens Tower, on the main campus of MD Anderson Cancer Center in Houston, Texas. And today I am seated with Dr. Charles Balch, who has come in to talk about many, many things related to surgery, and immunology, and the development of the institution. And so I wanted to say, first of all, thank you for coming in.

[00:00:32]

***Charles Balch, MD***

[00:00:32]

I'm pleased to be here.

[00:00:33]

***T.A. Rosolowski, PhD***

[00:00:33]

Yeah, I'm delighted! And just a few details, and we'll get into much more, of course, later: Dr. Balch was recruited to MD Anderson in 1985, to serve as Chair of the Department of Surgical Oncology, and Head of the Division of Surgery and Anesthesiology, and those were roles you served from 1985 to 1993, is that correct?

[00:00:57]

***Charles Balch, MD***

[00:00:57]

Correct.

[00:00:57]

Making Cancer History\*

Interview Session: 01

Interview Date: October 22, 2018

***T.A. Rosolowski, PhD***

[00:00:57]

Okay. And then Dr. Balch went on to serve several administrative roles, including Head of the Division—oops, I’ve got that already—VP for Hospitals and Clinics, and Executive VP for Health Affairs. And I also wanted to note he’s also Founding Editor-in-Chief of the *Annals of Surgical Oncology*.

[00:01:15]

***Charles Balch, MD***

[00:01:15]

That’s correct. I also started a journal here called *Breast Diseases*, which continued on after I left. So there were two journals that we started here.

[00:01:27]

***T.A. Rosolowski, PhD***

[00:01:28]

Very neat, yes. Sci Pubs [Scientific Publications] just had their anniversary just recently, and they were reviewing a lot of the journals that were created here at MD Anderson, so an interesting history. We’ll also talk about some time you spent away from the institution, and I wanted to add that you yourself are very interested in history and are starting to do an interview project on the history of surgery at MD Anderson, so I’m sure you’ll have things to say about that. Well, I wanted to say again thanks for coming in today, and let me say for the record it is about 23 minutes after 10:00. And I will start in my usual place, and ask you to tell me where you were born and when, and tell me a little bit about your family.

[00:02:15]

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## **Chapter 01**

### ***How a Son's Career Can Parallel a Father's***

#### **A: Personal Background;**

Codes

C: Leadership; D: On Leadership;

A: Personal Background;

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

B: Institutional Mission and Values;

B: MD Anderson History; B: MD Anderson Snapshot;

C: Portraits;

#### ***Charles Balch, MD***

[00:02:15]

Sure. So I was born in Delaware, during World War II. My father was part of a secret research group for DuPont and the Army to develop synthetic rayon for parachutes, because nylon was no longer available from the Japanese-held Philippines. And within a period of two years, they developed the process for large production of rayon for parachutes for the war. That was his contribution during the war. So I was actually born in Delaware. He went off to then work for DuPont as a research chemist, and then was recruited by a venture capitalist to come to Toledo, Ohio to start a new company called Maumee Chemical Company.

[00:03:12]

#### ***T.A. Rosolowski, PhD***

[00:03:12]

Can I interrupt you just for a sec? Will you share your birthdate?

[00:03:15]

#### ***Charles Balch, MD***

[00:03:16]

Sure. August 24th, 1942.

[00:03:19]

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***T.A. Rosolowski, PhD***

[00:03:20]

Okay, great. So in—

[00:03:23]

***Charles Balch, MD***

[00:03:23]

So the story is relevant, because who I am is really patterned after my father, who was a research chemist, who was an entrepreneur, who ended up becoming a chair of a department and then a dean.

[00:03:37]

***T.A. Rosolowski, PhD***

[00:03:38]

So how do you—where do you see those parallels?

[00:03:41]

***Charles Balch, MD***

[00:03:42]

Oh, I paralleled his career in many ways, although his career was in engineering and organic chemistry, and mine was all in medicine.

[00:03:51]

***T.A. Rosolowski, PhD***

[00:03:52]

What's your dad's name?

[00:03:53]

***Charles Balch, MD***

[00:03:54]

Clyde. Clyde Balch.

[00:03:56]

***T.A. Rosolowski, PhD***

[00:03:57]

And your mom?

[00:03:57]

***Charles Balch, MD***

[00:03:58]

Mary Joe.

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[00:03:59]

***T.A. Rosolowski, PhD***

[00:04:00]

Do you have any siblings?

[00:04:01]

***Charles Balch, MD***

[00:04:01]

I have two brothers.

[00:04:02]

***T.A. Rosolowski, PhD***

[00:04:03]

And their names?

[00:04:04]

***Charles Balch, MD***

[00:04:04]

They are Steve, who's an internist in Atlanta, now retired, and Randolph, who is a lawyer in Columbus.

[00:04:14]

***T.A. Rosolowski, PhD***

[00:04:16]

And what's your birth order?

[00:04:18]

***Charles Balch, MD***

[00:04:18]

I'm the oldest.

[00:04:19]

***T.A. Rosolowski, PhD***

[00:04:19]

Okay. Oh, okay. [laughs] So was that a thing? Was there a thing in your family, that your dad kind of expected you to follow in his footsteps or anything like that?

[00:04:30]



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***Charles Balch, MD***

[00:04:29]

I think a lot of it is the firstborn sibling order, because as I look back a lot of my philosophy of who I am, and tracking my career, in many ways paralleled that of my father.

[00:04:47]

***T.A. Rosolowski, PhD***

[00:04:49]

What about that entrepreneurial piece?

[00:04:51]

***Charles Balch, MD***

[00:04:51]

Well, when he went out to start a new chemical company with four other people from DuPont, to develop commercial quantities of raw organic chemicals, and he was the vice president for research, and among the things they did was develop the process and the base material for saccharine, for which they were the world's sole supplier. So, needless to say, the company grew. They had to buy a large chemical company in Cincinnati in order to increase their production, and when he was in his forties, Maumee Chemical got bought out by Sherwin-Williams, and he went back into academia as a chair of chemical engineering, which at the time was very small, and, of course, he built it into a very large and distinguished program. And then the President of the University of Toledo asked him to start a new program for adult and continuing education, which became the University College, which now has 20,000 students in that component of the University of Toledo that he started. So the point here is that he was very good at vision of starting new entities, whether they were commercial or academic, and planning, organizing the foundation that those could thrive and grow.

[00:06:30]

***T.A. Rosolowski, PhD***

[00:06:33]

Now, how did you pick up on all of this from your dad? I mean, did your dad come home and talk—

[00:06:39]

***Charles Balch, MD***

[00:06:38]

It was intuitive.

[00:06:39]

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***T.A. Rosolowski, PhD***

[00:06:39]

It was intuitive. Did he come home and talk about his work, or—

[00:06:43]

***Charles Balch, MD***

[00:06:43]

Not so much, but it was—role modeling is watching what people do, how they do it, and I think there is, among leadership qualities, a quality that I saw in my father, that I saw in Lee Clark, that I saw in Mickey LeMaistre [Charles A. LeMaistre, MD; oral history interview], and that quality is vision. It's seeing the future, and giving direction to groups, and then helping in developing the process for making the changes and getting to a new vision.

[00:07:16]

***T.A. Rosolowski, PhD***

[00:07:16]

And I think it's also—I think when you grow up with that, you understand that having a new vision is exciting rather than terrifying, you know? [laughs]

[00:07:27]

***Charles Balch, MD***

[00:07:26]

Yes. So another quality of successful leaders is making changes, and change leadership, because changes inherently mean there are people who will need to understand and follow the change, even though they don't have the vision. And there are many people who like things the way they are, and don't want to make the changes, and how you can organizationally make changes that over time people trust your leadership role, and will follow you to make those changes.

[00:08:07]

[interruption; not transcribed]

***Charles Balch, MD***

[00:08:16]

So let me go back, and we'll go back and forth, but Lee Clark had amazing vision. Lee Clark at the beginning had a vision for MD Anderson to be a premier, number one cancer center, as good or better than Memorial Sloan Kettering, which at the time was the reference cancer center in the world. And he had that vision, and he laid the foundation, and sometimes it takes years or decades for that to become fully implemented, but it starts with a vision or a direction, and recruiting people who will then implement the process and make it happen.

[00:08:58]

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***T.A. Rosolowski, PhD***

[00:08:58]

What was your first encounter with Lee Clark?

[00:09:01]

***Charles Balch, MD***

[00:09:03]

When I was first recruited here in the spring of 1985, Bob Hickey was in charge of the recruitment process. Mickey LeMaistre was President. Lee Clark was, of course, the past President, but I did have the opportunity early on to meet him. He obviously had—another quality of leadership is charisma. And you just wanted to listen to what he had to say. You hung on to every word. And you learned from who he was, and the things that he had to say. Tragically, soon after that Lee Clark had a stroke, for which he recovered all of his physical capabilities except for his speech, and he was not able to speak after that, and I think we lost a champion that we could learn from because of that unfortunate event in his health.

[00:10:08]

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## **Chapter 02**

### ***Creativity, Leadership, and Choosing Medicine***

#### **A: Personal Background;**

Codes

C: Leadership; D: On Leadership;

A: Inspirations to Practice Science/Medicine;

A: Character, Values, Beliefs, Talents;

A: Personal Background;

D: On Research and Researchers;

A: The Researcher;

A: Influences from People and Life Experiences;

#### ***T.A. Rosolowski, PhD***

[00:10:11]

Well, take me back to kind of your early family life, and also your school. Because obviously you're in this environment with this individual who's got—your dad—who's got this excitement, new vision, projects, lots of leadership abilities, scientific element within the family. How did you start discovering what you were going to bring to the party of the world? [laughs]

[00:10:41]

#### ***Charles Balch, MD***

[00:10:41]

Sure. Well, so at age four we moved to Toledo, Ohio, so I grew up in Toledo. I went to high school there. I went to the University of Toledo, and probably was not very passionate about my studies until I got to college.

[00:11:01]

#### ***T.A. Rosolowski, PhD***

[00:11:01]

What were you passionate about?

[00:11:03]

#### ***Charles Balch, MD***

[00:11:03]

Music. I was a jazz trumpet player. I had a dance band. But I was not a serious student in high school, but somehow when I got to college I finally understood the importance of not only getting a good education but having good grades so I could go on to medical school.

[00:11:24]

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***T.A. Rosolowski, PhD***

[00:11:25]

Tell me, though—let's linger a little bit over the music piece. I mean, what was it that drew you to the music? When did you start having this strong interest in music?

[00:11:35]

***Charles Balch, MD***

[00:11:36]

I started playing the trumpet at age five or six, and I grew up with that. I was very good at it. I think another part of leadership is creativity, and it's interesting that a lot of people who are creative in scientific fields, in medical research, many of them also have an artistic component, whether it's painting, whether it's music, whether it's singing, but I think there is something about creativity that is an essential part of research in our professional life, but for which many people have an avocation in music.

[00:12:18]

***T.A. Rosolowski, PhD***

[00:12:18]

Absolutely. I have seen that, and what's interesting, I actually, as an interviewer, began interviewing artists, and one of the things—

[00:12:28]

***Charles Balch, MD***

[00:12:28]

The person that comes to mind is Jim Allison, who plays a harmonica.

[00:12:31]

***T.A. Rosolowski, PhD***

[00:12:31]

Yeah, yeah. And I'm thinking, too—

[00:12:34]

***Charles Balch, MD***

[00:12:34]

And does it very well.

[00:12:35]

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***T.A. Rosolowski, PhD***

[00:12:35]

And does it very well. Yeah, there are lots of people who are musicians, who are visual artists, and that's one thing that I've really discovered, that the creative process is very similar across fields, and motivations for creativity—

[00:12:51]

***Charles Balch, MD***

[00:12:51]

To get back to that, if you do jazz, a lot of jazz music is impromptu, that you're not following the notes on a songbook; you are making up in your mind some themes and music that is impromptu. But it also has to be good enough that people want to listen to it and invite you back. So if you are a successful jazz musician, you have to be creative. And I think it's that creative process that is very important, as I developed into biomedical research. And also, it was a creative process even administratively. When you have a vision for something, you have to be creative of how you make changes, the process of change, the development of the implementation, the assembly of people to make the change, and then the documentation to show that, yes, you didn't see that vision at first but look at the documentation of how that enriched the life and the professional activities of the institution or the department that you're leading.

[00:14:11]

***T.A. Rosolowski, PhD***

[00:14:11]

That sounds like a cool article, the jazz music of leadership, [laughs] or the jazz music of research.

[00:14:18]

***Charles Balch, MD***

[00:14:20]

Yes.

[00:14:20]

***T.A. Rosolowski, PhD***

[00:14:20]

That's pretty cool. Now, tell me: you said that when you got to college there was a shift, and you suddenly became more interested in academics. Now, was your first impulse to be interested in science, or did you start with music at the University of Toledo?

[00:14:36]

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***Charles Balch, MD***

[00:14:36]

Now, that's—when I was in high school my aim was to go to a jazz music college, much to the horror of my parents, said, "You're not going to do that. You need to get a regular college education." And a lot of my foundation that drove me into medicine was in Boy Scouts. I was an Eagle Scout. When I was 14, I got First-Aid Merit Badge, and I remember the doctor who gave me the quiz that led to my First-Aid Merit Badge, I remember coming out of his office and saying, "I'd like to be a doctor just like that person."

[00:15:14]

***T.A. Rosolowski, PhD***

[00:15:14]

What was it that drew you at that time? What did you see that inspired you?

[00:15:19]

***Charles Balch, MD***

[00:15:18]

I really—that was intuitive. It became a reference point for me for the rest of my life of saying I want to be a doctor, and I kept testing that to other things, including music, and finally I decided when I got to college, I enrolled in—actually, here's another interesting story—I enrolled in pre-dentistry, because my high school counselor told me I wasn't serious enough to be a doctor. [laughter] So, by default, he said, "Go into dentistry." So I enrolled in pre-dentistry, and after two years I was accepted at the University of Michigan Dental School. Usually that's four years. And I thought, well, if I can get into dental school after two years, maybe I should stay another year or two and enroll into medicine. It's the same coursework. I was a biology major, a chemistry minor, and I did very well when I finally applied myself. So I had the innate ability to get good grades; I just had to have the motivation to do that.

[00:16:26]

***T.A. Rosolowski, PhD***

[00:16:26]

Now, when you were going through these courses and taking these science courses at the college level, what were the subjects that drew you particularly? And you obviously have thought a lot about how your brain works, and what your brain does, tracks you in certain areas. What were you seeing or intuiting when you were in college about that whole set of relationships?

[00:16:52]

***Charles Balch, MD***

[00:16:52]

So my passions were in biology, so much so that even as a sophomore I became a lab assistant in botany and zoology, because I had the highest grades in the class. And that's an interesting story

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because I met my wife in the botany class as when I was a lab assistant, and we got married, and we've been married now for 52 years.

[00:17:18]

**T.A. Rosolowski, PhD**

[00:17:18]

Wow. And her name?

[00:17:20]

**Charles Balch, MD**

[00:17:20]

Her name is Carol.

[00:17:21]

**T.A. Rosolowski, PhD**

[00:17:22]

And what was her maiden name?

[00:17:24]

**Charles Balch, MD**

[00:17:24]

Carol Albertson. So the answer to your question is I gravitated very naturally to biology, took all of the courses in biology, aced them all, and it was very clear that that was something that I was just following my passions. The other thing that happened while I was in pre-medicine is I had the opportunity to work at Toledo Hospital as a surgeon's assistant. At the time, there were no trainees at the largest hospital in my hometown of Toledo. It was a 5 or 600-bed hospital. It had a huge surgical program, but nobody to assist in surgery except for nurses. So we were trained as premedical students to be surgeons' assistants, so I was actually the first assistant in major abdominal cancers and so forth, and I gravitated to heart surgeons, which were the only ones in northwestern Ohio. I started working in their dog lab, and understanding how to assist in cardiac surgery, and became their first assistant for all their heart surgery.

[00:18:45]

**T.A. Rosolowski, PhD**

[00:18:45]

So in addition to having a musical mentality, you also have a lot of visual ability—

[00:18:54]

**Charles Balch, MD**

[00:18:54]

Yes.



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[00:18:54]

***T.A. Rosolowski, PhD***

[00:18:54]

—visualization skills, and sounds like motor skills and tactile, which, of course, goes with playing an instrument, as well.

[00:19:00]

***Charles Balch, MD***

[00:19:00]

But it also goes with being a surgeon. Eye-hand coordination and the ability to make irreversible decisions quickly are two components that are essential for a successful surgeon.

[00:19:15]

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## **Chapter 03**

### ***Medical School and Other Training: Breaking into Opportunity***

#### **A: Professional Path;**

Codes

A: The Researcher;

A: Professional Path; C: Evolution of Career;

C: Mentoring; D: On Mentoring;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

***T.A. Rosolowski, PhD***

[00:19:17]

So how quickly did you discover that you wanted to be a surgeon? I mean, was that—

[00:19:26]

***Charles Balch, MD***

[00:19:26]

During pre-medicine—

[00:19:27]

***T.A. Rosolowski, PhD***

[00:19:27]

That was it. So that was it.

[00:19:28]

***Charles Balch, MD***

So I ended up doing night courses at the university, working during the day at the hospital, because they wanted me around to help at surgery because I could first assist very well and they didn't have many alternatives. In fact, it led to a whole program that there were about a dozen of us that were doing that at Toledo Hospital. But the heart surgeons there, the two of them, really took me under wing. They mentored me. I operated on all of their cases. And it leads to an interesting story. When I was applying to medical school in my third year, instead of my fourth year, because I'd been accepted at Michigan Dental School the year before, I was applying to all the regional places—Ohio State, Case Western Reserve, Michigan, and so forth—and the heart surgeon said, "You should apply to Harvard and Columbia." So I went home and told my mom, who said, "Oh, you shouldn't do that. You would never get accepted." But he came back and said, "You'll never know unless you try."

[00:20:39]

***T.A. Rosolowski, PhD***

[00:20:39]

Can't win if you don't play. [laughs]

[00:20:40]

***Charles Balch, MD***

[00:20:40]

So I applied to Harvard and Columbia, among those other places, and guess what: I got accepted to interview at both Harvard and Columbia, as a third-year student, not a fourth-year student. So I went to do my interviews on a Friday at Columbia, and my interviews at Harvard were on a Saturday. The last person I interviewed was the dean, who made all the final decisions, and I told him at the end of my interview, because I was, I guess, very relaxed, I wasn't expecting I'd get in. This was just for the dry run before I applied the following year. But I told him I had to get on a plane to go up to Boston because I was interviewing at Harvard the next day. And he said, "Now, if you were accepted at both Harvard and Columbia, which one would you choose?" So in my mind, I wasn't expecting to get accepted to either one of them, and so my answer to him was, "I'll cross that bridge when I come to it." [laughter] The next Tuesday I had a letter of acceptance in the mail at Columbia College of Physicians and Surgeons, and later on he told me that that is one of his key questions he asks his candidates. "If you'd have said Columbia I might not have accepted you, but I'm looking for independent thinkers." Now, it was the wrong reason, but it really was a seminal event in my life that got me out of a regional mindset into one of the best medical schools in the country. And from there, I was able to succeed in leadership roles in my surgical training, in my immunology training, and so forth. So this was really a breakout for me that I might otherwise have been an ordinary candidate in the Midwest instead of going to a stellar medical school in the East, which was a culture shock for me, and I had to adopt and succeed, but it really launched my career in medicine.

[00:22:54]

***T.A. Rosolowski, PhD***

[00:22:54]

Yeah, interesting. So tell me about that whole shift. First of all, the culture shock, coming to New York City. [laughs]

[00:23:05]

***Charles Balch, MD***

[00:23:05]

Just coming from the Midwest to Manhattan was a culture shock itself. My competition was the people who were coming from Harvard, Princeton, Yale, and Columbia, and I had to really buckle down and be serious about my studies, and organizing my time, so that I could not only pass the courses but excel.

[00:23:32]

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***T.A. Rosolowski, PhD***

[00:23:32]

Did you find the expectations radically different in medical school, in these—

[00:23:37]

***Charles Balch, MD***

[00:23:37]

They were much higher, yes. And it's interesting: at Columbia at the time—this was in the '60s—80 percent of the class was from the Ivy Leagues—Harvard, Princeton, Yale, and Columbia—10 percent were women, which was radical, and the other 10 percent were geographic distribution from the rest of the country. So I was part of that geographic distribution. However—

[00:24:03]

***T.A. Rosolowski, PhD***

[00:24:03]

So you started—I'm sorry to interrupt you—you started in medical school in '63, then. That was the year that you got your—

[00:24:11]

***Charles Balch, MD***

[00:24:09]

Correct. In my junior year, but the University of Toledo allowed me to transfer credits back from medical school. I was eight credits short. And that allowed me in 1964 to get a bachelor's degree from the University of Toledo, even though I was enrolled in medical school.

[00:24:28]

***T.A. Rosolowski, PhD***

[00:24:28]

Wow, okay. Now, one detail I didn't ask you about from your undergrad experience at University of Toledo is that you have listed on your CV that you focused on immunology.

[00:24:42]

***Charles Balch, MD***

[00:24:43]

Yes.

[00:24:43]

***T.A. Rosolowski, PhD***

[00:24:44]

That's remarkably early for that. So tell me about that.

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[00:24:47]

***Charles Balch, MD***

[00:24:49]

Well, actually, I was focusing on cardiac physiology when I was in premedical school. I was interested in immunology later in my career at Columbia, and when I was at the NIH. You have to remember, in the '60s nobody knew about the immune system. We knew about immunoglobulins, and we knew that lymphocytes had some functions in immunity, but we didn't know their functions. But I worked in the dog lab and did some biomedical research on cardiac physiology during pre-medicine, and I think that really helped in setting the stage for me. And from pre-medicine through medical school, and even early in my surgical training, my ambition was to be a cardiac surgeon because all my role models were cardiac surgeons, including in medical school.

[00:25:51]

***T.A. Rosolowski, PhD***

[00:25:51]

But you were putting all the pieces in place, even very early. I mean, you wanted to go do the lab work. You wanted to have the direct surgical experience at the hospital—

[00:26:01]

***Charles Balch, MD***

[00:26:01]

Yes.

[00:26:01]

***T.A. Rosolowski, PhD***

[00:26:02]

—and you wanted to do research. So what was the impetus to doing the research piece?

[00:26:10]

***Charles Balch, MD***

[00:26:11]

I think it was getting back to my father as a role model who was vice president for research, and then who was an academic person at the university, both first as chair and then as a dean. And intuitively I always wanted to be in an academic center, even from the earliest days.

[00:26:34]

***T.A. Rosolowski, PhD***

[00:26:34]

So you never thought about private practice.

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[00:26:36]

***Charles Balch, MD***

[00:26:36]

No.

[00:26:36]

***T.A. Rosolowski, PhD***

[00:26:37]

Yeah, okay. What did being in an academic center mean to you at that age? I mean, that's pretty young, so what were you envisioning?

[00:26:43]

***Charles Balch, MD***

[00:26:44]

Creating new knowledge, and teaching. So even early on, those were aspects of my own career goals is to do research and teaching, in a clinical practice.

[00:27:04]

***T.A. Rosolowski, PhD***

[00:27:04]

Yeah, exciting, exciting thing to be looking at. So a lot of this, a whole new universe opening up coming to Columbia. So what were you finding when you got into your medical school training? How were things starting to open up inside you and for you?

[00:27:24]

***Charles Balch, MD***

[00:27:25]

So medical school was very challenging, intellectually and academically. And at the end of four years, just to finish the story, among the top 20 students at Columbia 15 of the 20 were either women or part of the dean's geographic distribution. And I think the reason for that, because we talked about it, we had to prove ourselves we'd come from outside of the Ivy League, the academic elite, and I think a lot of it was the determination and the drive to prove that we could succeed at Columbia, even though we didn't have that preparation at an Ivy League school.

[00:28:10]

***T.A. Rosolowski, PhD***

[00:28:11]

What were some high moments for you during that training period? I mean, it's just real learning moments, transformational moments.

