

## **James D. Cox, MD**

### **Interview Navigation Materials**

**Date submitted:** 31 January 2019

#### **Interview Information:**

One sessions: 19 March 2004

Total approximate duration: 2 hours

Interviewer: Lesley Brunet

**A CV is available. To request supporting materials, please contact:**

Tacey A. Rosolowski, PhD, [trosolowski@mdanderson.org](mailto:trosolowski@mdanderson.org)

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

#### **Interview Subject Snapshot:**

Name: James D. Cox, MD (1938-2018)

Interviewed: 2004, 2013

Primary appt: Division of Radiation Oncology

Research: radiation and combination therapies; proton therapy; thoracic radiation oncology

Admin: Physician in Chief and VP of Patient care (1988-1992); Head, Division of Radiation Oncology and Chair, Department of Radiation Oncology (1995-2014)

Other: Development of Proton Therapy Center

Interview link:

#### **About the Interview Subject**

Radiation oncologist James D. Cox, MD (16 July 1938 – 14 August 2018) came to MD Anderson in 1988 to serve as Vice President of Patient Care and Physician-in-Chief ('88-'92). He is a Professor in the Department of Radiation Oncology. In 1995 he became Head of the Division of Radiation Oncology and Chair of the Department of Radiation Oncology. In this interview, Dr. Cox explore MD Anderson's administrative structure, its transformations and its leaders.

## Major Topics Covered (2004 interview):

Personal and educational background, military experience

Leadership: leadership roles, the experience of leadership

MD Anderson administrative structure: restructuring under Charles LeMaistre, MD [oral history interview]; the divisional system

Institutional politics, controversies

Executive leaders and department chairs: personalities, leadership styles, leadership commitments

### **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).

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They do not represent the official views of any other individual or of  
The University of Texas MD Anderson Cancer Center.*

# **James D. Cox, MD**

## **Interview Contents**

### **Interview Session One: 19 March 2004**

#### **Chapter 01: *The Path to Radiation Oncology***

**Educational Path;** Personal Background; Educational Path; Character, Values, Beliefs, Talents; Inspirations to Practice Science/Medicine; Influences from People and Life Experiences; The History of Health Care; Understanding Cancer, the History of Science, Cancer Research; Portraits; Mentoring;<sup>1</sup>

##### **Abstract:**

In this chapter, Dr. Cox talks about his educational background, his training in radiation oncology, and his interest in cancer. He also discusses his further training in several European hospitals and the development of the field that used to be called “radiotherapy.”

#### **Chapter 02: *Appreciation for Surgeons and Surgery in Collaboration with Radiology***

**Overview;** Portraits; Mentoring; MD Anderson Culture; Influences from People and Life Experiences; The History of Health Care; The MD Anderson Reputation; Multi-disciplinary Approaches;<sup>2</sup>

##### **Abstract:**

In this chapter, Dr. Cox talks about the people who were major influences on him, his reflections on leading physicians at MD Anderson, and how surgeons often interacted with radiation oncologists.

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<sup>1</sup> A: Educational Path; A: Personal Background; A: Educational Path; A: Character, Values, Beliefs, Talents; 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; C: Portraits; C: Mentoring; D: On Mentoring;

<sup>2</sup> A: Overview; C: Portraits; C: Mentoring; D: On Mentoring; B: MD Anderson Culture; A: Influences from People and Life Experiences; D: The History of Health Care, Patient Care; B: The MD Anderson Brand, Reputation; B: Multi-disciplinary Approaches;

## Chapter 03: *Military Experience*

**Professional Path;** Military Experience; Evolution of Career; Joining MD Anderson;<sup>3</sup>

### **Abstract:**

In this chapter, Dr. Cox talks about his military service during the Vietnam War, his work being stationed stateside at Walter Reed Army Medical Center, and his treatment of patients with cancer. “We saw very large numbers of young men with Hodgkin’s disease and testicular cancer,” he said, “and women who were dependents of active-duty army personnel, with cancer of the cervix, breast, and so on.”

## Chapter 04: *Responsibilities at MD Anderson, the Limits of Leadership Roles, and Working with Other Leaders at MD Anderson*

**Overview;** Building/Transforming the Institution; Professional Path; Joining MD Anderson; Leadership; The Administrator; Character, Values, Beliefs, Talents; The Professional at Work; Institutional Politics; Understanding the Institution;<sup>4</sup>

### **Abstract:**

In this chapter, Dr. Cox talks about his decision to come to MD Anderson, his position as Vice President for Patient Care and Physician-in-Chief, and why that “title was a great title and it was a bad job, for me.” He also discusses being glad to return to being a practicing radiation oncologist, his reflections on MD Anderson President Dr. Charles LeMaistre, and the main differences between being a physician and being an administrator.