[00:28:19]

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***Charles Balch, MD***

[00:28:20]

My surgical mentors, when I got into my junior and senior year, it just kept reinforcing that I really wanted to be a surgeon, an academic surgeon.

[00:28:33]

***T.A. Rosolowski, PhD***

[00:28:34]

Who were those folks?

[00:28:35]

***Charles Balch, MD***

[00:28:36]

My cardiac surgery was Jim Malm, M-A-L-M, who was the Chief of Cardiac Surgery. And another person, Dr. Rogers, who was—I did a research project with him on the cardiac sounds, and how you interpret murmurs in the diagnosis of cardiac disease. I actually operated with a very famous person named Cushman Haagensen, who is the father of the radical mastectomy.

[00:29:12]

***T.A. Rosolowski, PhD***

[00:29:13]

Cushman—?

[00:29:14]

***Charles Balch, MD***

[00:29:14]

Haagensen. So he learned from—

[00:29:18]

***T.A. Rosolowski, PhD***

[00:29:17]

Actually Halstead is the name I associate with that. Interesting.

[00:29:20]

***Charles Balch, MD***

[00:29:19]

Yes, so Halstead trained Cushman Haagensen. Halstead was dead at the time. Cushman Haagensen was the person who was perpetuating the value of the radical mastectomy.

[00:29:33]

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***T.A. Rosolowski, PhD***

[00:29:33]

Wow, okay. So was that when—? Because another question, of course, is when oncology came onto your radar, but maybe that's not the right time to ask that question.

[00:29:45]

***Charles Balch, MD***

[00:29:44]

No, that came later, because at that time my whole ambition was to be a cardiac surgeon, and all of my mentors, all of my research was in cardiac surgery. And that led me to do my internship at Duke with Dr. David Sabiston, who was the Chair of Surgery there, and was probably one of premier academic cardiac surgeons in the country. Duke was—

[00:30:13]

***T.A. Rosolowski, PhD***

[00:30:13]

So you started that—

[00:30:14]

***Charles Balch, MD***

[00:30:14]

—one of the favored places for an internship.

[00:30:16]

***T.A. Rosolowski, PhD***

[00:30:17]

And you started that internship in 1967.

[00:30:20]

***Charles Balch, MD***

[00:30:20]

Correct. Now, the other part of the story is the Vietnam War was going on at the time. All of us were in the draft, and by lottery we had a randomly assigned deferment of between one and five years after finishing medical school. So I drew the lot that I had to go into the military after one year, after my internship. Dr. Sabiston was on the NIH committee of General Clinical Research Centers [GCRC], and he actually arranged for me to be invited to join the public health service, and to go on to the general clinical research centers program at the NIH for my military deferment. Now, this also was very important to me, learning about clinical research, because the GCRCs [at the time] were the largest grants in the NIH program.

[00:31:22]



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***T.A. Rosolowski, PhD***

[00:31:22]

GCRC is the—?

[00:31:24]

***Charles Balch, MD***

[00:31:24]

General Clinical Research Centers. And I was assigned because I was a surgical trainee to be the staff person for the 30 transplant centers in the United States. All of the transplant programs in the United States, both organ transplantation and bone marrow transplants, were all done in GCRCs, and I was the NIH staff that organized the site visits, that wrote up the site visit report on behalf of the committee, and was the administrator for the grants for all of the [leaders] in transplantation. So—

[00:32:05]

***T.A. Rosolowski, PhD***

[00:32:05]

So that's a really quite amazing administrative role pretty early.

[00:32:09]

***Charles Balch, MD***

[00:32:09]

Yes, as a young person, there were only five of us in that branch coordinating the largest program in the NIH.

[00:32:18]

***T.A. Rosolowski, PhD***

[00:32:18]

That's amazing.

[00:32:18]

***Charles Balch, MD***

[00:32:19]

At an administrative level.

[00:32:21]

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## **Chapter 04**

### ***Work in the Emerging Fields of Immunology and Surgical Oncology***

#### **A: Professional Path;**

Codes

A: The Researcher;

A: Professional Path; C: Evolution of Career;

A: Overview;

A: Definitions, Explanations, Translations;

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

C: Discovery and Success;

C: Mentoring; D: On Mentoring;

C: Leadership; D: On Leadership;

#### ***T.A. Rosolowski, PhD***

[00:32:21]

What did you learn about yourself during that process?

[00:32:23]

#### ***Charles Balch, MD***

[00:32:24]

Well, it gave me an interest in transplantation, and because of that interest in transplantation, because I was reviewing the grants, I enrolled in all of the courses at the NIH. It had its own courseworks in immunology, so for two years I took every immunology course at the NIH. They were led by Baruj Benacerraf, who got the Nobel Prize later on in immunology, and [Dr. Anthony Fauci] who [is now] the Director of the National Institute of [Allergy and Infectious Diseases] for over 30 years. So here I was as a young person being influenced by rising stars in immunology [ ]. I said, "I really like this [subject]." So after my two years at the NIH, I was accepted into the cardiac programs at the three best places in the country: at Duke, at Stanford, and at the University of Alabama, under Dr. John Kirklin. And because Dr. Kirklin had given me a [specific time] commitment of [completing both] my general surgery and my cardiac surgery [training] program, I went to Alabama [at Birmingham]. But when I went down there, I was already enthusiastic about the field of immunology, and asked him if I could do an immunology research fellowship during my training. Both Dr. Kirklin and the transplant surgeon there, named Dr. Gil Diethelm, arranged for me to do a two-year immunology fellowship at Scripps Clinic and Research Foundation, working with the person who trained John Najarian, who was the Chair of Surgery and one of the foremost transplant surgeons in the country. And so I ended up on the same lab bench as a very well-known transplant surgeon, and did some of the seminal work in rats on T lymphocytes, demonstrating for the first time that T

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lymphocytes originated from stem cells in the bone marrow and trafficked through the thymus. Most people at the time thought that T cells originated from the thymus, and B lymphocytes came from the bone marrow, but there was never any proof of that.

[00:35:03]

***T.A. Rosolowski, PhD***

[00:35:03]

So tell me about getting immersed in that research process.

[00:35:08]

***Charles Balch, MD***

[00:35:08]

So that was also another transition for me, of being in a very high-end research fellowship, doing actual postdoctoral research, but I had no postdoctoral training. [I had to] find a way to succeed in that [challenging environment with high expectations for research productivity].

[00:35:28]

***T.A. Rosolowski, PhD***

[00:35:28]

What were the challenges that you had to confront?

[00:35:32]

***Charles Balch, MD***

[00:35:33]

The assumption I think was made that my two years at the NIH was in research, but [the activities were really research administration], so I was probably accepted for the wrong reasons.

[ ]

[00:35:54]

***T.A. Rosolowski, PhD***

[00:35:54]

So how did you confront that?

[00:35:57]

***Charles Balch, MD***

[00:35:56]

You have to be creative and [resourceful about] how to [succeed. But] by the end of the two-year program, I had completed the project that I'd been asked to do, and these papers were published in the *Journal of Immunology* and the *Journal of Experimental Medicine*. And it was actually so successful, and I was so enthusiastic about immunology, that when I went back into

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my surgical training at Alabama, I told Dr. Kirklin I couldn't see a way to apply immunology to cardiac surgery, so I was going to be a transplant surgeon. And I was actually --even as a resident--, joined the laboratory of Dr. Max Cooper, who was the first person to describe T lymphocytes and B lymphocytes, and had a major immunology laboratory of almost 70 people. I [focused on] human T lymphocyte [research] in the laboratory, and was the first to [identify] human T lymphocytes [with a fluorescent labeled antibody.] [ ] So even as a resident, I was doing high-end immunology research and publishing papers [in basic science journals], even while I was in training.

[00:37:35]

***T.A. Rosolowski, PhD***

[00:37:35]

That's pretty amazing. Now, I missed the institutional affiliation of Max Cooper.

[00:37:41]

***Charles Balch, MD***

[00:37:41]

Max Cooper was Professor of Pediatrics and Head of the Cellular Immunobiology Unit in the Cancer Center [at the University of Alabama].

[00:37:51]

***T.A. Rosolowski, PhD***

[00:37:51]

Okay. At Alabama.

[00:37:53]

***Charles Balch, MD***

[00:37:53]

At the University of Alabama [in Birmingham]. So [even during] my surgical training, I was working in a [world class immunology] laboratory. [During the daytime, I was doing clinical work, and then came over to the laboratory in the evening before I went home. Dr. Cooper assigned to me] [ ] one of his best technicians [Mrs. Martha Dagg], who would do the work in the daytime, and then I'd come over and spend my nights, especially while I was on night call, reading slides or doing microscope work, and writing up [research].

[00:38:28]

***T.A. Rosolowski, PhD***

[00:38:28]

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So this is this exciting period of an early career where everything is just coming together.

[laughs]

[00:38:34]

***Charles Balch, MD***

[00:38:34]

Yes. So another person who had a major influence [on my career] was the Cancer Center Director, Dr. John Durant, who was President of ASCO, and who became President later on at Fox Chase Cancer Center. John Durant was also a very big influence on my life, and who trained me to [think and act] as an oncologist. And he and Max Cooper convinced Dr. Kirklin that they should hire me onto the faculty.

[00:39:00]

***T.A. Rosolowski, PhD***

[00:39:01]

So 1971 to 1973 is when you were doing your fellowship at Scripps.

[00:39:07]

***Charles Balch, MD***

[00:39:07]

Yes.

[00:39:07]

***T.A. Rosolowski, PhD***

[00:39:08]

And this was part of that five-year period, '70 to '75, when you were doing your clinical residency period at—

[00:39:15]

***Charles Balch, MD***

[00:39:15]

Right.

[00:39:15]

***T.A. Rosolowski, PhD***

[00:39:15]

—University of Alabama. So they're getting to know you—

[00:39:18]

***Charles Balch, MD***

[00:39:17]

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So I came back [to UAB] and did two more years as a general surgery resident, and by that time I'd done two years at the NIH, two years at a fellowship, and the question was—do I want to be a surgical oncologist, which didn't exist outside of cancer centers? [ ] Dr. Kirklin was not very comfortable with this new specialty called surgical oncology, so he insisted that when I finish—because I was trained in transplant surgery also—that I spend half of my time in transplantation and the other half in surgical oncology, in case surgical oncology didn't really create a practice environment that would be successful.

[00:40:15]

***T.A. Rosolowski, PhD***

[00:40:15]

Now, this is one of the—

[00:40:17]

***Charles Balch, MD***

[00:40:17]

So this just shows you how formative this field of surgical oncology was, that the Chair of Surgery didn't believe there was a place for it in a major academic surgery department.

[00:40:29]

***T.A. Rosolowski, PhD***

[00:40:29]

This was one of the theme lines I wanted to follow, because it really—you were really in at the foundation, the formation of this new field. So what was going on at the time? What were you—? I mean, obviously you're in it in the moment, in the ['70s], but now you're looking back. What were the forces that were coming together at that time to start creating this field? Why, for example, was Dr. Kirklin suspicious that this might have been some kind of intellectual fad, if you will?

[00:41:02]

***Charles Balch, MD***

[00:41:04]

[ ] At the time [in the early 1970s], the general surgery specialty was focusing on the cancer operation, but not the larger issue of cancer management; not the issue of multidisciplinary care; not the integration of giving systemic therapy before or after surgery; and nowhere was the field of immunotherapy [applied]. So a very important person in my life was John Durant, who was the medical oncologist and the Cancer Center Director [at UAB]. None of the medical oncologists wanted to treat melanoma, so he assigned me his chemotherapy nurse and said, "You're going to take care of all of the patients with melanoma, including those with metastatic melanoma, because I don't have anybody else to do it." I agreed to do it, as long as [the

treatment was part of] a clinical trial, and as long as the [ ] chemotherapy nurse would help manage the [chemotherapy].

And it led to another mentor who was very important in my life, and that was Dr. Donald Morton, who was at the time at UCLA. [Dr. Morton had one of the best surgical oncology programs in the nation and he was one of] the pioneers of immunotherapy. So at an early time in my assistant professorship, he invited me to come out to his place to learn how he'd organized surgical oncology, because [there were] no counterparts [at UAB] to help me organize such a program. [Dr. Morton] was the first to use BCG as immunotherapy, so when I came back I became one of the [early investigators] in giving BCG or *C. parvum* as adjuvant therapy in [melanoma, also in] different combinations with drugs as adjuvant therapy.

[I led several] national randomized trials [through the Southeastern Cooperative Group], trying to find a therapeutic benefit of these early forms of immune therapy [in melanoma. The survival results were all negative, with no improvement in survival]. [ ] But it taught me how to conduct clinical trials, both at a local level but at a national level, as well. [ ] [At the time, I was] And also doing translational [immunology] research in the laboratory, [mainly] human immunology studies, and correlating [the cellular immune response] with different diseases, including cancer, including [reports on] tumor-infiltrating lymphocytes. [ ]

[00:43:58]

So here I was doing translational research in the lab with different NIH grants, VA grants, pre- and postdoctoral fellows, and national clinical trials; had a busy clinical practice; and the research that we were publishing in melanoma was [impacting] the field. I had the good fortune of having some excellent postdoctoral fellows, and doing some of the first work on monoclonal antibodies. [ ] [We] developed a monoclonal antibody in NK cells and T cells, which now is known as CD57, and for which 30 years later I'm still receiving royalties from that discovery. [ ] I was really [productive,] getting our research published in highly-cited medical and immunology journals, such that I was promoted to be full professor in six years after joining the faculty in surgery, and a full professor in microbiology in seven years, [at UAB].

[00:45:37]

***T.A. Rosolowski, PhD***

[00:45:44]

Congratulations. [laughs]

[00:45:45]

***Charles Balch, MD***

[00:45:45]

So it gets back to another aspect. You asked me, "You move around," and if you look at my career, about every 10 years or 11 years I moved to another opportunity, because [ ] I'm a change

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agent, [ ] [and the adventure for me was to] recreate what I've learned in another academic environment. [ ]

[00:46:13]

***T.A. Rosolowski, PhD***

[00:46:13]

But before we go—because from 1982 to 1983, which was just before you made the move, you were Acting Director of the Comprehensive Cancer Center at the University of Alabama.

[00:46:26]

***Charles Balch, MD***

[00:46:25]

Correct.

[00:46:25]

***T.A. Rosolowski, PhD***

[00:46:26]

So tell me about moving in—here you are, you've got all this hotbed of research activity going on. Tell me about moving into this directorial role.

[00:46:35]

***Charles Balch, MD***

[00:46:35]

John Durant, who was my mentor from the beginning [of my training at UAB], [ ] assigned me to be the Associate Director for Clinical Studies. That meant I had the "keys to the kingdom" [in clinical research, including] the biostatistics core group and the clinical trials research nurses. [ ] [This] major leadership role in the cancer center [greatly increased my experience in] the conduct of clinical trials. So when John Durant then went off to become the President of Fox Chase [Cancer Center in Philadelphia], I was appointed the interim Cancer Center Director [at UAB]. That gave me a really good experience of understanding [senior management of a comprehensive] cancer center, [and really helped me understand the specialty of] oncology, which is oriented around [long-term] disease management, [in contrast to] the "episode of care" that we traditionally take focus on in surgery. So it really helped me become both a surgeon and an oncologist, and helped define, I think, the field of surgical oncology.

[When I later] became President of the Society of Surgical Oncology in 1992, I better understood [the components of surgical oncology] because of those early experiences [at UAB in developing a] surgical oncology [program]. As a discipline [ ] surgical oncology [could be distinguished from other surgical specialties] because you were both an oncologist and a surgeon, and your uniqueness was the multispecialty delivery of cancer services, that coordinated both medical radiation, surgical oncology, and the diagnostic services. And you brought in clinical trials as



part of your multidisciplinary programs. And, of course, those are all the elements that I brought to MD Anderson when I came here in 1985.

[00:48:57]

***T.A. Rosolowski, PhD***

[00:48:57]

Now, before we move to that moment, what was the process of getting people to understand what you just described, what a surgical oncologist does, the uniqueness of that particular role? Because it sounds to me, from conversations I've had with other people, that it took a while for individuals to get their head around that. So what was your experience with this?

[00:49:23]

***Charles Balch, MD***

[00:49:23]

Probably the reason that I succeeded, and the field succeeded, was the parallel emergence of effective systemic drugs that started out in patients with advanced cancer, but then moved to the surgical patient [as adjuvant or neoadjuvant therapy. The first] one was adjuvant therapy for breast cancer. And people forget that the lead author in the *New England Journal of Medicine* for the first adjuvant therapy protocol in breast cancer was Eddie Mansour, a surgeon, and then Bernard Fisher, of course, who started the NSABP, again, a surgeon. Also many of the surgeons of the cancer cooperative groups in the country were surgeons. And so as the field of systemic therapy advanced in stage IV cancers, especially in the treatment of breast cancer, the field began to migrate to the surgical patient. Then the question is: are the surgeons going to understand and integrate systemic therapy into the management of the surgical patients [with cancer], first as postoperative adjuvant management of the patients and then eventually even with preoperative systemic therapy.

[00:50:49]

***T.A. Rosolowski, PhD***

[00:50:49]

Was there resistance about that?

[00:50:51]

***Charles Balch, MD***

[00:50:51]

Of course.

[00:50:52]

***T.A. Rosolowski, PhD***

[00:50:52]

And why?

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[00:50:53]

***Charles Balch, MD***

[00:50:53]

And there were very few [champions in the surgical field]. You had to learn as you go, because there wasn't really a training program [for surgical oncology, especially in the management of cancer patients]. Neither Memorial Sloan Kettering nor MD Anderson were training surgeons to be oncologists [at that time]. They were training them to be very good surgeons, and many of them [ ] went into private practice to be very good surgeons, but not to [embrace] oncology management. So the evolution of the field that ended up combining advances in systemic chemotherapy and immunotherapy began to [show a survival benefit in] the surgical patient, and created a need for surgeons who understood [multidisciplinary cancer management and who could lead] clinical trials in oncology management. And I was there at the beginning doing that, both in the multidisciplinary management of melanoma and breast cancer.

[00:51:51]

## **Chapter 05**

### ***Melanoma Research and Comments on Research Disappointments***

#### **A: The Researcher;**

Codes

A: The Researcher; C: Discovery and Success;

A: Definitions, Explanations, Translations;

A: Overview;

***T.A. Rosolowski, PhD***

[00:51:51]

What was happening at this time to your own surgical skills, and perspective on working with surgical methods in the operating room?

[00:52:03]

***Charles Balch, MD***

[00:52:03]

Well, in the 1970s, we were trained to operate in all body cavities. So early on in my surgical career I did a lot of liver surgery, sarcomas, head and neck surgery, and pelvic surgery, because we were trained to operate in all of those areas. I was one of the first to put in chemotherapy infusion pumps [for liver metastases], and, again, with two other people, led a national clinical trial to pioneer the work in regional therapy with an implantable drug infusion pumps. [ ] My research was leading me into melanoma and breast cancer. [ ] So a lot of my interest as my career advanced gravitated towards melanoma and breast cancer, because of the multidisciplinary nature, and because of the randomized clinical trials I did on surgical treatment of melanoma, which is still used today, and because of the database management that we created with a biostatistician named Seng-Jaw Soong. We developed the largest melanoma databases in the world [at that time]. That allowed us to reform the staging system for melanoma that is still used today.

[00:54:00]

***T.A. Rosolowski, PhD***

[00:54:00]

So tell me about that a bit. It's a big, big project with enormous impact, as I understand.

[00:54:06]

***Charles Balch, MD***

[00:54:07]

It is. It's an interesting story about how you have to look for opportunities. [The story began when Dr.] John Durant, the Cancer Center Director, called me into his office, [where I met Dr. Seng-Jaw Soong], who'd just gotten his PhD on the clinical application of the Cox regression analysis, which we know today as the multifactorial analysis, and which is the standard statistical tool that everybody uses in the world. [This methodology] had never been used in a clinical study. And Dr. Soong, who was a brilliant Taiwanese mathematician, wanted to have a raw database so he could test the Cox regression analysis on real data, not on theoretical math. [Melanoma turned out to be the best candidate because] my senior partner, Bill Maddox, had followed his [melanoma] patients for their lifetime, and had careful records, including maps of exactly where the melanoma was located on the body. Dr. John Durant gave me a database management person and a research nurse, and we assembled a database with a survival outcome on 294 patients. Seng-Jaw Soong did a multifactorial analysis, and everything he found was different than [the criteria that others were using as] the staging criteria for melanoma. That was my first paper in melanoma, and it was a "grand slam homerun" because everything that we published turned out to be validated by others later on. So we were the first to describe that tumor thickness is better [predictor of survival compared to] level of invasion, the first to describe ulceration [as a predictor of survival], the first to demonstrate that there was a potential survival benefit of patients if they had their lymph nodes removed [electively]. [ ]

[00:56:31]

But it leads to one other part of my story, which has been an essential element of my professional success. At a surgical meeting in the United States, I met an Australian surgeon named Gerry Milton, who had a large practice in melanoma. It turned out it was the largest in the world, and he told me he had a large prospective database but no statistician. And I remember telling Gerry that I have a small database but a very good statistician, and perhaps we should collaborate together. So that led to a collaboration with the Australians that, when we combined our data, [comprised] the largest series in the world. Everything we published after that drove the whole staging system, because we had more data than anyone else. And it was so successful that I actually had a sabbatical leave in Australia [in 1983], and that's where I wrote my first book, the first edition of our *Cutaneous Melanoma* book, which is now in its fifth edition. But what I learned from that was the importance of collaborating with people outside of your own institution, and even outside of your own nation. And it's made me into what I am today, of looking for international collaborations that are beneficial from a research perspective, because you can add unique features or volume of patient material that you may not get within the United States, or in our own practice.

[00:58:10]

**T.A. Rosolowski, PhD**

[00:58:10]

Did you find that Gerry Milton had a slightly different perspective because of a difference in training, or—? I mean, that's part of the value of collaboration.

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[00:58:19]

***Charles Balch, MD***

[00:58:19]

What was amazing is we were identical.

[00:58:21]

***T.A. Rosolowski, PhD***

[00:58:21]

Really? Wow! [laughs]

[00:58:22]

***Charles Balch, MD***

[00:58:22]

And the philosophy of their care was very similar. So [he was the founding director of] the Sydney Melanoma Institute, which later became the Melanoma Institute of Australia, which is the largest such program in the world. [ ] He had the vision for creating the database, but he didn't have the statistical wherewithal to analyze the data, other than reporting a large patient series [ ]. But Seng-Jaw Soong brought that unique dimension of understanding how to sort out all of these variables with this new statistical method called the multifactorial analysis, for which we published a series of papers that set the stage for other people to use that same statistical methodology and come up with the same results. Because of that, I was invited to come onto the AJCC Melanoma Staging Committee, where we used a new database to radically reform the entire staging system for melanoma. That has now been consistently validated and approved, even now in the eighth edition, which was just published, and led by Jeff Gershenwald here [at MD Anderson].

[00:59:46]

***T.A. Rosolowski, PhD***

[00:59:50]

So I have kind of a funny question for you. You've talked about all of these studies that were incredibly successful, and hit on a hot button that just went through to success—

[01:00:01]

***Charles Balch, MD***

[01:00:01]

Yeah, I was hitting homeruns right and left.

[01:00:03]

***T.A. Rosolowski, PhD***

[01:00:03]

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You were. But was there something you took on that just didn't pan out? Because it's always interesting, with those things, what do you learn from it, whatever it might be? Because those are learning moments.

[01:00:16]

***Charles Balch, MD***

[01:00:18]

Yes, I think one project was some of the pioneering work on regional chemotherapy for liver metastasis in colorectal cancer, in partnership with a company called Infusaid in Boston, which was subsequently bought by Medtronic. [My collage, Dr.] John Niederhuber, who was at Michigan at the time, Dr. Robert Barone in San Diego, and I did the first studies on that. I wrote up in the *Annals of Surgery* a phase II study. We organized a phase III randomized trial, comparing conventional intravenous 5-FU chemotherapy versus our regional pump therapy. It took the NIH a while to fund it. The Infusaid company decided they don't have time to do this randomized study, [which was only possible] because at the time they restricted the distribution of the pumps to a few academic centers. The company decided they couldn't wait, and so they released the pump to anyone who would buy it. [ ] It dried up the ability of us to do the randomized study, which was never completed. [However,] twenty years later, Memorial Sloan Kettering did the randomized study and demonstrated there was a survival benefit. So part of my frustration was a company who decided they'd make a quick profit by releasing an investigational device early, and so did not allow us to prove it in a randomized clinical trial. [ ] In the absence of a randomized trial it really never got any traction [in standard practice]. The company made a big profit for about two years, and then finally lost money because it fell out of favor because of insufficient evidence. And I think that the key point here is if you have something that's new and innovative, you do have to demonstrate the value in prospective clinical trials compared to the current standard of care, if it's going to be embedded into our standard practice and be reimbursed by insurance companies and by patients.

[01:02:57]

***T.A. Rosolowski, PhD***

[01:03:00]

And I'm sure—

[01:03:01]

***Charles Balch, MD***

[01:03:01]

So it's always made me a champion of doing clinical trials and organizing your data in a prospective database and doing clinical trials as the way to advance the field.

[01:03:16]

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***T.A. Rosolowski, PhD***

[01:03:17]

Particularly—I mean, again, you're in this field that's becoming more and more complicated with multidisciplinary care, all these different approaches to manage cancer, so all of the elements have to be working together, and the only way to do that is to do these close investigations.

[01:03:32]

***Charles Balch, MD***

[01:03:33]

So there's one more story about a major professional disappointment. [We were] doing [some of] the first studies on immunotherapy with nonspecific immune stimulants, and later with a variety of melanoma vaccines. However, we did not understand the concept of immune tolerance. So for 25 years, all of our approaches in immunotherapy [were based on] an assumption that the immune system was crippled and deficient, and all we had to do was stimulate it in various ways [in order to stimulate] an immune rejection response. [All our trials failed to show a survival benefit of using various immune stimulation molecules.] It wasn't until people like Dr. Jim Allison discovered the concept of immune tolerance as the mechanism that tumors sneak through and grow that the field of immunotherapy has advanced, now with the checkpoint inhibitors and an understanding of immune tolerance. So I had 25 years of failed clinical trial efforts because we had the wrong strategy. We did not understand the concept of breaking immune tolerance and then coming back with all of these different immune stimulants, which are being tested again today.

[01:04:53]

***T.A. Rosolowski, PhD***

[01:04:53]

That's amazing.

[01:04:54]

***Charles Balch, MD***

[01:04:55]

So it gets back to you have to have the right strategy, and it has to have a scientific foundation.

[01:05:01]

***T.A. Rosolowski, PhD***

[01:05:04]

Very cool. So you ready to tell me how you got to MD Anderson? [laughs]

[01:05:10]

## **Chapter 06**

### ***Surgical Oncology at MD Anderson, Part I: Changing Surgical Tradition***

#### **B: Building the Institution;**

Codes

A: The Researcher;

A: Professional Path; C: Evolution of Career;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: Institutional Politics;

B: Controversy;

A: Definitions, Explanations, Translations;

B: MD Anderson Culture;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

#### ***Charles Balch, MD***

[01:05:10]

Sure. So in the '80s, I was pretty visible academically because of my research publications. I was also President of the Association of Academic Surgeons, which is comprised of the younger generations of academic surgeons. And in my presidential talk, I talked about the importance of surgeons doing clinical trials to validate new therapies. I was being asked to look at different leadership jobs [ ], and among those that I looked at, [I was most attracted to work with Dr.] John Durant, who'd gone to Fox Chase as the President, and Clyde Barker, the Chair of Surgery at Penn. They jointly recruited me to come to Fox Chase as the Chief of Surgery, and then a parallel appointment at Penn as the Chief of Surgical Oncology. So, because John Durant was my mentor, I wanted to come up and look. I went up about four times, including with my wife, Carol, to look at housing. And then I put together a resource package that was my vision for surgical oncology. And I remember when they looked at that, they said, "I'm not sure we can meet these resource needs that would match your vision." So I said, "Thank you very much, I'll put it on the shelf."

Just a few months later, Bob Hickey called me and asked me if I would come and look at the job as Chief of Surgery at MD Anderson, and I said, "Well, I have a vision for what I'd like to do if I were to move from Alabama," because my programs were going very well, and I knew this would be a different job in that I would have to give up a lot of the research and the program



leadership [ ]. So I actually sent him a draft of what I had in mind, and the resources it would take, and he called back and said, “That’d be a good fit. We can match that.” [laughter]

[01:07:36]

So I came out here and met with Mickey LeMaistre [oral history interview] and Irv Krakoff, and two people that really helped in getting me here were Josh Fidler [oral history interview] and Margaret Kripke [oral history interview]. Because, remember, I was doing translational immunology research. I [wanted to make sure that [Dr.] Kyoko Ito, whom I’d trained as a postdoc and who was now on the faculty with me and running my lab, would come with me, so I needed a slot in immunology. The Surgery Department here was an excellent clinical program. But it did not have much of an academic research program. It had some NIH funding, but not much. The program was a one-year fellowship program, and most, except for a few people over a 10- or 15-year period, went into private practice. [Most of the surgery departments] did not have clinical trials. The philosophy was that, “this is the MD Anderson way, and [that extensive experience should dictate the standards of care]” because we are the best cancer surgery program in the country.” But, in fact, [doctors] weren’t necessarily copying that way, because [they did not publish a lot of their surgical experience.] [ ] Nobody knew who Richard Martin and Ed White were, because they didn’t really organize their data [prospectively and get it published]. They didn’t do clinical trials. Irv Krakoff had [championed clinical trials in the Division of Medicine], and Mickey LeMaistre had wanted something in parallel in surgery, and so did Irv Krakoff. [ ] He had really organized an excellent clinical trials program [in medical oncology and I envisioned], that I could organize clinical trials within surgery if I were recruited here. There was a solid backing by [Dr. LeMaistre] to build an academic program in the Department of Surgery, with trainees who would become academic leaders, along with support for the role of clinical trials and database management in the Surgery Department.

[01:10:16]

***T.A. Rosolowski, PhD***

[01:10:16]

What were some of the talking points that you had, the specifics of that vision that you presented to Dr. Clark—or to Dr. LeMaistre and to Dr. Hickey?

[01:10:25]

***Charles Balch, MD***

[01:10:25]

Well, it was about having excellence in surgery [ ] [through superspecialization of surgical care]. The surgeons here would perform surgery in multiple anatomical sites, but no one was doing surgery in any one area. So one of the things that I’d seen was necessary for the high-end complex cases was super specialization, [surgeons focusing on primary cancer involving] one or two organs. [This concept] was part of the agreement that I was going to recruit people to do just liver surgery, just pancreas surgery, just breast surgery, as a way of superspecialization, and of

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[clinical research] leadership, because they focused on one disease. There was also the vision of having database management, biostatistics, [staff for] clinical trials, and then the idea of setting up multidisciplinary care. [So I saw an opportunity, as long as the resources were there and the support was there from the president, to create something that I could envision happening at MD Anderson. And it was really around developing excellent programs and faculty in academic surgical oncology.]

[Later on, we established] the first breast center [ ] with Eva Singletary and Gabe Hortobagyi [oral history interview]. And finally, the idea that we as surgeons do laboratory research that's NIH-funded, and you do that only because you could partner with good laboratory researchers [in basic science departments, for which at the time there were really three people: Josh Fidler [oral history interview] (cancer biology), Margaret Kripke [oral history interview] (immunology), and Garth Nicholson (tumor biology) who were [Chairs of the basic science departments]. Josh and Margaret were [great supporters and collaborators]. I was a Professor of Immunology in Margaret's department, and my laboratory was in the old Smith Building. In fact, just as one side note: they had to take out the side of the building to extract the old two-story freezer that R. Lee Clark had put in those buildings [laughter] in order to reconstruct a laboratory for me.

[01:12:31]

***T.A. Rosolowski, PhD***

[01:12:31]

That's really funny.

[01:12:32]

***Charles Balch, MD***

[01:12:33]

This is another story about how Lee Clark had a vision for food services for the entire University of Texas System. [ ]

[01:13:10]

***T.A. Rosolowski, PhD***

[01:13:11]

Now, when you came, and you were speaking to people here, taking the temperature, what did you feel—? I mean, obviously you wouldn't have come if you'd thought, oh my gosh, the leaders want this but the troops on the ground are just never going to make me able to create this vision in reality. But what was the temperature you were taking? What were some of the currents that you were envisioning about where stress was going to come from, or—?

[01:13:45]

***Charles Balch, MD***

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[01:13:44]

Oh, I was not well-received [at first by some] in the Surgery Department. First, I was younger than any professor that was here. I was actually one of the youngest surgery chiefs in the United States. [ ] So that was part of it. Also, I was the first person to come on faculty in recent years who did not train at MD Anderson. And more than that, my training was more based upon Memorial Sloan Kettering than MD Anderson, which—

[01:14:13]

***T.A. Rosolowski, PhD***

[01:14:13]

What are the differences there?

[01:14:15]

***Charles Balch, MD***

[01:14:17]

[ ] I'll give you one example. When I came here, that the surgeons at MD Anderson still had the concept that their surgical instruments [ ] would spread the cancer around and cause a recurrence. So each time they used an instrument they would put it in a pan, and a full-time person would go flash the instruments and bring it back. And when I found out about that, and the cost of administering that in every operating room, I ask about, "Well, why are we doing that?" And they said, "Well, that's what they do at Memorial Sloan Kettering." And I said, "They abandoned that a long time ago, and we're going to abandon it, also." Because there's no biological basis for it. So there was—a lot of my initial resistance was to changing the traditions of MD Anderson, which had been perpetuated for years. But in a sense, especially in the general surgery department, they'd become insulated to changes that were accepted in the outside world but weren't yet adopted here.

[01:15:29]

***T.A. Rosolowski, PhD***

[01:15:29]

Interesting. Could you give me a couple more examples of things like that? Nobody's ever gotten that granular about it, and it's just interesting to have that on record.

[01:15:37]

***Charles Balch, MD***

[01:15:38]

I think one of the major things that I had seen is that surgeons on the outside had begun to super-specialize, especially around the difficult cases: liver surgery, pancreas surgery, regional perfusions. We were doing limb perfusions here based upon tradition, but without any convincing evidence [on the indications], and I really questioned the indications [especially when used prophylactically]. Sometimes patients were referred for prophylactic perfusions, even

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though the risk of getting recurrent disease [ ] was low to nonexistent. And yet there was a cost and complications for these patients. What I observed didn't really have a legitimate indication other than "the doctor referred the patient for that reason."

When I came here [in 1985] we were the Department of General Surgery, which [was the tradition] first, with Ed White and then with Dick Martin. And the training was that surgeons did everything, outside of the specialty areas of gynecology, head/neck, and urology, [ ] but everything else was in the Department of General Surgery. There wasn't any [disease specific] specialization, and there wasn't any training of surgeons to become superspecialized surgeons, or to have a disease site area of expertise, clinically, academically or in their research.

[01:17:25]

***T.A. Rosolowski, PhD***

[01:17:27]

And that was behind the times.

[01:17:28]

***Charles Balch, MD***

[01:17:29]

It was way behind the times.

[01:17:30]

***T.A. Rosolowski, PhD***

[01:17:30]

Okay, yeah.

[01:17:31]

***Charles Balch, MD***

[01:17:34]

So one of the things I did early on was to reorganize the Department of General Surgery into the Department of Surgical Oncology, and set up sections within this: Section of breast surgery, Section of colorectal surgery [and so forth]. I recruited Mark Roh from Memorial Sloan Kettering, because I wanted to break that mold of "the MD Anderson way." Some of those traditions were good, but some of them needed to change, because the surgical field had changed. So I recruited Mark Roh from Memorial to do full-time liver surgery. And instead of restricting anybody's practice, I said, "If you do liver surgery, your outcomes have to be the same as Mark Roh's, so be careful on the patients you select, because we're going to be monitoring and looking at the outcome, including complications and mortality rates of the patients that you choose, and that the outcomes should be the same regardless of who does the surgery in our department." That was a philosophy of outcomes as part of credentialing, and not legislating what the faculty would do, but by telling them that you had to meet certain quality

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indicators if you're going to do high-end cases. [For many complicated cases,] you really can't do that and be a general surgeon.

[01:19:06]

***T.A. Rosolowski, PhD***

[01:19:07]

It also kind of, in terms of culture, it seems like it would help soften that whole environment of the ego, the superstar.

[01:19:18]

***Charles Balch, MD***

[01:19:18]

And you know what? People found that, "wow, Mark Roh does really good liver surgery." The nurses in the operating room started that, said, "He's really good." And it began to give a contrast with some people who were doing it occasionally. So I recruited two other people from Memorial that are part of the story. One is Michele Gadd, to do breast surgery here. Michele Gadd later married Ken Tanabe after he'd finished his fellowship, and they both are at Massachusetts General Hospital. And I also recruited Peter Pisters to come from Memorial Sloan Kettering for his first job to do sarcoma surgery here. In fact, that's an interesting story, since Dr. Pisters is now our President. So he and his wife Kathy, who is a medical oncologist in lung cancer, had finished their training and were considering staying with Memorial Sloan Kettering. So I flew up to New York with a written offer for Peter from me, and a parallel letter from Irv Krakoff for Kathy Pisters, to recruit them both to MD Anderson. I went to their apartment, and asked them to consider coming here, which wasn't, I don't think, on their radar screen at the time. So they did come down and visit, and they signed on, and the rest is history.

[01:20:47]

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## **Chapter 07**

### ***Surgical Oncology at MD Anderson, Part II: The First Multi-Disciplinary Breast Center in the US and the Success of a Surgical Oncology Approach***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

A: Professional Path; C: Evolution of Career;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: Institutional Politics;

B: Controversy;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

#### ***T.A. Rosolowski, PhD***

[01:20:47]

Wow. That's amazing. So with these particular recruits, how quickly did you feel that the Department of Surgical Oncology was shifting and moving in the direction that you were hoping?

[01:21:02]

#### ***Charles Balch, MD***

[01:21:03]

Well, you have to first organize it the way you want it to [be perceived], so part of this was saying we're not just general surgeons; we are a Department of Surgical Oncology, and we do disease management and multidisciplinary care, in addition to excellent surgery. We set up the Sections for organ-based leadership. So one interesting story involves the breast section, Fred Ames [Division of Surgery interview], who had the most experience of breast cancer, thought he ought to be the leader of the first breast section. Now, I'd recruited two people when I first came, and they were Raphael Pollock [oral history interview] and Eva Singletary, so they were still relatively junior. Raph was off getting his PhD with [Eva Lotzova], but I wanted to promote the career for Eva Singletary, because she was our first female surgeon. Fred did have the experience, and he was the best person to be the head of the section of breast surgery, so I appointed Eva Singletary as the first Chief of Melanoma Surgery, and that was the first appointment of a woman in the history of the Surgery Department at MD Anderson. This appointment was partly making a statement of promoting women in leadership. So Eva became

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the Chief of the Melanoma Section, and who did a little melanoma and a lot of breast surgery. Later on I convinced Fred that Eva really deserves to be the leader in breast cancer, and she became the second Section Chief [of Breast Surgery]. Eva was a force in herself, in terms of organizing and making things better [for patients], partnering with the medical oncologists, especially Dr. Hortobagyi [in Breast Medical Oncology]. She brought to us the story that her patients were traveling about a half a mile a day. She put a pedometer on them to measure the distant that they were going to go to Medical Oncology, to Surgery, to Radiation Oncology, to the laboratory, to X-ray, and so forth. And she said, “Wouldn’t it be better for us to have one place for the patients, and for all of the specialties to go to that one place?” So Eva Singletary and Gabe Hortobagyi [worked with Donna Sollenberger (oral history interview)] when I was the Hospital Director . We created the first disease site center [as a Breast Care Unit.] I think [this was the first] in the United States—it was certainly the first breast center [in a cancer center]—and that model became so successful that [ ] we converted the entire outpatient delivery system into disease site centers, and in doing so we eliminated the surgery clinic, and the medical oncology clinic. So the other thing that I think had probably the most profound impact here— [01:24:18]

***T.A. Rosolowski, PhD***

[01:24:18]

Well, let me just interrupt you before you start on that story. That’s a major transformation, creating those, so what—

[01:24:28]

***Charles Balch, MD***

[01:24:28]

It drives what we do in America today, and we were the first.

[01:24:31]

***T.A. Rosolowski, PhD***

[01:24:31]

Absolutely. So tell me about that process. What were the resistances? What were the pros, the cons, the process of getting it instituted?

[01:24:42]

***Charles Balch, MD***

[01:24:41]

Well, you have to start with a test model, as a pilot. But Eva Singletary and Gabriel Hortobagyi wanted it to happen. They were natural collaborators. They saw the value of them working side by side every day. And frankly, in some other departments that was also happening. The urologists were working with their medical oncology components. Head and Neck was doing that, with Ki Hong [oral history interview], and so forth. It just hadn’t happened in our area, our



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departmental area. So they wanted it to happen, they made it a success, and you could use the outcomes of that success to say, “This is so good for the patients. If we’re really a patient-centered institution, the patient should only go to one place, and the doctor should come to the patient, instead of the reverse.” So we also, just to finish that story, we found when we implemented it we saved a lot of money, because in the past patients would have to go check in with a clerk at each of those five places, but when they go to the Breast Center they only check in with one clerk, so we could downsize the number of clerks and nurses in the disease site center. And it also enabled the staff to specialize very narrowly around one disease, and become even more expert, such as physical therapy and social work, and in clinical research staff. [Instead of being] “masters of everything,” which meant really not having expertise in anything, the staff became super-specialized in one group of patients. So the whole delivery system improved by virtue of specializing around disease site centers.

[01:26:35]

***T.A. Rosolowski, PhD***

[01:26:36]

How did the faculty respond in the various areas?

[01:26:41]

***Charles Balch, MD***

[01:26:42]

It was mixed. The younger faculty, both in medical oncology and radiation—and in surgery, I think, were for these changes, because they grasped the concept of oncology [management]. The most important thing is that Mickey LeMaistre supported it, [laughs] because I’m sure those who didn’t like the changes would make their opinions known to Mickey, and as long as he supported this we were allowed to continue making the changes.

[01:27:16]

***T.A. Rosolowski, PhD***

[01:27:16]

Why was he invested in it? Why did he get it, as opposed to [not?]?

[01:27:21]

***Charles Balch, MD***

[01:27:21]

Mickey was a visionary. Mickey, like Lee Clark, was an amazing visionary. He also was focused around the central mission of MD Anderson as first being patient-centered, which Lee Clark had done. But also Mickey had a vision for MD Anderson being an academic center, and not just in having translational research going on in the laboratory, but doing prospective databases, clinical trials, and training leaders to go into academic centers.



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## **Chapter 08**

### ***Surgical Oncology at MD Anderson, Part III: Creating a Fellowship Program***

#### **B: Building the Institution;**

Codes

C: Education at MD Anderson;

B: Education; D: On Education;

C: Leadership; D: On Leadership;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

#### ***Charles Balch, MD***

[01:27:21]+

And so that gets into the other part of my story, which probably has the greatest impact of everything I've done here, and that was moving the training program from a one-year fellowship program, which had been there for 40 years, into a two-to-three-year fellowship program, and selecting candidates who wanted to go into leadership roles in academic medical centers or cancer centers. So to do that, I had to have more salary slots, in order to double or triple the number of fellows, and to have research fellows in the lab. So part of my—

[01:28:48]

#### ***T.A. Rosolowski, PhD***

[01:28:48]

Now, how had the fellowship program been organized before? So much shorter, but how else was it—

[01:28:53]

#### ***Charles Balch, MD***

[01:28:53]

It was small.

[01:28:54]

#### ***T.A. Rosolowski, PhD***

[01:28:54]

Very small.

[01:28:54]

#### ***Charles Balch, MD***

[01:28:55]

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Four to six people a year. And our vision was to have 20 to 25 fellows in the program. So part of my recruitment [package from] Mickey LeMaistre was, I think, six additional salaried fellowship positions. In addition, we submitted the first T32 training grant to the NIH, which I think asked for 12 positions. This was approved as requested and became the largest training program in the NIH. So that enabled us to have salaries for fellows to train in the laboratory, and, along with the salary position for the clinical fellows. We said we're going to select fellows who aspire to be leaders in academic surgical oncology, and purposed them to train them in all four areas, to not only be excellent surgeons but to be oncologists, and to be trained to do clinical research and/or translational research, but also people to aspire to be leaders. And as you know, from that point forward on between 85 to 90 percent of the graduates of our programs went into academic centers.

[01:30:24]

***T.A. Rosolowski, PhD***

[01:30:27]

Now, how did you—

[01:30:27]

***Charles Balch, MD***

[01:30:27]

So that was a major change. It also enabled us to look at the graduating fellows and recruit them onto the MD Anderson faculty. So that also was a way of making changes. I knew that changes would be more accepted when 50 percent or more of the faculty were people who I recruited, as opposed to those who had to adopt a [willingness to work with me.] [ ] So this had to evolve over time. There would probably be mixed opinions about whether we made changes too fast or not, but I made them as I saw them, and as Mickey supported the changes, and we had the resources to make the changes.

[01:31:15]

***T.A. Rosolowski, PhD***

[01:31:15]

Now, what were some of the details of how this program actually worked? I mean, once a recruit—or once a fellow arrived, how did you go about providing the training in each of these areas?

[01:31:30]

***Charles Balch, MD***

[01:31:30]

So we set up a program that had to be a minimum of two years, but we encouraged three years. We wanted them to rotate onto medical oncology services. We wanted them to rotate on pathology. We wanted them to have training to do database management in clinical trials. And

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we wanted them to rotate among the different specialty areas, as part of their training. And then, in addition, I had sessions with all the fellows, usually on Saturday morning, on qualities of leadership, and about enhancing their communication skills, which was—I'd learned early on that if you can't write well, you won't get your publications accepted or cited, and if you don't give an arresting talk at a major meeting, people won't take away what you've learned and adopt it into theirs. So I really emphasized from the very beginning the importance of writing well for scientific manuscripts, of writing good abstracts, and of giving an arresting talk at a medical meeting. And I think those elements were very essential for people to succeed. [ ]

[01:33:09]

***T.A. Rosolowski, PhD***

[01:33:09]

Absolutely, absolutely. Well—

[01:33:11]

***Charles Balch, MD***

[01:33:11]

And so we'd moved from empirical-based publications, which didn't get much traction, into evidence-based reports in the literature, which got traction [ ]. Plus, the graduates of our program went all around the country, and started surgical oncology programs that succeeded. And the element of success was two things that weren't being done at the time: they were oriented around oncology management, the multidisciplinary care of the patient, and they were oriented to be clinical investigators.

[01:33:52]

***T.A. Rosolowski, PhD***

[01:33:56]

That's a real mental shift.

[01:33:59]

***Charles Balch, MD***

[01:33:59]

It is.

[01:33:59]

***T.A. Rosolowski, PhD***

[01:34:00]

Real mental shift.

[01:34:01]

***Charles Balch, MD***

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[01:34:01]

So, in summary, it was taking an excellent surgery department that was doing traditional surgery, and training a few fellows to [go into academic surgery], into adding around [that traditional of clinical excellence into] super-specialization based upon organ sites expertises, and of adding clinical research, evidence-based research, and a training program to train leaders in academic surgery. At a time, that there were very few surgical oncologists in many of these academic centers. So we had to train them to how do you organize a surgical oncology program and show the value of it, and how to generate a referral practice that will compete with your other surgical counterparts, both in the community and down the hallway from you. And it worked. I'll give you one other example. Mike Henderson was the first person to be trained here at MD Anderson from Australia. He went back to Australia as the first trained surgical oncologist. Michael Henderson was not well received by the general surgery community, but just two years ago, when I became an honorary Member of the Royal Australasian College of Surgeons, Michael Henderson was given an award by the Australian College of Surgeons for the development of surgical oncology as a specialty in Australia. So [ ] if you break down the elements of success, and you can train people, they can take that and develop programs both here and elsewhere in the world, and develop a successful program, as well.

[01:36:07]

***T.A. Rosolowski, PhD***

[01:36:07]

That's amazing.

[01:36:08]

***Charles Balch, MD***

[01:36:10]

But part of that was the parallel evolution of the benefit of systemic tools, starting with standard cytotoxic chemotherapy, and then targeted therapy and immunotherapy, that could and should be used before or after surgery.

[01:36:29]

***T.A. Rosolowski, PhD***

[01:36:29]

Absolutely. We're almost at noon. Is this a good place to leave it?

[01:36:34]

***Charles Balch, MD***

[01:36:34]

Sure.

[01:36:34]

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***T.A. Rosolowski, PhD***

[01:36:34]

And we can kind of embark on that next phase of the story next time we get together?

[01:36:39]

***Charles Balch, MD***

[01:36:39]

Okay.

[01:36:39]

***T.A. Rosolowski, PhD***

[01:36:40]

This has really been fascinating, and I really thank you.

[01:36:43]

***Charles Balch, MD***

[01:36:44]

Okay. Yeah, because we should talk about—these were all Mickey's things. Mickey tapped me to be the leader in Managed Care here, so we started MD Anderson Outreach Corporation, and helped start MD Anderson at Orlando, MD Anderson at Fort Worth, MD Anderson Clear Lake, and so forth, that became the MD Anderson Network.

[01:37:08]

***T.A. Rosolowski, PhD***

[01:37:08]

You are a builder.

[01:37:09]

***Charles Balch, MD***

[01:37:09]

And then Mickey had me start what became NCCN, which establishes the guidelines for cancer care throughout the world. And there was a story about how that happened, but a lot of what I did was following his vision, his direction, and his backing. Because if you're making changes, the person at the top has to say to whoever says, "I don't like these changes," "I support these changes; let's see how it plays out."

[01:37:41]

***T.A. Rosolowski, PhD***

[01:37:41]

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Yeah. Well, a preview of coming attractions. And I want to thank you for your time today. This has really, really been great. And I am turning off the recorder at just one minute of noon.  
[01:37:57

## **Charles M. Balch, M.D. PhD (h.c.) FACS**

### **Interview Session Two: November 12, 2018**

#### **Chapter 00B**

#### ***Interview Identifier***

##### ***T.A. Rosolowski, PhD***

[00:00:01]

It is five minutes after 11:00 on November 12th, 2018, and I'm Tacey Ann Rosolowski, conducting this interview for the Making Cancer History Voices Oral History Project, run by the Research Medical Library at MD Anderson. And today Dr. Charles Balch is sitting with me for our second session together, so thank you for scooting down from downtown to—[laughs]

[00:00:25]

##### ***Charles Balch, MD***

[00:00:25]

I'm glad to be here, Tacey.

[00:00:27]

## **Chapter 09**

### ***Transforming the Division of Surgery, an Overview***

#### **B: Building the Institution;**

##### Codes

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Working Environment;

B: Growth and/or Change;

B: Obstacles, Challenges;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

C: Understanding the Institution;

C: Education at MD Anderson;

B: Education; D: On Education;

#### ***T.A. Rosolowski, PhD***

[00:00:27]

And we strategized a little bit beforehand, and I wanted to make sure that you felt you had adequately covered your years as Division Head. Because you came in 1985, and then transitioned away from that role in 1993. We talked about the training programs, the way you developed a new surgical perspective focused more on surgical oncology than on the traditional MD Anderson way of doing surgery. So was there—? You may not have perfect memory of everything we talked about, but was there something that you really wanted to make sure that we did talk about today?

[00:01:08]

#### ***Charles Balch, MD***

[00:01:08]

Remember, at that time I actually had two levels of responsibilities. One was as the Division Head, and at the time that was for all of the surgery departments and Anesthesia and Dental Oncology. And at that level, one of the things we really tried to do was to create some core resources that would be available to the faculty in all of those departments, and that included a clinical trials office, editorial office, a database management system, a library, because at those times everybody used print manuscripts and textbooks.

[00:01:51]



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***T.A. Rosolowski, PhD***

[00:01:51]

So was this a library research within—resource within the Division?

[00:01:56]

***Charles Balch, MD***

[00:01:55]

Within the Division of Surgery. Part of my story, too, is that when I was finally accepted for the position in March of 1983, the Lee Clark Clinic Building was being constructed. And they were going up one floor a week. So this was in March [1985]. I didn't start until July. And I was given the entire tenth floor. So I had to, within eight weeks, even before I showed up, have the finished architectural plans for the entire tenth floor, which was supposed to house the Division of Surgery Office [ ].

[00:02:39]

***T.A. Rosolowski, PhD***

[00:02:39]

So what were some of the kind of physical issues you were thinking about for that design?

[00:02:44]

***Charles Balch, MD***

[00:02:44]

So what we wanted to have was a division office with a conference room, and with the space for some of these resources. We had to recruit a division administrator. Remember, the Division of Surgery, Anesthesia, and Dental Oncology existed in name only. Bob Hickey was the head of that on an interim basis, and chaired the recruitment committee [ ]. So we had to put in place an entire concept of division administration that also included the capacity for doing clinical research, protocol office, conference rooms. At the time, a core resource was an information systems platform that would be available to all the faculty, which at the time was not consistently available. We didn't have things like laptops. We didn't even have mobile telephones. [ ] The architect for the building had to fly over to Birmingham on a number of occasions, and I had to come over here and meet in the hotel, in order to plan this tenth floor, because they had to have the concrete inserts and have the architectural plans finished in [the next] eight weeks. That was really a challenge for me and for the architects, but we did that.

[00:04:28]

***T.A. Rosolowski, PhD***

[00:04:28]

Now, let me ask you—

[00:04:29]

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***Charles Balch, MD***

[00:04:29]

And was not completed, of course, until later in the year, after I arrived.

[00:04:33]

***T.A. Rosolowski, PhD***

[00:04:34]

Now, this was part of a huge transformation in the institution when Charles LeMaistre put in the division system.

[00:04:42]

***Charles Balch, MD***

[00:04:42]

Yes.

[00:04:42]

***T.A. Rosolowski, PhD***

[00:04:42]

And so what, in your—and it's kind of an interesting conversation, about how that administrative decision was having a direct impact on the physical layout of things. Now, what is your view of the value of the division system to take MD Anderson into the next phase of its institutional life?

[00:05:06]

***Charles Balch, MD***

[00:05:06]

So what Dr. LeMaistre had already done before I arrived, it had a Division of Radiation Oncology, it had a Division of Radiology, and then had a Division of Medicine. And Irv Krakoff, who was the Chief of Medicine, I think had come one or two years before I arrived, and he'd already started in place of looking at core resources at the division level for all of the departments, especially around clinical research. So a lot of what I did was coming in to place those kind of things at a division level which didn't exist in surgery, but had already been in place in the Division of Medicine under Dr. Krakoff.

[00:05:54]

***T.A. Rosolowski, PhD***

[00:05:54]

Did that help the acceptance? Because I know—I mean, I've talked to people who have told stories about the resistance to the division system.

[00:06:04]

***Charles Balch, MD***

[00:06:03]

Yes. Well, remember, you had some very strong personalities in the department who liked the idea of reporting directly to Dr. LeMaistre, so having an intermediary between the departments and Dr. LeMaistre was something that, for some, really was difficult because of the history that they were formed a decade or two beforehand. Urology, Head/Neck, and Gynecology all had a direct reporting relationship, so taking on a new reporting relationship to some guy from Alabama was a new thing for them, and certainly not something you would expect that people would accept willingly. From Dr. LeMaistre's perspective, it made the administration easier to have something in Surgery and Anesthesia and Dentistry that paralleled what was going on in Medicine, especially if there was enough need for core resources that spanned those faculties, and that was part of my challenge was, one, to incorporate all of the department chairs into an Executive Committee, so they felt an ownership in the Division, and so we strictly kept the Division administration and authority and resources to those things that were common to multiple departments.

[00:07:35]

***T.A. Rosolowski, PhD***

[00:07:35]

What were some of the bumps and knocks along the way of that? I mean, again, strong personalities in a Division of Surgery. Setting up this Executive Committee, how did you go about doing that?

[00:07:49]

***Charles Balch, MD***

[00:07:49]

Well, so there several things we had to do besides the facilities and the core resources. We also had to hire a division administrator, which also was just another layer of administration, but one that could make the division components more influential at the senior administration level.

[00:08:16]

***T.A. Rosolowski, PhD***

[00:08:16]

And this person was—?

[00:08:18]

***Charles Balch, MD***

[00:08:18]

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So we hired a division administrator whose name I can't remember, but I'll get it for you, who lasted for, I think, three years, and then he moved on, and then we hired Donna Sollenberger [oral history interview] from the University of Southern Illinois, who became the Division Administrator, then the Hospital Director, and is probably one of the most influential hospital administrators in the country. So the value we had to demonstrate was could we really develop the programs, the resources, and then execute in a way that the departments, however unwillingly politically, would still feel like their issues and their needs were being met. The other part of this, Tacey, that I think was very important, was brilliant on Dr. LeMaistre's part, is at that time you could not recruit people in the specialties to be in a division underneath some department chair, and so flipping the division and department titles I think really was critical. That was part of Dr. LeMaistre's brilliance, to say if we're going to really recruit top people, we want to continue to recruit them at a department chair level, and those people who were currently department chair were not going to be demoted by having another divisional title, so that having a department reporting to a head of a division was really a very important move, and allowed us then to recruit, besides those that were here in Urology, Gynecology, and Head/Neck, to recruit new chairs of thoracic surgery, neurosurgery, plastic and reconstructive surgery, and so forth, which would not have been possible if they were being recruited into a division level. So one of the other parts early on, the first recruitment was Jack Roth [Division of Surgery interview] and Elizabeth Grimm. I don't think I covered that before, did I?

[00:10:32]

***T.A. Rosolowski, PhD***

[00:10:32]

No.

[00:10:33]

***Charles Balch, MD***

[00:10:33]

So these were leading people from the NIH who were actually going elsewhere, and I was able to convince them, as a husband and wife team, and their academic and research experience, to come to MD Anderson.

[00:10:49]

***T.A. Rosolowski, PhD***

[00:10:49]

Why were they so desirable?

[00:10:51]

***Charles Balch, MD***

[00:10:52]

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Well, because they brought two things: one is Jack Roth was Board-certified in cardiothoracic surgery. No one at MD Anderson was Board-certified [in cardio-thoracic surgery]. Also, Jack Roth and Elizabeth Grimm both had very significant research programs and research funding. So it was, for me personally, a statement to make that, one, we were going to develop a full-fledged research program, including laboratory research that would be fundable by the NIH, but also we wanted to create a new Department of Thoracic Surgery. To do that, you had to have Board-certified thoracic surgeons. The other component of that that I thought was important from a training perspective was to partner with Dr. Denton Cooley to have the first ever Board-certified cardiothoracic program that specialized in thoracic surgery, because at that time the training everywhere else in the country was 18 months of cardiac surgery, six months of thoracic, and most of the thoracic surgery for lung cancer and esophageal cancer was done by general surgeons or cardiac surgeons who did this part-time. So part of our original vision was to have thoracic surgery specialists who specialized in lung cancer, but to be Board-certified they had to have at least six months of cardiac surgery. So we did create and had approved the first ever cardiothoracic Board approval for a program that was 18 months thoracic and six months cardiac. Denton Cooley wasn't going to do that with anyone else who wasn't Board-certified, so it was critically important to have a Board-certified person come in.

[00:12:57]

***T.A. Rosolowski, PhD***

[00:12:57]

Now, what was Denton Cooley's role within all of this? Planning, and—?

[00:13:02]

***Charles Balch, MD***

[00:13:02]

Yes. Well, I introduced him to Jack Roth, and he agreed that he would provide the six months cardiac experience, which, as you know, their volume was such that it equaled most other programs in 12-18 months, so the American Board of Cardiothoracic Surgery saw the wisdom of doing this as a pilot because of the partnering of the largest cancer center and one of the largest cardiac programs in the country. And that, as you can see now, was the beginning of a whole group of thoracic surgeons around the country who really provide a level of expertise for patients with lung and esophageal cancer that didn't exist before. So that was the first department, and that was the first recruitment. We also had to have lab space for Jack Roth and Elizabeth Grimm. Elizabeth Grimm worked with Steve Rosenberg at the NIH, and she brought both experience and, as you know, funding, and worked in the Division of Surgery, first in melanoma, and she's still here 30 years later, now in the Division of Medicine. But that made a very important statement, that we were going to bring a bona fide, established laboratory research program to MD Anderson, through Jack Roth and Elizabeth Grimm, which, as you know historically, they went on and had not only R01 grants but program project grants, and have one of the leading thoracic surgery programs in the United States, if not in the world.

[00:14:57]

I knew also that the other surgical specialties were scattered. They were either in the Department of General Surgery or in the Department of Head and Neck Surgery. So Milan Levins was the neurosurgeon who was in the Department of Head and Neck Surgery. We knew if we were going to have a broad level of expertise we had to create a new Department of Neurosurgery, and we were very fortunate to be able to get Ray Sawaya [oral history interview; Division of Surgery interview] to come and be the first Chair. As you know, that's now grown to be the premier neurosurgery program in the country through his leadership, which was started from scratch. It had to be a vision and a support of the resources, including training and laboratory research and so forth, and the technology in the operating room in order to do sophisticated brain surgery.

[00:15:54]

***T.A. Rosolowski, PhD***

[00:15:54]

And, again, the very comprehensive vision that he had for all the facets that go into that kind of care.

[00:16:01]

***Charles Balch, MD***

[00:16:01]

And we were one of the first to have these navigation devices [in the operating room], to be able to understand in three dimensions where you are within the brain, when you're operating through a small hole, trying to take out a tumor in places that previously were not resectable. So he brought some very innovative programs, both at the clinical level and at the laboratory research level. The other major area as a department—this is in my role as Division Head—was to create a Department of Plastic and Reconstructive Surgery, which, again, the only person at the time was Steve Kroll, who was an ENT-based plastic surgeon in the Department of Head & Neck Surgery. And that wasn't enough to build a broad program. We also wanted to have a major program in breast reconstructive surgery. Because people were not going to be referred to MD Anderson for us to do mastectomies, we had to offer something that wasn't readily available, and that became skin-sparing mastectomies, for which we were one of the first, and also breast reconstructive surgery with autologous, microvascular tissue flaps, to reconstruct the breast. And we recruited Mark Schusterman, again, from the University of Pittsburgh, who brought microvascular surgery for the first time here. And because of that expertise at breast cancer, we became the leading place for autologous flap reconstructive surgery, which, of course, brought a lot of breast cancer patients to the institution with early disease who ordinarily would not have come here in the first place for doing standard mastectomies, whether it's total mastectomies or partial mastectomies.

[00:17:57]

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Now, what's also important here is this meant we needed to have very sophisticated operating room facilities. We inherited some operating rooms that were not very well utilized. We did not have any day surgery, and we didn't have much space [in the ORs]. So one of the things I did as a division head early on was create the first outpatient or ambulatory surgery space. We were able to take a biopsy room that wasn't being used, add another room next to it for so-called ambulatory surgery. That freed up the other operating rooms that were being used for minor or small procedures, so that they could be equipped and be used the entire day for major cases.

[00:18:46]

***T.A. Rosolowski, PhD***

[00:18:46]

When did you accomplish this?

[00:18:49]

***Charles Balch, MD***

[00:18:49]

This was around 1988 or '89. This was a major advance of the concept of day surgery, and we were one of the first in the country. In fact, we wrote an entire paper about being able to reduce the length of hospital stay by having day surgery facilities. But the other part of that, it enabled us to make better use of the operating rooms that existed. We also moved towards extended hours, so we had two shifts of nurses, so that we could work into the evening time, which wasn't being done before. And then we had to have specialized operating equipment for both neurosurgery and for microvascular surgery. [ ] The strengths, when I came, were largely in the specialty surgery—Urology, GYN, and Head & Neck—but there weren't that many distinguishing features of services provided in the Department of General Surgery, because they were doing general surgery, which meant they were doing GI, breast, and other things, but not that much different—it was excellent surgery—that isn't the point—but were they really different from what was in the community, or elsewhere in the Texas Medical Center, which was also vying for patients? So, for example, we drove the whole breast surgery program, because we had breast reconstructive surgery as a primary reason that patients were being referred to the institution.

[00:20:36]

## **Chapter 10**

### ***Transforming the Division of Surgery, Part of the Institution's Strategic Plan***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Research;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

C: Understanding the Institution;

C: Education at MD Anderson;

B: Education; D: On Education;

B: The Business of MD Anderson; C: The Institution and Finances;

B: MD Anderson History; B: MD Anderson Snapshot;

#### ***T.A. Rosolowski, PhD***

[00:20:36]

Now, I wanted to ask you, because I noticed that you, from 1988 to 1996, served on the Executive Committee of the Strategic Plan.

[00:20:49]

#### ***Charles Balch, MD***

[00:20:49]

Yes.

[00:20:49]

#### ***T.A. Rosolowski, PhD***

[00:20:50]

And I'm curious—I mean, I had made a special note of that, because obviously when you're making the strategic plan, this broad range of goals is something that's always under discussion, not only how do we become better at research, tracking outcomes, but how does that then translate into something that makes us marketable as an institution.

[00:21:12]



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***Charles Balch, MD***

[00:21:12]

Yes.

[00:21:12]

***T.A. Rosolowski, PhD***

[00:21:13]

So I'm curious: did your conversations on—? What was it like being part of that executive committee, and how did that help shape your decision-making, and vice versa?

[00:21:27]

***Charles Balch, MD***

[00:21:27]

So this was also part of Mickey LeMaistre's brilliance, that he allowed the division heads as a group to collectively drive the strategic plan and the distribution of resources to the clinical faculty together. And this goes back, actually, to a brilliant piece of Lee Clark that there was [a single institutional] practice plan. In most other cancer centers, there are economic silos that may make it difficult for surgeons and medical oncologists and radiation oncologists to work together because there was a concern about how the revenue was flowing from one to another, whereas we're one big practice plan. There were no economic barriers to practicing multidisciplinary care at this institution, which I could tell you, having worked at other centers, is an under-the-table but real barrier sometimes to who takes care of the patients, where does the money flow, in a patient where they're coming for multidisciplinary care. So this was also part of Lee Clark's brilliance, to have a single-practice plan, and Mickey LeMaistre's brilliance in leadership to really engage the clinical division heads as the executive group for the institution, and to come up with a strategic plan that we could work together on for the benefit of patients in providing multidisciplinary care.

[00:23:07]

***T.A. Rosolowski, PhD***

[00:23:07]

So what were some of the kind of foundational decisions of that group?

[00:23:12]

***Charles Balch, MD***

[00:23:12]

The biggest one, which was a fundamental change, was doing prospective clinical trials, which, remember, for Irv Krakoff, he had to get past that in the Division of Medicine with people who had a philosophy which was prevalent at the time, [of conducting] the empirical-based clinical research. "We report our retrospective studies, and you believe us and practice what we do because of our experience." And Irv brought, at Mickey LeMaistre's request, the strategy of

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doing clinical trials, beyond our experience of proving [our expertise with prospective] evidence. There were not clinical trials when I came here in surgery, so one of the things that I brought was an approach to doing clinical trials, of having a clinical trials office, and database management that provided the evidence prospectively for why we do what we do, or to practice innovative therapy through clinical trials. And this was something that we really brought at the division level as a resource for all of the departments, but I was able to implement it more easily because Irv Krakoff had already instituted that in the Division of Medicine, and that was part of the mandate for Mickey LeMaistre.

[00:24:44]

And let me just finish one other story at the Division level, because at that time outside of the three specialties that I mentioned, the Department of General Surgery did everything. And one of the things we did strategically was to say, "We're going to subspecialize based upon the disease sites," and so I converted the Department of General Surgery, which had been there from the beginning, into a Department of Surgical Oncology, and created the sections of Breast Cancer, GI Cancer, Pediatrics, Biliary, Pancreatic, and then, importantly, a section of Orthopedic Oncology, and recruited John Murray from the outside, which then was the forerunner of the Department of Orthopedic Oncology. Then with John Murray we recruited Alan Yasko to be the formal full-time section head of that. And then, a section Pediatric Surgery, which we got Richard Andrassy to come and be the section head part-time, even though he was based at UT Houston and Hermann Hospital.

[00:25:59]

There was one other key thing that I did when I came here, and that was to affiliate with the University of Texas at Houston, and Hermann Hospital. At the time, Frank Moody was the Chair of Surgery, and Frank appointed me as the Vice Chair of the Department at the UT Houston, so that we could have a formal affiliation and a chief resident service here.

[00:26:27]

***T.A. Rosolowski, PhD***

[00:26:28]

I'm sorry, I actually don't know what you're referring to when you say "UT Houston."

[00:26:33]

***Charles Balch, MD***

[00:26:33]

Hermann Hospital. University of Texas at Houston. So there were fellows here who did a one-year fellowship, but part of having an academic program is having residents, so one of the things that I did, which was not here at the time, was having a formal affiliation with the University of Texas at Houston, which meant they had to appoint me in their department, and we had to make sure that we had a service that did not compete with the [surgical] fellows, so that the Residency

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Review Committee would approve MD Anderson as a component of the UT Houston residency training program. This also was important to recruit faculty who were academic, who wanted to have residents and students as part of their training responsibility. And then I also affiliated with the Methodist Hospital in the Baylor program, so that the residents from PG1 to PG4 could also be here.

[00:27:36]

***T.A. Rosolowski, PhD***

[00:27:37]

What's PG1 and PG—

[00:27:38]

***Charles Balch, MD***

[00:27:38]

Postgraduate [levels], the interns up to the senior residents [ ]. So part of the program that we put together, which was very important for the recruitment of future faculty, was to recruit faculty that saw fellows and residents and students as part of our academic responsibility. It also enabled us to recruit a different type of fellow candidate who didn't want to come here do the intern work, because there was nobody below them, but had a team of residents and fellows that could work on these different services, which we reorganized around the training programs.

[00:28:25]

***T.A. Rosolowski, PhD***

[00:28:27]

How long did it take to set all this in place?

[00:28:29]

***Charles Balch, MD***

[00:28:30]

We did this in the first two to four years.

[00:28:33]

***T.A. Rosolowski, PhD***

[00:28:33]

Wow, so pretty quick.

[00:28:34]

***Charles Balch, MD***

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[00:28:34]\$\$

It was very quick, and, of course, there was a lot of pushback, because we were making a lot of changes quickly. But on the other hand, the mandate from Dr. LeMaistre is he wanted to see an academic program and an academic faculty that he was not seeing with the current leadership in General Surgery. So that meant changing the training program so that the fellows, instead of being a one-year clinical fellowship, which was what they'd had from that point into a two- to three-year fellowship, to train what we called leaders in academic surgical oncology, which meant they had to have research training, also, as part of their training program, in addition to the clinical training. And then to recruit faculty that were bona fide academic surgeons in all the specialties, we had to have a full-fledged academic program, and that meant having medical students, residents, fellows who were training to be academics, and a research program, both in the laboratory and a clinical research program that all had to be put in place fairly quickly if we were really going to transform the Division of Surgery, and in the Department of Surgical Oncology. So these kind of things also were applied in the other departments that existed to some degree, but not to the extent that it did when we were all doing that together.

[00:30:11]

## **Chapter 11**

### ***Subspecialization: The Key to Building a New Division of Surgery***

#### **B: Building the Institution;**

Codes

A: Personal Background;

D: Technology and R&D;

B: Research;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

C: Understanding the Institution;

***T.A. Rosolowski, PhD***

[00:30:11]

What were some of the smooth points and rough points in doing that? I'm just kind of thinking that that—a level of change, and all of the moving parts that are being set in place, some of which are brand new moving parts. And understand how I am asking here, it's kind of lessons learned.

[00:30:31]

***Charles Balch, MD***

[00:30:31]

Yes.

[00:30:31]

***T.A. Rosolowski, PhD***

[00:30:32]

So it's sort of that evaluation of how things got implemented on the ground. What are some of your observations around that?

[00:30:40]

***Charles Balch, MD***

[00:30:39]

So, a few things looking back. First of all, MD Anderson was very traditional, and the mindset when I came is we do this way because it's, quote, "the MD Anderson way." And so my challenge was to kind of break out of that mold and say, we're going to think of ourselves in a new way. We're going to be leaders nationally. We're going to train future leaders. And we're going to develop a clinical and laboratory research program that, for the most part, did not exist.

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That doesn't mean there wasn't research going on, but there wasn't papers published, there wasn't peer-reviewed grants from the NIH and other sources, and in order to do that you had to have bona fide people to recruit into the program that did not exist at the time. I think there were two things that allowed us to make these transformational changes fairly quickly. First, this is what Mickey LeMaistre wanted. So I'm sure when we announced these changes, or made these changes, people were in his office, and if he didn't agree with the changes they wouldn't have happened. The second is we developed the Division Executive Committee so that nothing was done without the input of all the chairs and the administration. It was really important, even if we had to make some changes that not everybody agreed to, that everybody could weigh in on it and have some input. And the third thing, which you mentioned earlier, we used the strategic planning process so that we could not only achieve some consensus in the words we used on what is our strategy, what is our objective, what are the resources and the timelines, but we could use the strategic plan as a way to communicate to the faculty and everybody, here's our strategic plan, here's our priorities, and it's all here in writing; there's no surprises. And the strategic planning was something that Mickey used very nicely at the leadership level for the institution, among other division heads, and then in turn that I think we used quite well in order to describe the change and the reasons for them at the Division of Surgery level. And those major changes were mainly around new and competitive programs in laboratory research, new clinical protocols, and training of individuals not for a one-year clinical experience, most of whom went into private practice, but to train future leaders of American surgery in all of the specialties.  
[00:33:34]

***T.A. Rosolowski, PhD***

[00:33:35]

Did all of this—? I'm—

[00:33:37]

***Charles Balch, MD***

[00:33:37]

And that was the vision. Coming in, that was the vision.

[00:33:41]

***T.A. Rosolowski, PhD***

[00:33:41]

I'm thinking about the changes that you were committed to making, Dr. LeMaistre was committed to making, in the 1980s and into the '90s. And I'm thinking about what was going on when Ronald DePinho [oral history interview] came. And I'm seeing a little teensy bit of a parallel, in the sense that it's kind of raising the bar. It's raising the bar for people who are already at the institution. And I'm curious: when you were taking on this vision, and implementing these complicated changes, how was culture being impacted at that time? Was there a sense that, ooh, I mean—[laughs]

[00:34:29]

***Charles Balch, MD***

[00:34:29]

Mickey LeMaistre would say I had a target on my back the whole time I was here, because I was a change agent. But I also knew, being a younger member of the faculty, that we had to make change with a process that allowed people to have input. You can't ignore tradition, and you have to be able to, sooner than later, be able to demonstrate that the changes add value. Just for example, when I came here, if we're going to increase the training of fellows from one year to two to three years, you have to have more salaries. So one of the things that Mickey LeMaistre did was provide, I think, at least six extra salaries for trainees from the institutional budget, or I couldn't have done it. In addition, he told me I had to, if we have research training, go out and get NIH money to do that. So we did apply, and we ended up on the first try to have the largest T32 grant the NIH had ever granted for MD Anderson, which is now, I think, in its 32nd or 33rd year. That enabled us to have salaries, and the stature of having a T32 grant that attracted really good people to apply for the training program, and it gave us salary support during their clinical time, but, importantly, it gave us salary support for their laboratory time. And at first, we had to have them in other departments. This is where Josh Fidler [oral history interview] and Margaret Kripke [oral history interview] were so important, because they welcomed surgeons coming in to immunology and tumor biology for training at the laboratory level, and, of course, my laboratory was in the Smith Building, so that was also an important statement, that that was a center that attracted young surgeons who wanted to do laboratory research training, to be in that environment where they're around, really, two entire departments of really good people that would influence their training and promote the collaboration. So I would give a lot of credit to Dr. Fidler and Dr. Kripke of also embracing the training of surgeons in laboratory research, which, in turn, enabled us to recruit the kind of people who are today chairs of surgery department or leaders right here in MD Anderson.

[00:37:07]

***T.A. Rosolowski, PhD***

[00:37:08]

Were there some people who left or had to be let go because the institution was becoming different?

[00:37:16]

***Charles Balch, MD***

[00:37:16]

There was nobody that was let go. There were a few people that I helped get into positions elsewhere, but that was a mutual decision. Because we were raising the bar of expectations, both in terms of you had to be an academic surgeon to be on the faculty, and you had to be an excellent clinician, and the only way to do that was to subspecialize around diseases. So two

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things that I did were set up the sections, and people who have expertise in more than one area could be in two sections, but it was over time to encourage people to focus on either GI surgery, liver surgery, breast surgery, and so forth. And it also enabled us to recruit people who came in with the view that my expertise, at an international level, is because I'm so good in one disease. I think I may have mentioned before that part of kind of breaking the mold, because as I was the first person to come from outside of MD Anderson, was to recruit three people from Memorial Sloan Kettering, including Dr. Peter Pisters, who came here for his first job to do sarcomas and GI surgery. Dr. Mark Roh, who we made as the Chief of Liver Surgery, and you remember a lot of people were doing liver surgery, some not as good as they might, and I said the standard of care and the outcomes for everybody in the department, it will have to be the same as Mark Rowe, who's doing it full-time. And if you can select patients so that your outcome is the same as his, that's fine; I'm not going to tell you what to do. But part of what we introduced was quality outcomes, and we had to, for some time, pull the credentials and stop the program for isolated limb perfusion, which was being done without a protocol, without the consistent indications, and for which the treatment was not consistent, and there were some complications, including limb amputations, that said we have to put a halt to this, and it can only come back if it's done in a consistent way on a protocol with prospective data. And it's an example of something that reflected what people were doing, sometimes on an occasional basis, with indications for which there was no consistency. One that I remember that led to an amputation was a young person who was referred for perfusion, and it was done because of the referral, but you look at the indications and say there's no way this patient would have benefited from that procedure, and in doing so this person lost their leg. So it was part of the culture at the time that some of these complex procedures were done without the rigor of testing the outcomes, without the rigor of saying we're going to limit our indications to people who benefit. I think partly that patients need to be properly informed about the risk and the benefits for their indication.

[00:40:49]

***T.A. Rosolowski, PhD***

[00:40:49]

What was your process for establishing the protocols that could be pointed to as the source for consistency?

[00:40:58]

***Charles Balch, MD***

[00:40:58]

Remember, if I'm Chief of Surgery, then I can say we can only do these big, high-risk procedures if they're done on a protocol, with consistent indications, with outcomes of the reporting, and with a prospective database, so that we can report our results.

[00:41:18]



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***T.A. Rosolowski, PhD***

[00:41:24]

I'm asking the question in that way because—

[00:41:26]

***Charles Balch, MD***

[00:41:26]

So I guess, in a way, this was the first quality of care safety type of things that we formalized. As part of going from an empirically-based, “We do this because it’s the MD Anderson way,” to an evidence-based system that says, “We’re going to gather the data prospectively and we’re going to report on it inside, and everybody who contributes to that operation should have the same outcomes if they’re doing it safely and having it done in a quality manner.”

[00:42:03]

***T.A. Rosolowski, PhD***

[00:42:03]

To what degree were other institutions doing this, as well?

[00:42:07]

***Charles Balch, MD***

[00:42:07]

We were one of the first.

[00:42:09]

***T.A. Rosolowski, PhD***

[00:42:09]

One of the first, yeah, yeah. I mean, it’s just fascinating. I mean, how do you regulate this complexity with these—?

[00:42:19]

***Charles Balch, MD***

[00:42:20]

You have to remember, all of these things were interconnected. You can’t have an academic training program unless you have a clinical research training, unless you have a good laboratory program, unless you have a faculty that is geared towards training the leaders in academic surgery, not just—because what we had before was training people to be excellent clinical surgeons. That was always here. But not people—there were a few exceptions. There were four that I could name who went into academics over the years, but most everybody else went into private practice after a one-year training program. The other part of that, if you have an academic program, you have to have the full-fledged medical students and residents as a component of this. So really, to end up with high-quality faculty, and to train future leaders in

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surgical oncology, you have to have specialization clinically; you had to have clinical trials; you had to have laboratory research; you had to have the training programs; and all of that had to be put together as a package as quickly as possible, if you're really going to transform into a bona fide academic surgery program that was the same or better than any other program in the nation.  
[00:43:50]

***T.A. Rosolowski, PhD***

[00:43:56]

We've got about ten minutes left today, and so I wanted to ask you your choice: would you like to tell the story of transitioning out of the Division Head role to your next administrative role—  
[00:44:11]

***Charles Balch, MD***

[00:44:11]

Let's do that next time. I think there are still more stories in the Surgery Department, so—  
[00:44:18]

***T.A. Rosolowski, PhD***

[00:44:18]

Please tell.

[00:44:19]

***Charles Balch, MD***

[00:44:19]

One of the things that happened during those times, especially the period from about '90 to '94, was the surgical leaders in all the specialties, including me, had risen to leadership in their specialty area: Helmuth Goepfert [oral history interview] in the Head & Neck; Andy von Eschenbach in Urology; Taylor Wharton in GYN Oncology; and I became the President of the Society of Surgical Oncology in 1992. Before then, I'd gone through all the leadership roles at Vice President and Secretary and so forth. And it was interesting at that time in 1992, our meeting was at the Waldorf Astoria in New York, and my talk was on the future of surgical oncology in the twenty-first century. So this was 1992, and I wrote a manuscript which was published on what I thought surgical oncology would look like in the next century. And what I described was multidisciplinary care, disease site specialize, and made the statement then that surgery will not be the major initial treatment for cancer care in the twenty-first century, and that we would specialize by disease more than our surgical specialty. I also gave the first PowerPoint presentation at a national medical meeting, and to do that I had to work with the IT people here to develop a PowerPoint on a computer that actually had moving parts, and that person had to fly up to New York with me. And so we had a computer at the dais, and I actually had slide projectors in the balcony in case the computer failed, and the computer person sat next to me behind the dais, because I didn't know how to use the computer. You have to remember also

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that the computer had a 12-inch disc—that's what we used—and it was the first time in New York. They actually had to truck in a projector from Philadelphia that connected to the computer, because there wasn't such a projector in New York City. So I remember when I finished my talk I held up the disc, introduced the guy who was hidden behind the dais, and said, "This will be the communication vehicle of the twenty-first century: PowerPoint." [laughter] And that actually did become the standard.

[00:47:08]

So because of our leadership, there's a whole other story, which we've published, on the transformation of the Society of Surgical Oncology, which at the time was underwater in its budget, was languishing in its membership, and part of the leadership was transforming the SSO into the organization it is today. In addition to that, we scheduled to have the meeting come here in Houston in 1996, which was a highly successful meeting. Included in that is we bused everybody to Space Center Houston for an evening of space travel, and had 17 astronauts circulating around and giving their presentations about the history of space travel. But that's part of what Houston is: it's not only the Texas Medical Center, but NASA was also part of this.

[00:48:05]

Maybe another part of the story in these waning moments is when we moved here we looked around for where are we going to live. My wife Carol --we had four children. They were in three different levels of intermediate, grade school, and high school at the time. And while they were traveling to Galveston, to go to the beach, they decided to get off at Clear Lake, went past Clear Lake High School, which had a sign out in front that they just received a national award as one of the best educational systems in America. So she came back that night and said, "We're going to move to Clear Lake, Texas, because that's the best place for our kids' education." That's important because of our location. I ended up getting very engaged with NASA and the Astronaut Corps. I was a member of the Astronaut Evaluation Committee, and was appointed to the Founding Board of Space Center Houston, and helped with Walt Disney Imagineering and the NASA people to build Space Center Houston. Also, because of that connection, my laboratory got involved in putting experiments into space. We actually did six different experiments on the effect of a microgravity environment on lymphocyte function, and Neal Pellis, who was running my lab at the time as a PhD, actually went on after I left to NASA as a science director. So there was, even at that time, which is interesting—there is today, because we have Robert Satcher, who is an astronaut who is a member now of our Orthopedic Surgical Oncology group, but part of who I am, because of my wife's selection of Clear Lake, is we early on got connected with NASA, because the kids who were with my kids, their fathers, many of them were astronauts. Because of that I met the astronauts and got engaged in that, and through that became well known in NASA, so they invited me to be part of this new board to build Space Center Houston.

[00:50:22]

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***T.A. Rosolowski, PhD***

[00:50:22]

Oh, cool. And I don't think I had asked you before: what is your wife's name?

[00:50:26]

***Charles Balch, MD***

[00:50:27]

Carol.

[00:50:27]

***T.A. Rosolowski, PhD***

[00:50:28]

Carol. And when were you married?

[00:50:29]

***Charles Balch, MD***

[00:50:29]

Nineteen ninety-six. So we have been married now 52 years.

[00:50:36]

***T.A. Rosolowski, PhD***

[00:50:36]

Wow, wow. Nineteen ninety-six?

[00:50:38]

***Charles Balch, MD***

[00:50:40]

No, 1976, sorry.

[00:50:44]

***T.A. Rosolowski, PhD***

[00:50:44]

Nineteen seventy-six, there we go. I was like—and your children's names?

[00:50:49]

***Charles Balch, MD***

[00:50:49]

So Glen is the oldest, and he started out at Clear Lake High School. He's now the Chief of Colorectal Surgery at Emory University, which is at an equal level to the Division of General Surgery and the Division of Surgical Oncology. So it's one of the largest colorectal programs in the country. He trained at Memorial Sloan Kettering. My second son, Alan, went the PhD route,

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and he's the CEO of the Patient Advocate Foundation in Virginia, and in Washington, which has one of the largest programs in the country for case management, copayment assistance. For patients with life-threatening chronic disease, the majority of those are cancer patients, and they helped, for example, provide services for over 90,000 patients last year alone. And then my daughter Laura, who went to Clear Lake Intermediate School, then Clear Lake High School, then TCU and University of Houston, and finally at UTMB, to become a PA, started here 17 years ago. She's still a Senior Physician Assistant in the Department of GI Medical Oncology.

[00:52:05]

***T.A. Rosolowski, PhD***

[00:52:05]

So an entire family involved with healthcare—

[00:52:08]

***Charles Balch, MD***

[00:52:08]

Yeah, and then my youngest son Mark went the hospital administrative route, and he is a senior administrator for the Veterans Hospital.

[00:52:17]

***T.A. Rosolowski, PhD***

[00:52:18]

And your wife? Did she have a career before family, and—?

[00:52:22]

***Charles Balch, MD***

[00:52:22]

Now, Carol actually—we met in pre-medicine at the University of Toledo. She went to medical school at Columbia. She was two years behind me. Because I did my internship at Duke, and I knew I would have to go into the military right after that, she took a year off and did research for the Chair of Medicine at UNC, then came up to the NIH, where I was, and went to Georgetown Medical School, and for several reasons, in the fourth year, decided that it would take too long to finish. We had children, and she wanted to take a leave of absence to raise our first son, which turned out that we kept having children, and she never went back. But what's important is since she went into the fourth year, she honored what I was doing, and when I wasn't there, instead of poisoning the well—and I think her role had a major influence on way our children ended up in healthcare and not in some other area, because she was a full partner in what I was doing, and supported what I was doing, even those times that I was away.

[00:53:35]

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***T.A. Rosolowski, PhD***

[00:53:35]

Yeah. Well, it sounds like Clear Lake was a good choice, and added a whole interesting dimension to the—

[00:53:42]

***Charles Balch, MD***

[00:53:42]

Yes, and actually for two of the kids they met their spouse there and are all happily married.

[00:53:46]

***T.A. Rosolowski, PhD***

[00:53:46]

That's very cool. Well, we're almost at noon. Would you like to leave it there for today, and—

[00:53:52]

***Charles Balch, MD***

[00:53:52]

Let's leave it there. Then we can start out on 1993, on a fateful Saturday morning when Mickey LeMaistre invited me to his office, which never happens, [laughter] and said, "On Monday morning, you are the new Vice President for Hospital and Clinics."

[00:54:09]

***T.A. Rosolowski, PhD***

[00:54:09]

Wow. Wow.

[00:54:11]

***Charles Balch, MD***

[00:54:11]

And the rest is history.

[00:54:13]

***T.A. Rosolowski, PhD***

[00:54:13]

The rest is history. All right, well, hey, that's a good cliffhanger. [laughs]

[00:54:15]

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***Charles Balch, MD***

[00:54:15]

Okay.

[00:54:15]

***T.A. Rosolowski, PhD***

[00:54:16]

All right, Dr. Balch. Well, I'm saying for the record that I'm turning off the recorder at one minute of 12:00. Thank you very much for coming in.

[00:54:23]

## **Charles M. Balch, M.D. PhD (h.c.) FACS**

### **Interview Session Three: December 18, 2018**

#### **Chapter 00C**

#### ***Interview Identifier***

***T.A. Rosolowski, PhD***

[00:00:01]

I'm just saying for the record I'm Tacey Ann Rosolowski, and today is December 18th, 2018, and I'm on the 17th floor of Pickens Tower, on the main campus of MD Anderson, in the Division of Surgery, and for my third session with Dr. Charles Balch. So thanks very much for doing this.

[00:00:21]

***Charles Balch, MD***

[00:00:21]

I'm glad to be here with you.

[00:00:23]

***T.A. Rosolowski, PhD***

[00:00:23]

I have a feeling we're going to have another interview session, at least [laughs] one more. Oh, and I just want to say, for the record, it is about 21 minutes after 10:00.



## Chapter 12

### *Building the Division of Surgery: One Precursor to Disease-Site Reorganization*

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Research;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

C: Understanding the Institution;

B: The Business of MD Anderson; C: The Institution and Finances;

B: MD Anderson History; B: MD Anderson Snapshot;

B: MD Anderson Impact; C: MD Anderson Impact;

#### ***T.A. Rosolowski, PhD***

[00:00:23]+

And we spent about a session and a half talking about the work that you did coming here to transform the Division of Surgery. So I wanted to ask you, by the time you were ready to transition into your next role in 1993, what do you feel had been accomplished in the Division, and where was the Division poised to go at that moment?

[00:01:03]

#### ***Charles Balch, MD***

[00:01:03]

Sure. Well, the strategy when I first came here, and the charge from Dr. LeMaistre, was to transform the Surgery Department, starting with the Department of General Surgery, and the entire division, which included all the surgery departments, anesthesia, and dental oncology, into an academically-oriented program at each of those departments.

[00:01:32]

#### ***T.A. Rosolowski, PhD***

[00:01:32]

And I just want to remind you that we did talk about a lot of those details, so sort of more of a global view.

[00:01:38]

***Charles Balch, MD***

[00:01:38]

But I think, in the main, some had already developed those programs: Head & Neck Surgery and Urology and Gynecology; the Department of General Surgery, which we changed and transformed into the Department of Surgical Oncology, and started training people that would become leaders, such that people like Kelly Hunt, who's now Chair of the Department of Breast Surgical Oncology, and Funda Meric-Bernstam is now Chair of the Department of Personalized Cancer Patient Therapeutics. These are very large departments that spun off from the Department of Surgical Oncology. And as you know, we also had a charge of creating new departments that became the Departments of Thoracic Surgical Oncology, Plastic Surgery, Orthopedic Surgery, and Neurosurgery. All were started under that leadership. And I think all of those programs have grown and thrived as departments, and all of them have both clinical research programs and training of people who are now becoming leaders in American surgery in their specialty areas.

[00:03:03]

***T.A. Rosolowski, PhD***

[00:03:03]

Let me ask you a question, because particularly it just hit me when you mentioned the Department of Personalized Cancer Therapeutics, that in some ways the development of these spin-off departments, if we want to just call them that with a colloquial term, also was reflecting transformations of fields, and the creation of new fields. And what's interesting always to me is the way that an administrative structure within an institution needs to be able to respond to that.

[00:03:33]

***Charles Balch, MD***

[00:03:33]

Yes.

[00:03:33]

***T.A. Rosolowski, PhD***

[00:03:34]

So what's kind of your perspective on how that was happening at the time?

[00:03:38]

***Charles Balch, MD***

[00:03:38]

Well, even when I first came, my first recruit was Jack Roth [Division of Surgery interview] and Elizabeth Grimm, and Jack Roth brought molecular biology and gene therapy in lung cancer. He set a standard for other departments to follow that is now, especially as younger people finishing their fellowship here grew up in the system, established leadership roles, and increasingly over the following 20 years embraced molecular therapy, genetics, immunotherapy, all of these things that we laid the groundwork for so many years ago.

[00:04:24]

***T.A. Rosolowski, PhD***

[00:04:25]

And your finding at the time was that the leadership and the Executive Committee for the Strategic Plan was very open to the creation of departments to funnel resources in those new areas. What was the reaction about that kind of growth?

[00:04:45]

***Charles Balch, MD***

[00:04:45]

Well, all of this had the endorsement from Mickey LeMaistre, who wanted to have the surgery departments collectively establish a greater presence and visibility nationally and internationally, in leadership roles, and, in addition, to be able to document their experience through prospective databases, and to conduct innovative therapies through clinical trials. Now, this wasn't done in isolation. Irv Krakoff in the Division of Medicine had already begun several years before I arrived to do this in the Division of Medicine, and because of those parallel moves, there then began in an evolutionary way to be a cross-fertilization between surgery, medicine, and radiation therapy, which ended up into disease site research programs and disease site clinics, for which the disease orientation became the first—the focal point of the specialties from surgery, medicine, and radiation therapy to work together, both in research and in patient care.

[00:06:10]

***T.A. Rosolowski, PhD***

[00:06:10]

And a lot of that disease site focus was—I know from interviewing folks—it was happening in kind of little isolated ways all over the institution—

[00:06:19]

***Charles Balch, MD***

[00:06:19]

Yes.

[00:06:19]

***T.A. Rosolowski, PhD***

[00:06:19]

—but then kind of there was a framework.

[00:06:22]

***Charles Balch, MD***

[00:06:22]

Well, we could make it all happen when I was the Vice President for Hospital and Clinics, so I had the authority to reorganize these in that role. It started out in breast diseases, with Gabriel

Hortobagyi and Eva Singletary. It was much easier in Urology and Head & Neck because they already had been oriented that way, and the same in Gynecology, Oncology. So there were pockets of multidisciplinary care that were already there. While I was the Vice President for Hospital and Clinics we formalized that throughout the whole institution, and in doing so we eliminated the surgery clinics and the medical oncology clinics. They are gone.

[00:07:16]

***T.A. Rosolowski, PhD***

[00:07:16]

Yeah. It was an amazing transformation. Tell me about the transition—

[00:07:20]

***Charles Balch, MD***

[00:07:19]

Yes. And it was the first in the country to do that.

[00:07:22]

***T.A. Rosolowski, PhD***

[00:07:21]

Yes, that's incredible. Well, tell me about the transition. So what made you decide to leave the role of Head of Division of Surgery and take on this greater role?

[00:07:32]

***Charles Balch, MD***

[00:07:32]

And before I do that, let me just finish one other thought. The reason we could do this—because I've been in other institutions which have separate practice plans based upon the department—one of the genius of Lee Clark was to have a single practice plan for all of the physicians. Finances could be a barrier to collaborating together because people would fight over where the money goes, and which department it goes to, but with a single practice plan it was much easier for people to work together in a multidisciplinary program that took a while longer in other institutions where the practice plans were separated by departments and specialties.

[00:08:18]

***T.A. Rosolowski, PhD***

[00:08:18]

Yeah, a financial territory. [laughs]

[00:08:21]

## Chapter 13

### *Head of Hospitals and Clinics: Managed Care and the Origin of the National Comprehensive Cancer Network; The MD Anderson Outreach Corporation*

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

A: Professional Path; C: Evolution of Career;

B: Beyond the Institution;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

B: The Business of MD Anderson; C: The Institution and Finances;

*Charles Balch, MD*

[00:08:21]

It could be a big barrier. So the question is how I got into the Hospital and Clinics. This was not my plan. Mickey LeMaistre had—the hospital VP had left on a Friday. Mickey LeMaistre called me into his office on Saturday morning, which was a rare event that we had Saturday morning meetings, and said, “On Monday you’re going to be the interim Vice President for Hospital and Clinics.”

[00:08:53]

*T.A. Rosolowski, PhD*

[00:08:53]

Who was the outgoing?

[00:08:55]

*Charles Balch, MD*

[00:08:55]

It was Dan Oldani, who actually went to Georgetown Hospital to be their Hospital Director. So this was more of a directive, “I need you to do this on Monday.” [laughter] This was not something I was looking for. In my role as the Division Head I’d been very involved in the managed care of MD Anderson, the contracting and marketing. I’d been very involved in the establishment of MD Anderson Outreach Corporation, for which Bob Shaw was the CEO and I was the first Medical Director. And we were establishing MD Anderson outposts in Clear Lake, Texas, in Fort Worth, Texas. We had begun the discussion for what became MD Anderson in Madrid, Spain. And the concept then was to establish a network in Texas, and even internationally. I had also been very involved with Mickey and a guy named Dr. Buck Brown in Orlando, to establish what started out as the Orlando Cancer Center and then became MD Anderson at Orlando. So all of these things were going on while I was the Division Head, in the

Managed Care and the networking, and for me and for Mickey it would have been natural, at least, to help out the institution on an interim basis. Now, of course, I'm not trained to be a hospital administrator in budgeting, financing, and personnel, so part of the issue, which Mickey agreed to, was to get Donna Sollenberger on that same Saturday to say, "Starting Monday you will come with me to the Office of the VP for Hospital and Clinics." Donna became the Executive Director of this. She is magical in her ability to organize people to develop implementation of strategy, to manage budgets, to decrease expenses and raise revenues, and it was a bit of a surprise to everybody that we not only maintained things but they got better. And for that reason, Mickey didn't want me to go back to the Division Head, and he stopped the recruitment and said, "I want you to just continue doing this with Donna Sollenberger," and the staff that we'd assembled.

[00:11:41]

***T.A. Rosolowski, PhD***

[00:11:41]

So what were the first items that you really attacked?

[00:11:46]

***Charles Balch, MD***

[00:11:47]

Well, at this time, in 1993, the wave of managed care was taking place in the West Coast, especially in California, and our consultants, which included some people from the West Coast, had said, "This is going to move to the East. It will involve you. You will be involved in managed care contracts. Your revenue will decrease, and you have to find a way to reduce your expenses, as well. And the sources of revenue are going to dramatically change." So part of the first thing that we needed to do was to become leaner in our expenses. Even in that first year we had a goal of reducing our expenses and reducing staff. In fact, we had cut almost \$90 million from our budget, and by volunteering retirement and reduction in force, we took out 1,000 positions in that two years, from the hospital and clinics and later as we moved into the EVP office. Now, this was in anticipation of a managed care event which didn't materialize in Texas to the same degree it had in California. But the good news for the institution is these very significant reductions, without any interruption of personnel—no strike forces or things like that—we did this in a way that was humane to the employees—when positions became vacant we took them out. Nobody was fired. We had some voluntary retirement packages, which people took advantage of—but by the time 1996 came the institution had a significant reduction in its expenses. It maintained its level of revenue so that the margin in between actually increased during that time. We also were very aggressive in managed care contracting. We doubled the number of managed care contracts that were there, and actually because of that activity we had some private discussions with Memorial Sloan Kettering about doing national managed care contracting. They were interested in exploring that, but they wanted to do this under the radar screen without anybody to know it. John Durant, who was one of my mentors from UAB, had become the President of Fox Chase Cancer Center. I asked John about it, who was nationally very attuned to managed care, and while we didn't want to meet in either Houston

or New York, John Durant and his CEO, Jay McKay, volunteered to have Fox Chase be the neutral ground for MD Anderson and Memorial Sloan Kettering to come together and have a discussion on national managed care contracts, led by our two organizations. So we actually had three meetings. I represented MD Anderson. A CEO from Memorial whose name I can't remember right now and I met in John Durant's office on three occasions. And from that, we decided to form a new organization called the National Comprehensive Cancer Network. That concept was that cancer centers in the major cities, comprehensive cancer centers, but only one in each geographic region, would be part of this NCCN that would then go to market for managed care contracts nationally, with the same pricing adjusted to the market cost in each geographic area.

[00:16:01]

***T.A. Rosolowski, PhD***

[00:16:01]

Why was this an advantage, forming this?

[00:16:05]

***Charles Balch, MD***

[00:16:05]

Well, because at that time, in 1993 to 1995, all of the hospital administrators in the consensus in the country was we were going to transform into managed care contracts and do away with fee-for-service reimbursement. So we brought this back. David Hohn and Roger Wynn were helping in the implementation of this. Now, instead of going for the market for fee-for-service, we wanted to price things based upon an episode of care, either six months or 12 months of care. In order to price that, we had to develop guidelines of how we would manage patients using standard care protocols, so that we could then determine what the price would be for six months of care that was multidisciplinary, or even 12 months of care, and take that to the marketplace. So we'd organized national experts to develop those guidelines. Now, the irony is that the managed care contracts never materialized, but NCCN became the standards in America, and now in the world, for guidelines with algorithms for cancer care throughout the world. But that was the genesis of it was to begin managed care contracting at a national level, and work with the major insurance carriers to have national managed care contracts.

[00:17:48]

***T.A. Rosolowski, PhD***

[00:17:51]

How does the NCCN and the guidelines and algorithms that they've established, how does that relate to the creation of the algorithms that are being done in-house now? Are they connected?

[00:18:06]

***Charles Balch, MD***

[00:18:06]

This was a later event that had to do with quality of care and measuring outcome, having consistency among physicians and their staff in caring for patients in exactly the same way, regardless of who was taking care of them. And that, led by Tom Aloia, Randy Weber, and others here have shown that you can decrease length of stay, decrease complication rates, shorten and both improve the quality of care for the patients and save money at the same time. But what we had started was a little bit different, more at the institutional level and not down at the individual physician level. It was a vision that, interestingly, turned out to be very important, but we started out for the wrong reasons. The other thing I was—

[00:19:08]

***T.A. Rosolowski, PhD***

[00:19:08]

So this—I'm sorry, I just wanted to make sure I understand that NCCN is still in existence, it's got a life of its own now, or—?

[00:19:14]

***Charles Balch, MD***

[00:19:14]

Yes, and it sets the standard of care that people follow, not only in the United States, throughout the United States, but also many countries in the world use these as the starting point for the guidelines and the management of care, and what becomes the so-called standard of care. This is the reference source for standards of care. It doesn't say you should do this one thing, but it gives you the options that should be considered based upon the diagnosis, the stage of disease, molecular markers, and so forth.

[00:19:50]

***T.A. Rosolowski, PhD***

[00:19:50]

What were the conversations like with Memorial Sloan Kettering? I'm curious. I mean, there's obviously always been a kind of rivalry, or some sort of—

[00:19:59]

***Charles Balch, MD***

[00:19:59]

Well, that's why we met in secret, [laughter] because we are known to be rivals, but we both knew that we were the two largest cancer centers in America, and if we agreed, that it would be much easier for other smaller cancer centers to follow, if we agreed to do something at the outset and organize things. Just as one segue, Murray Brennan, who became the Division of Surgery Chief at Memorial on the same day I did, July 1st, 1985, both agreed since we had the largest number of surgical oncology fellows in the world between the two of us, that we wanted to do those things that were right for getting the applicants, giving them a fair chance to choose



between our institutions. And Murray Brennan and I, behind the scenes, worked with the Society of Surgical Oncology to set up the match program for fellows and a number of other things that became standards for training surgical oncology fellows in the United States, because we had agreed the two of us will do things in the same way and set these standards, which other institutions and training programs followed. So even though there is this so-called rivalry, there were still a lot of conversations between the two institutions to work together, because we knew we had the responsibilities as the two largest cancer centers, the two largest surgical oncology programs in the world, and to set high standards and consistent standards for the good of both cancer patients and trainees.

[00:21:46]

***T.A. Rosolowski, PhD***

[00:21:46]

Well, amazingly good outcomes with that—

[00:21:48]

***Charles Balch, MD***

[00:21:48]

Yes.

[00:21:48]

***T.A. Rosolowski, PhD***

[00:21:48]

—including unexpected of the NCCN.

[00:21:52]

***Charles Balch, MD***

[00:21:51]

And not many people know about that, [laughter] because we did that quietly.

[00:21:54]

***T.A. Rosolowski, PhD***

[00:21:54]

Yeah, very cool story.

[00:21:55]

***Charles Balch, MD***

[00:21:56]

But the other thing that's a good story is the creation of the MD Anderson Outreach Corporation. And, again, this was Mickey LeMaistre's vision, to begin to export the standard and quality of care to other geographic regions so that patients did not need to travel to downtown Houston in order to get their care. And we started out in a few locations in Texas, but Mickey's vision was bigger than that, and that's why we started with Buck Brown, what became MD Anderson at

Orlando, and even had the Tex Moncrief MD Anderson Cancer Center in Fort Worth. And this was because Tex Moncrief, who was a benefactor of both UT Southwestern and MD Anderson, his wife had developed breast cancer. He brought her here for me to treat her, and because of that relationship he was willing to fund a new cancer center, largely around radiation therapy, in Fort Worth, much to the consternation of the leadership at UT Southwestern, because it was in their backyard. And interestingly, now there is the Tex Moncrief Cancer Center under UT Southwestern, after Mickey and I had departed from MD Anderson.

[00:23:27]

***T.A. Rosolowski, PhD***

[00:23:28]

Interesting story.

[00:23:29]

***Charles Balch, MD***

[00:23:29]

But this is something that was the forerunner of what is now the MD Anderson Network, the Houston area MD Andersons, and the international areas. All of this was established because of Mickey's vision, and we planted some of the initial seeds in that period of 1993 to 1996.

[00:23:57]

## Chapter 14

### *Comments on Leadership*

#### **A: Overview;**

Codes

C: Leadership; D: On Leadership;

***T.A. Rosolowski, PhD***

[00:23:58]

So you were interim from '93 to '94, and then—

[00:24:02]

***Charles Balch, MD***

[00:24:02]

Yes, then that had gone so well that Mickey knew that he was going to retire, which he announced in 1995, to be effective in 1996, once a new president-elect was identified by the University of Texas Board of Regents. There was not, at that time, a formal Executive Vice President for Medical Affairs. So what he organized was two EVPs: the EVP for Medical Affairs that I was appointed to for the two years before his presidency; and David Bachrach was the Executive Vice President for Administration. So I moved up to the tenth floor, next to David Bachrach's office and down the hall, away from Mickey's. And that position, actually, even had a larger area of authority throughout the Medical Center, which included the practice plan, managed care, and things even beyond the authority of the hospital and clinics.

[00:25:19]

***T.A. Rosolowski, PhD***

[00:25:19]

Did you enjoy this work?

[00:25:20]

***Charles Balch, MD***

[00:25:21]

I did it out of—I wouldn't say I did enjoy it, and there's a story with that. I did it because of my loyalty to Mickey, and his request to do this. I've learned over the years, being a VP, an EVP, and a president, that my core values is being an academic oncologist. I was a CEO for 11 years, both at the City of Hope and with the American Society of Clinical Oncology, but my joy is taking care of patients doing research, teaching, and mentoring, and I was glad that I had the opportunity to recycle doing that later in life. So it wasn't my passion, it wasn't my ambition, but I did it at the request of the president who hired me, and for whom I was very loyal to.

[00:26:19]

***T.A. Rosolowski, PhD***

[00:26:20]

Well, I interrupted you with that question. You were starting—

[00:26:24]

***Charles Balch, MD***

[00:26:24]

No, that was a really good question at a personal level.

[00:26:27]

***T.A. Rosolowski, PhD***

[00:26:27]

Yeah. Well, I mean, there are a variety—

[00:26:29]

***Charles Balch, MD***

[00:26:29]

And I've examined that over the years, and say, no, this is not my core values.

[00:26:34]

***T.A. Rosolowski, PhD***

[00:26:34]

Yeah, I can imagine so, because sometimes you're in an area and you're doing really well and accomplishing a lot, but it's just not hitting your sense of purpose, in a sense.

[00:26:43]

***Charles Balch, MD***

[00:26:43]

Yeah, and I advise people that they really have to understand it's a different job when you're doing program leadership, which I was doing, and doing very well, if you step into administrative leadership. And as you rise to higher levels in administrative leadership, you get more of the tougher decisions that you have to make on your own, the so-called win/lose decisions that no matter how much information you have somebody's going to win, somebody's going to lose, and those that lose are not going to be very happy at your decision, but you have to make those kind of decisions. It goes with the job.

[00:27:22]

***T.A. Rosolowski, PhD***

[00:27:23]

Who were the people you called on for support, feedback, to bounce ideas off of?

[00:27:31]

***Charles Balch, MD***

[00:27:32]

Well, the most important person in that time, as VP and EVP, was Donna Sollenberger [oral history interview]. Donna was just remarkable in her administrative leadership. She was a primary advisor in the things that I did. And I'd say David Bachrach was also a very good advisor to me, as well, because I'm a clinician. I don't have an MBA. I'm not trained as an administrator, and in budgeting. One good thing that Mickey did for all of us at the time was he organized a leadership course with the people at Rice University, and all of us both work collectively on Saturdays on these leadership courses, which brought us together as a working team, but also helped equip us with some of the basics of leadership, management, budgeting, and so forth, so that we were more on an even knowledge about these things in working together.

[00:28:43]

***T.A. Rosolowski, PhD***

[00:28:43]

I just came back not too long ago from interviewing Ray DuBois [oral history interview], and he said, over and over now, that individuals who are getting MDs really need to get another degree, some—

[00:28:57]

***Charles Balch, MD***

[00:28:57]

Yes.

[00:28:57]

***T.A. Rosolowski, PhD***

[00:28:57]

—in business, something related to business, so they can understand the environment.

[00:29:01]

***Charles Balch, MD***

[00:29:01]

My son, Glen, the next generation, has an MD and an MBA, because you do need to do that. I think one of the things that we all learned from this, in these days where physicians didn't get those degrees, is there is a value of physician perspective in leadership roles, even in the administration. And that doesn't mean they replace those who come through the MBA route and the administrative route, but bringing the perspective of physicians, bringing the perspective of service to the patients, which you can only understand if you've been in that arena, I think was one of the reasons that we were successful as VP for Hospital and Clinics, is understanding both the patients and physician issues that they faced every day in the trenches.

[00:29:56]

***T.A. Rosolowski, PhD***

[00:29:56]

What's the kind of thing that a physician would know in a leadership role that an MBA who doesn't have clinical experience would not?

[00:30:04]

***Charles Balch, MD***

[00:30:04]

Well, one of those that we did in that time was to use the profits from the margins, if you will, from the hospital and clinics, and reinvested it back into infrastructure for the physicians, and that included what's now called the midlevel providers—the physician assistants and nurse clinicians—so that physicians had a team around them to implement. We also hired more database managers to help physicians organize their data, and research nurses to implement protocols. Part of this transformation was in the '70s and '80s, the physician really did everything. They had a secretary and maybe a nurse that carried out instructions. But what we really organized that we see today is the physician leading a team of people, and using their experience and their time more efficiently for those things that required their expertise and their education, but delegating more routine things to the team around them. And also, if we were going to be a clinical research organization, that's team science. Physicians cannot do that on their own. They can't counsel patients. They can't do all of the paperwork. So you need a team who was trained to do clinical research, and to follow all the rules that's in the protocols, do the follow-up, and make sure that the data that's required is collected at the time that's required in the protocol. So I think part of that transformation was creating teams of people, working together in the clinical enterprise, that allowed us to use physician time better, as we were increasing the volume of patients coming to MD Anderson, and to embrace innovative care through clinical trials, which it started under Irv Krakoff's area in medicine, but really was incorporated fully in most of the surgery departments, as well. And then the final part was bringing together the specialties into disease site teams, which really accelerated the progress and the efficiency and the quality of patient care, and the conduct of clinical research.

[00:32:44]

## Chapter 15

### *Disease-Site Reorganization; Building Rotary House*

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Multi-disciplinary Approaches;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

B: The Business of MD Anderson; C: The Institution and Finances;

B: MD Anderson Impact; C: MD Anderson Impact;

#### ***T.A. Rosolowski, PhD***

[00:32:44]

What were the discussions like leading up to that reorganization?

[00:32:47]

#### ***Charles Balch, MD***

[00:32:48]

Well, actually, I know how it started. Eva Singletary and Gabe Hortobagyi [oral history interview] had worked together very closely, but they were in separate departments, and they worked in different locations. Eva Singletary actually put a pedometer on some of her patients. This is something where you can tell how many steps you walk, and what the distance is. And she brought the data to us, she and Gabe Hortobagyi, that my patients are walking almost a half a mile in one day, even though they're sick, or they may be suffering from their treatments, and checking into Surgery, Medicine, Radiation Oncology, Radiology, and Laboratory, five different places in one day. That's not very good for the patients. And it was actually their idea that the doctors should go to one place, and the patients—the doctors should come to the patients instead of the patients coming to the doctors. That was a singular change in the mindset that we said, "All right, let's do that experiment, and we'll start out in breast cancer," formed the first multidisciplinary breast cancer that had been done, and it was such a success in that also at that time a lot of the specialty areas were working together collaboratively, but they weren't in the same geographic location.

[00:34:20]

#### ***T.A. Rosolowski, PhD***

[00:34:20]

So was this controversial, given the context?

[00:34:25]

***Charles Balch, MD***

[00:34:25]

I wouldn't say so, because of the philosophy of care here that was multidisciplinary. And so even articulating—and also the service for the patients. So articulating that it's better for the patient if the doctors come to the patient, instead of the patients coming to the doctor; it's better for the patient—it resonated with the medical staff. So I wouldn't say that there was a lot of resistance. There was a lot of logistics in reorganizing things, and, for example, in my personal practice I was taking care of breast cancer patients in melanoma. Those patients came to my surgery clinic, so the reverse for me, without a change in my time commitment, is I had to go to the Breast Center and the Melanoma Center, but I was fine about that if we worked out the scheduling for it. So the other thing that happened in the VP for Hospital and Clinics, and transitioning into the EVP, was buildings and fundraising. These were really big issues. I think during that time we raised 80 to 90 million dollars cash, and all of the funding that was necessary to build a new hospital, to build new radiation therapy, to build new clinical research facilities. And then another concept—again, this was part of Mickey LeMaistre's vision—was to create a hotel for the patients. Most people don't remember that Mickey had money left over, and he built a bridge over Holcombe Boulevard that went nowhere. It was just over the street, because he had enough money. But he knew that at the other end of the bridge there was going to have to be a faculty building and a hotel, and it would need to be connected to a clinic that was not yet built. So we had the Lee Clark Building, that was being built when I came in 1985, but we had to raise the money and build what is now the LeMaistre Clinic, and then connect all of those with the overheads, including the bridge over Holcombe, which sat in isolation for at least five or six years, with everybody saying, "What is this bridge doing here that just goes over the street but doesn't go anywhere?"

[00:37:00]

***T.A. Rosolowski, PhD***

[00:37:00]

I'm sure that people had some annoyed things to say about that.

[00:37:04]

***Charles Balch, MD***

[00:37:03]

But he had a campus master plan in his mind, and he was a master at raising funds, so he got the Rotary Club in Houston to do the seed money for building this hotel for patients, and that's why it was called the Rotary House. He also had the wherewithal to say, "We're not in the hotel management business, so we'll contract with the Marriott Corporation to manage the hotel." So those were the partnerships that emerged to build the first version of the hotel, but he also had the vision that if this works we're going to run out of space, so we built in the original architectural plans a mirror image on the property that at the proper time you could double the size of the hotel, because the architectural plans and the groundwork was already done to do that. And, not surprisingly, the hotel had a 90-plus percent occupancy early on, and it wasn't too many years later that the money was put in place to double the size of the hotel. And this was --



outside of the Mayo Clinic in Rochester-- was one of the first times that there'd been a hotel owned by a hospital that was connected to the hospital. When we opened the Rotary House, within the first week the length of stay in the hospital was reduced by a full day.

[00:38:36]

***T.A. Rosolowski, PhD***

[00:38:36]

How did that happen?

[00:38:38]

***Charles Balch, MD***

[00:38:38]

Well, because patients that you wouldn't send out of town, because they were too sick, were in the bed, but not needing nursing care, but it was okay for them to be across the street in our hotel. And so we actually reduced the use of the hospital beds and the care by nurses where patients' family could do the same thing, in feeding patients, in doing things, giving them their oral medications, and having them across the street, so that they could come to the outpatient area on a daily basis for their follow-up. And this really was the forerunner of day hospital, day care, outpatient basis. In many countries, even today, in the year 2018, the delivery of care is all in the hospital. When the care is given, the intravenous lines are out, but the patients are too sick yet to travel, they're too weak, they stay in your hospital bed, cared for by expensive nurses, sometimes for a week or more. So people were having hospitals with a thousand, two thousand, even more beds, but without a parallel outpatient area. Part of Mickey LeMaistre's strategy was to use the hospital for intermediate and intensive care patients, but to build an ambulatory network around that so that patients would not need to be cared for by nurses when they didn't need to, to train caregivers, and this was a formal program to train the spouses and family members to understand what to look for, and to participate in the care of the patients.

[00:40:40]

***T.A. Rosolowski, PhD***

[00:40:40]

Who offered that training program?

[00:40:42]

***Charles Balch, MD***

[00:40:43]

This was part of our volunteer network and our training by the nurses to give patients and their family members written instructions, such as measuring the amount of drainage, taking the temperature every eight hours, and writing it down so they could bring it—and also if the drainage or the temperature exceeds this amount, call this number. So this was a very important part of taking care of the same volume of patients with a small number of hospital beds that other places in America and around the world were doing in a more expensive way with inpatient facilities. And even in Mickey's strategy, grand strategy to not only have it on the campus of the

Texas Medical Center, but to allow patients in a more convenient way to be seen on an outpatient basis somewhere around Houston, such as in Clear Lake, where we started MD Anderson at Clear Lake, or even in other cities, like Austin, Corpus Christi, Fort Worth, Waco, and so forth, and even nationally or internationally, which we started in Orlando and Madrid.

[00:42:03]

***T.A. Rosolowski, PhD***

[00:42:03]

The sister institutions, yeah.

[00:42:04]

***Charles Balch, MD***

[00:42:04]

So this was all part of this grand vision for giving good care and exporting the quality of care and the standards of care outside of the Texas Medical Center, and reducing cost and improving the quality of care for patients by reducing the length of stay in the hospital.

[00:42:26]

***T.A. Rosolowski, PhD***

[00:42:28]

I wanted to briefly go back to the period of doing the disease site centers, because you talked about some of the direct outcomes of some of these other changes—putting in the hotel, reducing stays, all of that. What were some of the outcomes that you began to see with the multidisciplinary care sites?

[00:42:52]

***Charles Balch, MD***

[00:42:52]

The outcome was so amazing, there were so many benefits that everybody saw immediately, that I think this concept was embraced pretty quickly. The biggest outcome that I think was a surprise was the specialization by the staff. The doctors were used to working together, but we had surgery nurses, medical nurses, we had research nurses, but they were off in separate parts of the organization, in physical therapy. Physical therapists specialized in surgical rehabilitation, but not lymphedema of the arm in patients with breast cancer. So what we found is when you have the multidisciplinary center, it's not just the doctors working together but the nurses, the staff, the physical therapists, the social workers, the volunteer patients, all specialized in one disease. Instead of being a surgical nurse that they might have to deal with routines of breast cancer, melanoma, GI cancers, and so forth, they really didn't have a chance to be super-specialized the way the doctors were. So that became very valuable and very efficient. We also found that the patients loved it, because in my surgery clinic if a patient relapsed and developed distant disease, the change in nurses, the change in location was more emotionally traumatic, or at least the same level as the fact that they had developed distant disease. They had to have a whole new set of nurses, a new location, they had to physically move somewhere else, whereas

with the disease site center the doctors were caring for the same patient. The patient never moved out of that examining room. The nurses didn't change. There was a continuity of care that we didn't have with the specialty organized clinics that we received, and the patient saw the value of by having disease site specialization. That also allowed the patients in the waiting room, [who were?] the same patients in network together. And finally, the thing we found: we saved a lot of money. In fact, it was surprising, the reduction in costs. But think about it: before, a patient had to go to the surgery clinic. They checked in with a clerk. They go to the medicine clinics; they check in with a clerk. They go to all of those places, they have to check in again, whereas in the disease site center they check in with one clerk and they see one nurse, instead of seeing pieces of people based upon their specialty. And we found that we could reduce the staffing very significantly when we reorganized into the clinics, because of the efficiency of patients seeing one group of staff. So we reinvested that money back into infrastructure for more comprehensive care, such as physical therapy, social workers, clinical research nurses, and so forth.

[00:46:10]

***T.A. Rosolowski, PhD***

[00:46:12]

Were there any downsides to either the specialization of individuals taking care of patients or to the reorganization itself? Anything that came up?

[00:46:24]

***Charles Balch, MD***

[00:46:24]

No, only the resistance you always get in making changes, and not everybody benefits to the same degree as the champions who want to make the changes, but you can't do it halfway. You either have to make it all disease-oriented, or all specialty-oriented. So there was a little bit of resistance in some circles, but I wouldn't say it was very much, because the culture of the institution was about service to the patient, and if you're making these changes because it benefits the patients, people will rally around that, and make the adjustments to do it. One other thing that I might mention when I was the Director of Hospital and Clinics is we ran the largest pharmacy in the world. In the world. Roger Anderson[oral history interview, phase 1] was the most amazing director of the pharmacy. And, of course, because we could buy wholesale and we could charge at retail price for the insurance companies, our pharmacy became a very big source of profit. Roger ran this amazingly well. We started the first automated pharmacy with robots, to make sure that we had the dose correct and everything the same. But this was the first robotic pharmacy that had ever been done that he instilled. But also, because we knew that profit source, we put the profit of that back into the clinical research enterprise, because the innovative therapy was the reason that patients came. Most of that innovative therapy was more around new drugs, or different types of systemic agents, so it was logical if that's the reason patients come to use the profits from the pharmacy to reinvest it back into that part of the enterprise. And so if you're going to invest in clinical research, and there's a cost of research personnel and

doing this, you have to have sources of money to do that, and the pharmacy profits were a very important source of doing that.

[00:48:46]

## **Chapter 16**

### ***Creating the First Prevention Program***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
B: Building/Transforming the Institution;  
B: Multi-disciplinary Approaches;  
B: Growth and/or Change;  
B: Research;  
B: Prevention;  
B: Institutional Politics;  
B: Controversy;

***T.A. Rosolowski, PhD***

[00:48:46]

You had also mentioned at one point beginning the prevention program, and I believe this happened while you were EVP?

[00:48:53]

***Charles Balch, MD***

[00:48:53]

That's correct.

[00:48:54]

***T.A. Rosolowski, PhD***

[00:48:54]

Can you talk about that a bit?

[00:48:56]

***Charles Balch, MD***

[00:48:56]

So, as you know, Mickey LeMaistre was one of the authors of the Surgeon General's risk of smoking and lung cancer. He was not trained as an oncologist; he was a pulmonologist. And he always had a vision for prevention and smoking cessation, but even more than that—at the time we were doing chemo prevention for colon cancer, breast cancer, and those kind of studies. And one of the leaders in this was, of course, Bernard Levin [oral history interview]. So Mickey gave me the charge when I was the EVP to establish the Division of Cancer Prevention. There were some politics in that, because everybody in Cancer Prevention was currently in the Division of Medicine, so that means some of the stars would need to come out of the Division of Medicine, into a new Division of Cancer Prevention, including their budget and their research. I give a lot

of credit to Irv Krakoff, that I think all of us were responsible for specialty areas, like surgery and medicine, but we always had a higher loyalty to what's good for the institution, even if it meant making some changes or taking some good people out of your division in order to create something new and different. Now, the context here was there were no programs in the United States or in the world on cancer prevention as an organizational entity, so this was really new. And, again, this was part of the vision of Mickey LeMaistre, that he had the vision, but he gave us the backing to say, "Now you need to go implement this." So we did create the first Division of Cancer Prevention. Bernard Levin was made the first Division Director. Jim Abbruzzese and there's one other person I'll have to add, who became the Department of Clinical Prevention. We also [laughs] recruited a great person in here of Ellen Gritz [oral history interview], and Margaret Spitz [oral history interview], into the Division of Cancer Prevention. Those two ladies, Spitz and Gritz, were the most energetic and innovative people. We could never give them enough space, because as soon as we did they got grants and filled that space, and said, "Now, we need to grow more." So they really had some major roles in the early growth of the program, in the research programs, in getting grants from various sources, including the federal government, for cancer prevention studies, and then the Department of Cancer Medicine began doing very innovative studies on prevention. And as you know, that now has grown to be the largest cancer prevention program in the entire world.

[00:52:09]

***T.A. Rosolowski, PhD***

[00:52:10]

What's your view of the difficulties of creating an effective interface between prevention work and then the more cure-based work that will happen after disease has actually happened? A lot of people have talked about frustrations because it's the treatment of disease that actually gets reimbursed, and so there's a problem with getting traction, with promoting this before-the-fact activity.

[00:52:41]

***Charles Balch, MD***

[00:52:41]

Financing cancer prevention is always a problem, because since you don't have a diagnosis. You're a person at risk but you're not a patient, so getting funding for these kind of things was always very difficult. And that meant you had to market to individuals that if they were at risk that they would need to pay cash for doing these things, and we also had to advocate for reimbursement based upon clinical trials. So one of the things that was inherent to the Division of Cancer Prevention was clinical studies to prospectively prove whether drug interventions, such as tamoxifen, in individuals—they weren't patients—at risk for breast cancer, or to give the class of drugs for patients at risk for colon cancer, which was a major study that Bernard Levin had started. And then, of course, smoking cessation became part of that, but the vision was to go beyond smoking cessation more broadly, into identifying people at risk, based upon environment and genes and heredity, and then to see if you could detect cancer earlier and more treatable, or prevent it altogether. And so the boundaries were pretty easy here. If you don't have a diagnosis

of cancer, then that's cancer prevention, but as soon as a patient does develop cancer, then that goes into a cancer therapeutics department. And that even holds true today: if a patient calls MD Anderson and they have a breast mass, they don't go to the Breast Department; they go to Cancer Prevention for their evaluation. If there's a diagnosis pathologically of breast cancer, then they come into the Department of Surgical Oncology in the Breast Center. So even at the beginning the boundaries between individuals at risk but do not have a diagnosis of cancer was different than those who were [in directive?] treatment.

[00:55:04]

Now, there's another blurred boundary, is once a patient gets beyond five years or so, and they may be cured of their first cancer, they are at increased risk for developing a second cancer, and those patients actually migrated back into the long-term follow-up clinic. And the staffing of that does not need to be done by oncologists, so this was another part of what Mickey and Irv Krakoff had done, was to have internists, such as gastroenterologists, do endoscopy, and started some of the first endoscopy clinics here in patients who needed follow-up for colon cancer, or for gastric cancer, and so forth.

[00:55:50]

***T.A. Rosolowski, PhD***

[00:55:50]

So were those folks affiliated with prevention?

[00:55:54]

***Charles Balch, MD***

[00:55:54]

Yes. And that was, as you know—now, a lot of the entry point in cancer prevention is not done by oncologists who are trained to treat patients with cancer, but by internists and general physicians who are good at risk assessment, screening, and so forth in patients at the front end.

[00:56:20]

***T.A. Rosolowski, PhD***

[00:56:20]

Well, and that's a whole specialization of its own.

[00:56:22]

***Charles Balch, MD***

[00:56:22]

Exactly.

[00:56:22]

***T.A. Rosolowski, PhD***

[00:56:22]

I mean, seriously. Yeah. Very interesting, because I've had conversations with people who are in that ever-evolving field of survivorship, and the importance of educating physicians out in the community, how do you actually—what do you watch for in an individual who's had cancer? How do you really effectively determine whether or not cancer's come back? So it is a whole other specialization.

[00:56:47]

***Charles Balch, MD***

[00:56:47]

Why don't you stop that for a second?

[00:56:50]

***T.A. Rosolowski, PhD***

[00:56:50]

Okay, I will do.

[00:56:51]

***Charles Balch, MD***

[00:56:51]

I want to look up—

[00:56:52]

[break in audio]

***T.A. Rosolowski, PhD***

[00:56:55]

All right, so you were talking about that drug, so it's—

[00:56:58]

***Charles Balch, MD***

[00:56:59]

Yeah, so the class of drugs that Bernard Levin led is a colon cancer prevention in individuals who were forming polyps in their colon was the so-called COX-2 inhibitors. And these were a commonly used class of drugs that had been used on a short-term basis for patients who might have pain or headaches. And the surprise in that study was although the risk of colon cancer apparently was reduced, there was an offsetting risk of cerebral issues and other healthcare that offset this to a degree that the study had to be stopped, because of the unknown complications that occurred with the long-term use of these drugs that had never been prescribed on that length basis over a number of years. But it was an interesting outcome, and because of that untoward outcome no drug prevention study has been done since then, because drug companies can't take the risk of having untoward effects with long-term use and have the liability associated with that.

[00:58:26]



***T.A. Rosolowski, PhD***

[00:58:26]

Wow, that's amazing.

[00:58:27]

***Charles Balch, MD***

[00:58:27]

So that was the last of the chemo prevention studies that was led by Bernard Levin, which is the reason you do these studies: it's about safety, and things that you don't know unless you study these prospectively.

[00:58:42]

***T.A. Rosolowski, PhD***

[00:58:41]

Right, right. I'm looking at our time, and it looks like we need to close down for today, so why don't I do that, and then we can have our other conversation quickly.

[00:58:51]

***Charles Balch, MD***

[00:58:49]

Okay. So next time we should talk about buildings, and the fundraising, and the important legislation that we did together, an anonymous vote by the Texas legislature as the first order of business and signed by Governor George W. Bush, that allowed MD Anderson to act as a private institution that was tax-supported.

[00:59:17]

***T.A. Rosolowski, PhD***

[00:59:17]

Oh, man. Well, this is a cliffhanger. [laughs] All right, well, let me just say for the record—

[00:59:24]

***Charles Balch, MD***

[00:59:25]

Remember this: Mickey, in his way of convincing the legislature, had a reception with George Forman, and so all the legislators got to come up with George Forman. George Forman's hands are twice the size of my hands. He's a huge man. And, of course, George whispered, "Now, if you don't want to get anything, you vote for Mickey LeMaistre when that legislation comes up."

[laughter] Mickey didn't have to say a thing. George Forman—

[00:59:56]

***T.A. Rosolowski, PhD***

[00:59:55]

That's really funny.

[00:59:56]

***Charles Balch, MD***

[00:59:57]

—did, and he did it with a smile and a joke, but it was passed unanimously as the first act of the Texas legislature. We'll have to get the year. But it was masterful on Mickey's part, because he was Chancellor of the University of Texas. He knew how to work the legislature as well as Lee Clark did.

[01:00:15]

***T.A. Rosolowski, PhD***

[01:00:15]

Amazing.

[01:00:16]

***Charles Balch, MD***

[01:00:16]

And so all the employee laws, the bid laws, the equipment laws, Mickey convinced Bob Bullock, who was the head of the Texas Senate, who really—if he was supportive of things, most people got in line. He was a kingpin of the legislature. And Mickey had everything lined up, so when the legislation came there was no debate; it was passed by voice vote, and signed that afternoon by the governor, Governor Bush.

[01:00:52]

***T.A. Rosolowski, PhD***

[01:00:52]

That's amazing. All right, well, more to come. All right, so I will say for the record, thank you, and I'm turning off the recorder at 24 minutes after 11:00.

[01:01:04]

## **Charles M. Balch, M.D. PhD (h.c.) FACS**

### **Interview Session Four: March 26, 2019**

#### **Chapter 00D**

#### ***Interview Identifier***

##### ***T.A. Rosolowski, PhD***

[00:00:00]

I am Tacey Ann Rosolowski, and today is the 26th of March, 2019, and we're in the Historical Resources Center Reading Room, and I am talking to Dr. Charles Balch for our fourth session together. So I wanted to thank you for coming by today.

[00:00:16]

##### ***Charles Balch, MD***

[00:00:17]

Thank you, Tacey. I'm glad to be here.

[00:00:19]

## **Chapter 17**

### ***Addressing the Managed Care Crisis (mid 90s)***

#### **B: Building the Institution;**

Codes

D: The History of Health Care, Patient Care;

C: Leadership; D: On Leadership;

B: Building/Transforming the Institution;

B: Growth and/or Change;

B: MD Anderson Culture;

C: Professional Practice; C: The Professional at Work;

B: The Business of MD Anderson; C: The Institution and Finances;

C: Portraits;

B: Multi-disciplinary Approaches;

B: MD Anderson History; B: MD Anderson Snapshot;

B: Beyond the Institution;

B: MD Anderson and Government;

#### ***T.A. Rosolowski, PhD***

[00:00:19]

And the last time we talked you were just about to tell the story of Charles LeMaistre's impact on the institution by helping to organize that shift in legislation that enabled MD Anderson to function a bit differently in the marketplace. So I wanted to invite you to tell that story.

[00:00:37]

#### ***Charles Balch, MD***

[00:00:37]

Thank you. So at that time, which was in the timeframe of 1993 to 1995, MD Anderson was struggling a bit financially, and it had some limitations because of state regulations, including that patients could not self-refer from within Texas. The Texas law was a cancer patient coming to MD Anderson had to be referred by a Texas physician. Now, people could be self-referred from out of state, but a large part of our volume was in-state. The second is the legislation said we had to take care of all Texas patients, regardless of their ability to pay, and we were finding that Harris County patients, who in every other county would have been paid for by the County, were coming to MD Anderson as a State institution, and it was causing a lot of financial issues of us of absorbing care which we felt some of which could be properly accounted for within the County. The other thing in the State is when we do capital expenditures or bid laws for construction you had to follow the State rules, which were usually the lowest bidder, which in healthcare may not be the best quality for the patients. And the other part was state regulations for employees—hiring and firing and so forth. All of these things, after an analysis led by

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Mickey LeMaistre, were things that should be changed in the legislature if we were going to achieve a financial neutrality or a positive red line. And he took the position that our competition is the private institutions within the Texas Medical Center, and that we are not able to compete financially, or in terms of patient referrals, and in terms of building the institution to the excellence that it needed to with resources to do that, that there had to be a change in the legislature.

[00:02:54]

Now, as you know, one of the uniqueness of Mickey LeMaistre was that he was the former Chancellor of the University of Texas. Mickey was a master at knowing everybody in the legislature, and the governor. He knew the legislative process backwards and forwards. So now, as President of MD Anderson, he started working the process in order to initiate legislation to essentially free MD Anderson from these state regulations that were not enabling it to get to the level of clinical excellence and financial independence that it should have as a state institution. So, of course, he worked the process for some time, until the legislation was crafted. Once it was crafted he held several receptions in Austin that all of us went to, in order to inform the legislature that MD Anderson is unique as a resource in the state, and it should uniquely be freed from state regulations that other University of Texas and other state institutions would not have the same qualifications. So we had to make the case that why should we do this for your institution and not for everyone else. And finally, I remember fondly is that Mickey had a big reception with George Forman, and invited all the legislators to come and have their photo taken with George Forman. And, of course, he was a very popular figure then, and I remember George Forman, whose fist was two to three times the size of mine, holding it up and said, "I want you to fight for this legislation," to everybody, with a smile on his face. But it was clear that he was a really strong advocate.

[00:04:48]

***T.A. Rosolowski, PhD***

[00:04:48]

Was it controversial in any way?

[00:04:50]

***Charles Balch, MD***

[00:04:51]

Not that I know of. I'm sure that there were some people in the background who would say, "Well, if you're going to change the laws for MD Anderson, you should change it for our State institution, as well." And that, obviously, was not going to work if everybody else chimed in, and it was going to be too broad a legislative change. Nevertheless, on the first day of the legislation in 1995 HR 192 was presented first to the House. It passed unanimously as the first piece of legislation for the year. It went immediately to the Senate, where it was passed unanimously. And Governor George W. Bush signed the legislation that afternoon. So this

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actually made a huge difference to MD Anderson going forward. It's one of the reasons that it thrives today is because at that time we were struggling with some negative budgets. We had to downsize our employees, and do it fairly and appropriately. We actually, by reduction in force and attrition, without firing anyone, reduced the size of our employee base by a thousand people. And that was in preparation for what we were told by experts was going to be the managed care coming from the West Coast, affecting everyone around the country, including MD Anderson, and that there would be a further reduction in our revenue for providing the same high-quality services. In addition, we couldn't compete in Texas if physicians had to refer patients and patients couldn't self-refer. What was happening is patients who were at the end of their line, who were burned out, who had lost their insurance, were then being referred to MD Anderson as a last resort. That's fine for us to take care of those patients but you have to balance that with revenue and a full spectrum of patient care that included early patients who wanted to come to MD Anderson but couldn't necessarily get a physician to refer them. It was really an onerous part of the legislation for us. And then, finally, there were millions of dollars of indigent patient care that was not paid for by the State, and for patients who lived in Harris County. And that was also an issue that we felt as a State institution that Harris County, like other counties throughout Texas, had to absorb some of the indigent patient care in their budget, and that they had a responsibility for doing that. But in our legislature, it said, "We will take care of all Texas patients, regardless of their ability to pay."

[00:07:52]

And then the final area was in the State bid laws. We were doing major construction. We had a lot of capital expenditures of high-end equipment. And in order to build high-quality hospitals with the technology and the infrastructure that we needed to, at the same level of St. Luke's Hospital, Methodist Hospital, Hermann Hospital, and other hospitals in the Texas Medical Center, we had to make our bids based upon the quality and the experience of the construction people and the equipment that we were purchasing, not necessarily whether it was the lowest bid price. So that major legislation, landmark legislation, enabled MD Anderson very quickly to get to more revenue-neutral in our budget, to absorb some of the impact of managed care contracting, which we had to get into, and for which I was the Medical Director of the Managed Care Department, including recruiting a new Associate Vice President for Managed Care. This is something we take for granted now, but it didn't exist within the organization.

[00:09:12]

***T.A. Rosolowski, PhD***

[00:09:12]

I want to ask you more about those roles in just a minute, but I also wanted to get just a little bit more detail on that period after the legislation was signed. How was their planning done to begin to act on the changes, these official changes?

[00:09:34]

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***Charles Balch, MD***

[00:09:35]

Well, in all of these areas, because of the new legislation, we could inform the Texas public that they could self-refer to MD Anderson, so we opened up hotlines for patients to call to review their circumstance and the appropriateness of coming here. It jumpstarted our new patient referrals, especially with those patients who were fully insured and who had earlier-stage disease who otherwise did not have a pathway for getting to the institution.

[00:10:11]

***T.A. Rosolowski, PhD***

[00:10:11]

Do you have a sense of—? I mean, I know it's hard to recall numbers years after the fact, but what was the increase, and how quickly did it increase?

[00:10:20]

***Charles Balch, MD***

[00:10:20]

It increased within 12-24 months. It was pretty rapid. At the same time, with David Bachrach as the EVP for Administration, I was the EVP for Medical Affairs and Donna Sollenberger [oral history interview] was the VP for Hospital and Clinics, and the administrative team worked very diligently. We actually formed an Executive Council, which I chaired, of all the vice presidents, the president of MD Anderson Outreach Corporation, which Bob Shaw was the CEO and I was the first Medical Director of MD Anderson Outreach, so that we had coordination across the institution, both in our planning programmatically but also, importantly, of syncing our budgets and making the budgets transparent to everyone so that we had a collective input of how are we going to work together to be revenue-neutral and then revenue-positive as an institution, which meant both increasing revenue and reducing expenses. And we did such things that were pretty innovative at the time. We closed entire floors because their occupancy was too low, and we were paying staff for an occupancy that was less than 60 or 70 percent. So we—

[00:11:47]

***T.A. Rosolowski, PhD***

[00:11:47]

These were inpatient?

[00:11:48]

***Charles Balch, MD***

[00:11:48]

Inpatient floors. So we closed floors in a rolling way, depending upon the census. So we had floating nurses and staff on call so that, depending upon the census on any given day, we could

open and close units, but it had a major reduction in our overhead by keeping our occupancy at around 85 percent.

[00:12:13]

***T.A. Rosolowski, PhD***

[00:12:22]

Would you like to say more about this executive team that worked together, the EVPs? So these were new roles with new kind of scopes of responsibilities to respond?

[00:12:34]

***Charles Balch, MD***

[00:12:34]

Yes. When Mickey asked me to become the Executive Vice President for Medical Affairs, other people, such as Bob Hickey, had those roles, but they never had an office, and what Mickey envisioned as the EVP office would be a companion to the Executive Vice President for Administration under David Bachrach, and that we would work together for the oversight programmatically and in the budget for the entire institution. So included in that was setting up an Executive Council, so then all of the Executive Vice Presidents and the VPs responsible for budgets and programs throughout the institution would meet together once a month and review our progress, make recommendations for strategic directions, get updates on where we were in the budget. We instilled quite a bit of budget discipline, which wasn't coordinated in the past. And the reason for that is when you're in a circumstance where your budget is becoming difficult because of declines in revenue, you had to fix both sides of the equation: increasing revenue through patient care, through managed care contracts, which would increase revenue, for which we went from almost no managed care contracts to 90 managed care contracts within about a 12- or 14-month period of time. That enabled patients to come under those insurance contracts that otherwise would not have been able to come to the institution, because we would have been out of network. We also set up the MD Anderson Outreach Corporation, and that was something I also worked with Bob Shaw, and we set up MD Anderson Cancer Center in Clear Lake, under a doctor named Dr. Roger Rodgers, who was a medical oncologist there. That helped us in referrals for that part of the city, and that was the forerunner of the Houston-area network that is in place today. We also established the MD Anderson Cancer Center in Fort Worth, named after Tex Moncrief, which was yet another way of working with referring physicians in the Fort Worth area, and had discussions in other cities.

[00:15:07]

I think one of Mickey's proudest accomplishments in the outreach corporation was his vision of working with a physician named Buck Brown in Orlando, for which we made many trips to Orlando to help establish the Orlando Cancer Center, which then after a little bit of growth became the MD Anderson Cancer Center in Orlando. And this, again, was part of Mickey's vision of creating something that wasn't there, of selecting Central Florida as an area that was



underserved with regard to multidisciplinary cancer care, and working with the Orlando regional healthcare system, and with Buck Brown, and I worked with the Surgical Department and the surgical community. Several of our fellows that we'd trained in surgical oncology went out there to practice. And after a beginning, it now has grown to what is now a ten-story building, fully funded, and is the major referral hub for multidisciplinary care in Central Florida. Now, in fairness, with subsequent presidents there wasn't the same kind of service, and the payments for carrying the MD Anderson brand were out a bit, and in recent years MD Anderson and the Florida institution became divorced, and it no longer carries that logo. But I think the value of providing multidisciplinary care in a large population segment was something that Mickey even looked outside of the state to see where could we add value by exporting our excellence in our organization and multidisciplinary care, and that was a huge success in Orlando, and still is today.

[00:17:01]

***T.A. Rosolowski, PhD***

[00:17:05]

Is there anything else you want to say about those roles, and the transformation of administration within the institution?

[00:17:12]

***Charles Balch, MD***

[00:17:12]

Sure. Well, at that time, in 1994 to 1996, managed care was something that was taking place, especially in the West Coast, that involved managed care contracts that significantly reduced revenue for the same types of medical services. And our consultants, some of whom were from California, said, "This is going to come to Texas. You need to be prepared for it." So we did initiate a Managed Care Office, started negotiating managed care contracts, and preparing for a reduction in revenue by decreasing the cost of operating the institution. In fact, when John Mendelsohn came afterwards, it was clear, in retrospect, the managed care wave didn't quite reach Texas, but he had the benefit that we had really made the institution leaner, and enabled a foundation with a positive budget for him to build on. I also remember, interestingly, when the search was going on for the president that there were quite a lot of prominent leaders at MD Anderson who said our budget couldn't get beyond \$1 billion. We were already too big. We weren't a family anymore. And I said, I don't know how to cap a budget when you're doing something excellent and people are coming to see us, that we have to accommodate the growth. And of course, as you know, when John Mendelsohn left the budget went from \$950 million when Mickey and I finished to over \$4 billion at the end of his presidential year. But I think it speaks to the fact that when you're doing a good job, and you have the resources based upon your grants, your contracts, the philanthropy, and your patient care revenue, that it's proper to grow to continue to provide that level of excellence. There's always the downside as you get bigger that you may not be able to give that personalized service, but I think it's been remarkable

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that over the years, as MD Anderson has grown, it still has that reputation that it well deserves of providing excellent service. It still competes better than almost any institution for federal and other grants to support its research. And its support by the philanthropic community has been astounding. All of those things collectively have enabled it to continue to grow and to thrive.  
[00:20:12]

## **Chapter 18**

### ***A New Chapter as CEO at City of Hope and Other Roles***

#### **A: Professional Path;**

Codes

A: Personal Background;

A: Professional Path; C: Evolution of Career;

C: Leadership; D: On Leadership;

A: The Researcher;

#### ***T.A. Rosolowski, PhD***

[00:20:14]

Now, the period that we're speaking about—and you just mentioned the search for the new president, so you want to talk about throwing your hat in the ring for all of that? [laughs] I mean, that's an interesting experience.

[00:20:26]

#### ***Charles Balch, MD***

[00:20:25]

Well, when Mickey appointed me as the Executive Vice President, he made it clear that I should be a candidate for being president. He also told me at the time that you will have a target on your back, and that there will be people who are opposed to the changes that have been part of the LeMaistre era who will come out of the woodwork, and they surely did. There were a number of other people who thought they also should be candidates for president—David Hohn being one who was in our Division of Surgery, and who had then become the Vice President for Hospital and Clinics, the Medical Director for the Hospital, Andy von Eschenbach. There were others. But I say that because when I left and went to City of Hope as President, David Hohn, I think because he had positioned himself as a candidate for president, actually went off to be President of Roswell Park. And it's something that commonly happens: when candidates for a high level of office are not selected based upon the search committee, they're still positioned to carry on that responsibility, and people watching that event play out, once the winners and losers are determined, that there's multiple offers to take that position at other places.

[00:21:54]

#### ***T.A. Rosolowski, PhD***

[00:21:54]

What was the vision that you brought as you discussed the possibility of being president?

[00:22:01]

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***Charles Balch, MD***

[00:22:01]

Well, remember, there were three finalists at the end, and that was John Mendelsohn at Memorial Sloan Kettering, myself, and Ted Copeland [Division of Surgery interview], who was at the University of Florida, who I think at that time was the Dean at the University of Florida. Recall that Ted Copeland was one of the very first people who trained at MD Anderson, came on to the faculty here for many years, had a very distinguished service here as a Professor of Surgery, and then went on to become Chair of Surgery at the University of Florida, and then was a Dean at the University of Florida, and was always somebody who had a loyalty to MD Anderson. So the three of us were the finalists, and we went through the usual process with the Board of Regents, which was a very difficult time in going through all those interviews. I spent a lot of time interviewing with the faculty and the staff. And—

[00:23:04]

***T.A. Rosolowski, PhD***

[00:23:04]

What made the Regents challenging in its own unique way? I mean, I know it's an odd process.

[00:23:09]

***Charles Balch, MD***

[00:23:09]

I think all three of us were qualified, so among the qualified people they chose somebody from the outside. I think one of the things John Mendelsohn [oral history interview] articulated very well that may have edged towards his selection was he had a very distinguished research career, and he may have articulated the need for MD Anderson to go beyond what it was doing, which was excellent, and rise to a new level in translational research as part of its areas of excellence. But that being said, he's done an outstanding job. In the 15 years that he was president the institution grew in remarkable ways, and his leadership is one that we can all be proud of.

[00:24:00]

***T.A. Rosolowski, PhD***

[00:24:03]

So what was the next step for you, after your candidacy didn't work out? What was your transition period?

[00:24:11]

***Charles Balch, MD***

[00:24:11]

So soon after that appointment was made for John Mendelsohn to come as president, I got a call from Korn Ferry asking if I would be interested in the vacant position at the City of Hope

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National Medical Center in Duarte, California, outside of Los Angeles. And, of course, I went and looked. I had interviews with their Board of Directors over several occasions, and they finally made a formal offer for me to come out and be a candidate as President for the City of Hope. And that did occur. I started on September 1st. There were some here who thought I exited quickly, but the reason for it was a very practical one: I still had a son in high school, and I wanted to have—they start me on September 1st so my son could register in high school in Arcadia, California. It had nothing to do with leaving the institution early; it had everything with a personal decision to secure a position for my son in high school and not have him transfer in the middle of the year.

[00:25:29]

***T.A. Rosolowski, PhD***

[00:25:29]

Was this in 1996?

[00:25:30]

***Charles Balch, MD***

[00:25:30]

That was in 1996. So I went out to the City of Hope for almost five years. I did recruit Donna Sollenberger, who came out to be the CEO of the City of Hope. And this was three organizations: it was the City of Hope hospital and clinics; it was the Beckman Research Institute; and it was the City of Hope Philanthropy, which actually is the second largest medical philanthropy in the nation, after St. Jude's, in raising money nationally to support its programs. So while I was there, we built a new clinic building; we built four new research buildings; we added a PhD program in biology; and designed a new hospital, which became the highest structure in Pasadena, which, remember, was in an earthquake zone, so we had to get a lot of earthquake mitigation to build a structure that was seven stories high, six or seven stories. The highest our buildings were was three stories, so you could imagine building something that high we had to go through a lot of architectural approval to make sure that if there was an earthquake that the hospital wouldn't collapse. And, in fact, it had more steel in its structure, and was built on rollers so that, in fact, if an earthquake happened the building would tip, or tip over. It would not collapse, because of the construction. And that was very expensive, so we had to raise a lot of money in order to do that.

[00:27:23]

After that period of time—and also, the City of Hope at the time was underwater financially. It had a lot of major issues with its infrastructure, even utilities, its billing systems. Many things had been neglected because there had not been a president in office for almost two years, so that there was a lot we had to tend to, to resurrect the institution, to get it back in shape. After four years or so, we delivered to the institution its best financial year in its history of 83 years, but it took a piece out of me with all the changes, and I decided, because of some health issues with

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my wife and some other issues, to retire as President, with the acceptance of the Board, who allowed me to complete my contract. And then, right after that, I was asked if I would come to the American Society of Clinical Oncology to be its Executive Vice President and CEO. Now, this is known as ASCO. It is the largest oncology organization in the world. I'd been on the Board of Directors, and, in fact, had helped select the first EVP, which was John Durant, my old mentor from the University of Alabama at Birmingham. And John actually knew that I was available, and made recommendations that I be a candidate for that position. So I did come up and interview. I was offered the position, but I wanted to maintain my clinical excellence. Even at the City of Hope, in my contract was that I would have one day a week for practicing surgery. I continued to edit our melanoma book, run a journal, the *Annals of Surgical Oncology*, and operated some as City of Hope, but most of it because I didn't want to be—for a variety of reasons, I worked actually at LA County Hospital doing breast surgery there with patients, many of whom were indigent, in caring for them as a way of making connections with USC.

[00:30:01]

But getting back to the story with ASCO, I didn't want to give up my clinical responsibilities, so part of the requirements if I was going to accept is that I would have an academic appointment, and one day a week with clinical responsibilities at Johns Hopkins, and that happened, so that when I went up to ASCO as the CEO I also was appointed as Professor of Surgery, Oncology, and later in Dermatology, as well, at Johns Hopkins. We moved to Annapolis, Maryland, which was halfway between Johns Hopkins and the ASCO office in Arlington, Virginia, or Alexandria, Virginia. And I did that for five years. During that time, ASCO grew tremendously. It more or less doubled in its membership, its staff, tripled its revenue, and grew mightily during that time.

[00:30:58]

***T.A. Rosolowski, PhD***

[00:30:58]

What do you think the impact of that was? That change?

[00:31:02]

***Charles Balch, MD***

[00:31:04]

I think a lot of that, it was vision and strategy, and having the combination of volunteer presidents, who were elected as president, and me, as the senior staff person, a full-time staff, working together to develop visions and strategies for growth. When I first went there, in the year 2000 or 2001, it was known as the American Society of Clinical Oncology. It had a 35-year-old logo. It was in a stable position. It wasn't growing. We changed this to being ASCO, be known by the letters. We put the globe, the world globe, in the O to say our first name is American but our last name is we're a global institution. And because of that, by the Board, of accepting that, we instituted a Division of International Affairs. I hired the first person, Paula Reger from MD Anderson, who then went on after that to become the CEO of the Oncology

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Nursing Society. And the international component of MD Anderson is now one of its largest components, and it is a global organization, but it was a vision of, first, Larry Einhorn, who was President when I first came, who was at MD Anderson and then went to Indiana; Larry Norton, from Memorial Sloan Kettering; and Paul Bunn, B-U-N-N, from the University of Colorado. Those three in succession had a vision for growth, a vision for global programs, and led the Board to direct us to move in those directions, and it was very successful. But I have to say, being a CEO is a tough job. Any job as president or an upper level has a lot of win/lose decisions, which can be sometimes difficult. Even though you could go either way, you know that politically and in a lot of ways some people will not be happy with your decisions. So after ten years of being a CEO, I went back into full-time clinical practice at Johns Hopkins. And one reason for that is the new Chair of Surgery, whose name was Julie Freischlag, the first woman chair in Johns Hopkins history—

[00:33:40]

***T.A. Rosolowski, PhD***

[00:33:40]

I'm sorry, her name again?

[00:33:41]

***Charles Balch, MD***

[00:33:41]

Julie Freischlag, F-R-E-I-S-C-H-L-A-G. Embraced surgical specialties, including surgical oncology. Now, I'd been going up there one day a week, and really enjoyed it, and she enticed me to come back full-time, and to lead in the areas of melanoma and breast cancer and surgical oncology. I also became, as part of that recruitment, the Deputy Director for Clinical Trials and Outcomes Research for all of Johns Hopkins, and that also was intriguing because that was a startup program to provide infrastructure for all of the Johns Hopkins medical institutions in research training, clinical trials training, statistical infrastructure, and I actually helped—I started the Johns Hopkins Clinical Trials Network with ten hospitals in the region, in order to expand our clinical trials capacity, and allow patients with earlier disease that would not ordinarily come to Johns Hopkins to enter into clinical trials in these community settings, and it was very successful, and is still there today. So that was for five years. I was very busy doing both breast cancer and melanoma, and a number of academic things at the institutional level.



## **Chapter 19**

### ***A Return to MD Anderson in 2016 and Reflections on a Career***

#### **A: Contributions;**

Codes

A: Personal Background;

A: Professional Values, Ethics, Purpose;

C: Leadership; D: On Leadership;

C: Mentoring; D: On Mentoring;

A: Contributions;

A: Activities Outside Institution;

A: Career and Accomplishments;

A: Professional Path; C: Evolution of Career;

D: The History of Health Care, Patient Care;

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

#### ***Charles Balch, MD***

[00:33:41]+

Finally, at age 70, as my children were finishing their training, I wanted to follow them. My oldest son Glen had come on to the faculty at the University of Texas Southwestern, in surgical oncology. So I retired, quote-unquote, from Johns Hopkins. They had a very nice *Festschrift* for me, and we actually had people from all over the world who came to that to celebrate my retirement from Johns Hopkins. I said at the time I'm not really retiring; I'm going to stop my clinical practice, but I'm still going to do teaching and research. So I came back to the University of Texas Southwestern for five years on the faculty there, across the hallway from my son, and provided mentoring and career development for the young faculty there in surgical oncology. Did my own areas of teaching and research. Glen Balch then was appointed as the Chief of Colorectal Surgery at Emory University, and moved to Atlanta. I did not want to start out in a new location once again, and Jeff Lee, who is the Chair of Surgical Oncology here at MD Anderson, who was one of my fellows, and I had a conversation about my coming back to MD Anderson. And as you know, part of what we had done, even in my Anderson days, was to talk about burnout and career development among surgeons, and the need for mentoring. So Jeff Lee hired me part-time for mentoring, career development, and job placement for the fellows and the young faculty, and I was delighted to come back 20 years to the week of being gone, of coming back onto the faculty at MD Anderson.

[00:37:30]

#### ***T.A. Rosolowski, PhD***

[00:37:30]



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And the date of that was? Or the year?

[00:37:33]

***Charles Balch, MD***

[00:37:32]

That was in 2016. So the other motive for coming here is my daughter Laura Balch Sloan was a physician assistant here at MD Anderson. My two grandsons are here in Houston. So a major motive for moving here was also to follow my family. Just as another part of the story that's interesting is I hired the first physician assistant at MD Anderson, a lady named Carol Lacey who worked with me in the Melanoma area, who is still an employee now in the Division of Medicine. At a Christmas party, Carol Lacey saw my daughter, who was in pre-nursing at Texas Christian, and convinced her she should be a PA instead of a nurse, so she switched. She ended up going to UTMB as a physician assistant, and her first and only job was to come to MD Anderson, and she's now the senior physician assistant in the Department of Medical GI in the Division of Medicine. So part of that story is not only MD Anderson, but a personal story of my family being here, as well.

[00:38:52]

***T.A. Rosolowski, PhD***

[00:38:52]

Yeah, and having a real impact on people's growth patterns into the professions.

[00:38:57]

***Charles Balch, MD***

[00:38:56]

Yes, and what a privilege for me at this point in time with the experience of almost 45 years in medicine, and a real networking capability of helping fellows and faculty get connected in terms of research collaboration, educational opportunities, mentoring, and job placement for the fellows as they finish their programs.

[00:39:22]

***T.A. Rosolowski, PhD***

[00:39:22]

What do you see—? Well, maybe I should ask it differently. What are some of the differences in career challenges, comparing early in your career with what's been going on now? Because the whole environment for work and research is so different.

[00:39:39]

***Charles Balch, MD***

[00:39:39]

Yeah. Well, the practice has changed—could you turn that off?

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[00:39:45]

***T.A. Rosolowski, PhD***

[00:39:45]

Oh, certainly.

[00:39:45]

***Charles Balch, MD***

[00:39:46]

I need to get—

[00:39:47]

[break in audio]

***T.A. Rosolowski, PhD***

[00:39:48]

All right, we're back on.

[00:39:49]

***Charles Balch, MD***

[00:39:50]

So the practice of oncology, both surgery and all of the disciplines, has changed remarkably over the last 20 years. First of all, it's all digital. All the medical records, instead of paper, are electronic. That is both good and bad. The information systems that we use today, the so-called Epic system, capture a lot of information, but in doing so it captures a lot of information that may not be relevant to each patient, but it slows down entering all the data in the record. But nevertheless, I think the net effect is a good thing that we have electronic and digital records that can be transported between institutions, and are much easier to have the documentation that's legible by the physicians and the staff. The second is the revenue, and the billing and the billing codes has become much more sophisticated and difficult and complicated than it was before, and the documentation that goes along with it. So the business practices of medicine have changed dramatically. It used to be fairly straightforward and simple; now it's very complicated. It takes, I think, time away from the personal time that we've had with the patients. A very important part of this that I mentioned earlier is the midlevel providers. We've gone from being a doctor taking care of a patient with a nurse occasionally around him to team practice, in that we really now are the head of a team for which the midlevel providers, the nursing staff, social workers, physical therapy, the financial people, all are focused in specialty areas, become very expert in that, and that the team collectively, I think, allows the physicians to be more efficient in their time, to see more patients, but the routine management of the patient can be handled by the team under their direction.

[00:42:15]

***T.A. Rosolowski, PhD***

[00:42:16]

Not many people are trained in that, either. [laughs]

[00:42:18]

***Charles Balch, MD***

[00:42:18]

No. The other thing that's changed dramatically here that I had a major role in is the development of surgical oncology as a Board-certified discipline. So this was something that actually we started when I was President of the Society of Surgical Oncology, and those that were presidents before me, to have a specialty recognition of surgical oncology. There was a lot of resistance about this from the general surgeons, especially those who did gastrointestinal surgery, worried about the fragmentation of general surgery. We actually set up the training programs in the SSO. We did it in a way that could be transferred to the American Board of Surgery and the Residency and Review Committee, and it took 20 years of debate and discussion until the American Board of Surgery, the RRC, and all of the other governing bodies finally approved surgical oncology as actually complex general surgical oncology; we had to add those words so that the general surgery community and others wouldn't be concerned that all cancer patients had to be treated by a surgical oncologist. It had to be general surgical oncology so that the specialty surgeons, such as urology and gynecology, wouldn't feel like their specialty was threatened. But finally, through all these negotiations it finally was approved, and I think it has now had an impact in the world because once the American Board of Surgery had approved this as a specialty, the specialty of surgical oncology is being recognized in training programs, implemented around this model, in many places around the world. And this was something that I led in both the Society of Surgical Oncology and the American Board of Surgery in the early years to set the foundation for that.

[00:44:31]

***T.A. Rosolowski, PhD***

[00:44:35]

I was curious in how some of these changes—

[00:44:37]

***Charles Balch, MD***

[00:44:37]

Oh, one other thing. When I started practice, we were trained to operate in all body components, to take care of multiple cancers. And, in fact, a lot of my practice early on was abdominal cancers, not breast cancer and melanoma, for which I'm well-known. Today, the practice of surgical oncology for most people is limited to one organ system. You either operate on the liver or the pancreas, the colorectal area, the breast, but not multiple areas. And that's a major change.

Remember, I mentioned the concerns about the fragmentation of general surgery. Well, now there's the fragmentation of surgical oncology, where there are not many people, even at the community practice, that care for multiple disease sites, but they super-specialize based upon their excellence in one organ system. Now, in one way that is not so good because we tend to focus on the organ and not on the whole patient, but on the other hand you get super skilled at doing the same thing in one organ, and the quality and the outcome improves dramatically by that focus in one area, doing it repetitively, and selecting patients so that you can get them through it safely. So it's just reality now that we are surgical oncologists in a broad sense but, in fact, everybody specializes within that to only one or two organ systems, in order to take on complex cancer care, the whole management, not just the surgery but the oncology management, and to do that with good outcomes.

[00:46:30]

***T.A. Rosolowski, PhD***

[00:46:32]

How has this transformation of the environment for practice influenced how people are mentored, or the kind of mentoring that individuals who are more advanced in their careers will offer to newcomers?

[00:46:49]

***Charles Balch, MD***

[00:46:50]

Actually, one other thing related to this. When I was growing up, the object of an academic surgeon was to be the triple threat person: you did excellent patient care; you did teaching; and you did research, including laboratory research that was funded by the NIH or other national organizations. The ability for surgeons now, because of the sophistication of translational research, to do high-end translational research is much more difficult today, and fewer and fewer surgeons are trained or do all of those things at the same time. The good news is that I think our ability to do clinical research, clinical trials, outcomes research, health services research, even global surgical research, has increased to a point that you can develop an academic program and a scholarly activity around those things, without doing molecular biology in the laboratory, and still have a contribution and an academic record to become promoted. So this is also a major change, and it goes to how we train our fellows. There are some who always had a desire to be involved in translational research, and come with that record. In order for them to do that they're going to have to spend 50 or 60 percent of their time in the lab. You can't do it on a small, part-time basis and keep up with a rapidly moving area. But many of them have MPH degrees, or master's in clinical research, advanced degrees in statistics, and other things that I think prepare them for contributing to evidence-based medicine by doing prospective databases, prospective clinical trials. And I think that's a very important thing that has emerged in the field of surgery and in the field of oncology, of documenting what we do in a prospective way, and building on that evidence as all of these major changes occur with new agents, new technology, new

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instruments. The major changes in our operating room, where we're now bringing in imaging equipment, ultrasound, CT, MRI, navigation instruments—the technology in our operating room has just been a remarkable advance, so the surgical trainees have to understand that, capture the essence of what makes excellent care at MD Anderson, and be able to export that to wherever they go at other institutions.

[00:49:58]

***T.A. Rosolowski, PhD***

[00:49:59]

What about mentoring people for leadership, and the leadership pipeline?

[00:50:02]

***Charles Balch, MD***

[00:50:03]

Well, part of the program in Surgical Oncology, and I think for most of the programs here, is to train people not only to be excellent surgeons, to be academic, trained in teaching and some type of research, to be oncologists. Now, an oncology perspective is disease management across the long-term continuum, whereas surgery is more about the episode of surgery and the immediate time before and after surgery. So the surgical oncologist has to be both a surgeon and an oncologist, and be a full partner in multidisciplinary care. And then the fourth area that we teach and try to entrain our fellows is in leadership, and that is about characteristics of leadership. It has to do with personnel issues, hiring and firing. It has to do with budgeting. It has to do with practicing wellness, and ensuring that part of leadership is having an environment that promotes wellness within their people in charge of them, both physicians and staff. So those are things that we teach as part of the program to prepare people for not just getting leadership roles but succeeding in them.

[00:51:30]

***T.A. Rosolowski, PhD***

[00:51:33]

What have all these years of your career at all these different organizations done for you?

[00:51:38]

***Charles Balch, MD***

[00:51:39]

Hmm. I've had almost 900 publications. I've contributed in research. My publications have been cited almost 28,000 times, even today. But my biggest legacy are two things: my children, all of whom have done well, 53 years of marriage; and the second is the people that I've trained. My legacy, the long-term legacy that I'll leave behind, is not the patient care or the research that comes and goes and is temporary, but the durable legacy of the people you trained and the outcomes of the next generation of my family. And that, to me, is the greatest part of the success

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is watching people that you recruited as undifferentiated young people, but had the enthusiasm and the skills to rise to leadership in MD Anderson, all over the world in various leadership roles. And that's something that I couldn't be more proud of.

[00:52:51]

***T.A. Rosolowski, PhD***

[00:52:51]

Is that something you went through yourself? Did you know you had it in you when you started?

[00:52:56]

***Charles Balch, MD***

[00:52:58]

When you live through the times, you don't really think through that way. Those are recognition events that occur after the fact. If you're ambitious for the sake of being ambitious and having titles, I think people see through that and you don't succeed. I really believe, and I talked to people about servant leadership. This, again, is something I learned from John Durant, my mentor in Alabama, and Mickey LeMaistre. It's the servant leadership, what can I do for you, not what can you do for me. And I think as one embodies that and practices it, you can have people around you who will work with you, who are loyal to you, and when you tell them we're going to take the risk of making changes, they will trust that you're leading in the right direction and follow that.

[00:53:51]

***T.A. Rosolowski, PhD***

[00:53:53]

Is there anything else you would like to add?

[00:53:56]

***Charles Balch, MD***

[00:53:56]

No. Thank you for the opportunity to have this time together, to document my own history, both at MD Anderson and elsewhere.

[00:54:05]

***T.A. Rosolowski, PhD***

[00:54:05]

Well, I want to thank you for the time. It's been a really interesting conversation.

[00:54:09]

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***Charles Balch, MD***

[00:54:09]

Thank you, Tacey.

[00:54:10]

***T.A. Rosolowski, PhD***

[00:54:11]

And I want to say for the record I'm turning off the recorder at ten minutes after 12:00.

[00:54:16]