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<sup>3</sup> A: Professional Path; A: Military Experience; A: Professional Path; C: Evolution of Career; A: Joining MD Anderson;

<sup>4</sup> A: Overview; B: Building/Transforming the Institution; A: Professional Path; C: Evolution of Career; A: Joining MD Anderson; C: Leadership; D: On Leadership; A: The Administrator; A: Character, Values, Beliefs, Talents; C: Professional Practice; C: The Professional at Work; B: Institutional Politics; C: Understanding the Institution;

## **Chapter 05: *Inside Institutional Structures: Personalities and Remaking the Division System***

**Building the Institution;** Leadership; The Administrator; The Professional at Work; Institutional Politics; Understanding the Institution; Institutional Processes;<sup>5</sup>

### **Abstract:**

In this chapter, Dr. Cox talks about various personalities at MD Anderson and difficulties regarding its organizational structure, specifically related to its departments and divisions. He also shares what he considers his biggest mistake: his efforts to restructure the institution.

## **Chapter 06: *On Executive Leadership Styles within the Division System***

**Overview;** Definitions, Explanations, Translations; Discovery, Creativity and Innovation; Discovery and Success; Professional Practice; Multi-disciplinary Approaches; Understanding Cancer, the History of Science, Cancer Research; The History of Health Care; Technology and R&D; Patients, Treatment, Survivors; Industry Partnerships;<sup>6</sup>

### **Abstract:**

In this chapter, Dr. Cox talks about the varied leadership styles of people in the MD Anderson division system. Many, he said, “were considered kind of wild and crazy and off in their own world, and although they were enormously creative ... they were always a little suspect.”

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<sup>5</sup> B: Building the Institution; B: Building/Transforming the Institution; C: Leadership; D: On Leadership; A: The Administrator; C: Professional Practice; C: The Professional at Work; B: Institutional Politics; C: Understanding the Institution; B: Overview; B: Institutional Processes;

<sup>6</sup> A: Overview; A: Definitions, Explanations, Translations; C: Discovery, Creativity and Innovation; C: Discovery and Success; C: Professional Practice; B: Multi-disciplinary Approaches; D: Understanding Cancer, the History of Science, Cancer Research; D: The History of Health Care, Patient Care; D: Technology and R&D; C: Patients, Treatment, Survivors; B: Industry Partnerships;

## **James D. Cox, MD**

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## **Interview Session One (of one): 19 March 2004**

### **Chapter 01: *The Path to Radiation Oncology***

#### **A: Educational Path;**

##### Codes

A: Personal Background;

A: Educational Path;

A: Character, Values, Beliefs, Talents;

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C: Portraits;

C: Mentoring;

D: On Mentoring;

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*Lesley W. Brunet, CA*

**00:00:09**

You're originally from Ohio. I was interested to see that.

*James D. Cox, MD*

**00:00:52**

Yes.

*Lesley W. Brunet, CA*

**00:00:53**

Where in Ohio?

*James D. Cox, MD*

**00:00:54** I was born in Steubenville, Ohio, but I didn't live there for very long. My family moved to Charleston, West Virginia, and so I spent the first eight years of my life in Charleston. Then we moved back to Dayton, Ohio, and then lived there through my teenage years.

*Lesley W. Brunet, CA*

**00:01:09**

Then you went to school at Kenyon College?

*James D. Cox, MD*

**00:01:10**

I went to [Kenyon College](#) in Gambier, Ohio, about which I am very proud. I graduated with high honors. Then in 1997, I actually got an honorary Doctorate of Science degree from Kenyon, and they asked me to become a trustee, so I've sort of recommitted myself to Kenyon after thirty-five years of not going back.

*Lesley W. Brunet, CA*

**00:01:47**

There's something about that thirty-year rule.

*James D. Cox, MD*

**00:01:48**

Yes. Then I went to the University of Rochester Medical School in Rochester, New York, and spent three years there. The summer between my second and third year, I became interested in a program that had been popular at the University of Rochester, which is where medical students took a year out to do something else. Now, these days, everybody wants to compress it. This was the opposite. It was started by a pathologist. The original idea was that the students would spend a year doing autopsies and learning the pathology of disease from autopsies, but then it became working in a laboratory.

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For me, I became interested in cancer, and I wanted to go to a cancer hospital. At the recommendation of a surgeon who was the cancer coordinator at the University of Rochester, Charlie Sherman, I wrote to several places and got a variety of responses, but the most encouraging response came from Juan del Regato, who was the head of a small cancer hospital in Colorado Springs, Colorado, which, as it turned out, was *the* major training ground for radiation oncologists at that time. But I went there not because of radiation oncology; I went there because I was interested in cancer, and I spent a year at that small cancer hospital in Colorado Springs.

Then through the influence of Dr. del Regato and that experience, I decided to go into radiation oncology, went back to the University of Rochester, got my degree, again with honors, and then did an internship that I sort of tailor-made at the University of Chicago, again geared toward cancer—six months in medicine, six months in surgery—which I have now replicated for our residents here.

*Lesley W. Brunet, CA*

**00:04:06**

So that's your interest in surgery here?

*James D. Cox, MD*

**00:04:07**

Yes. So I spent that one year in Chicago and then went back to Colorado Springs and did my residency training there in radiation oncology, which at that time was called therapeutic radiology.

*Lesley W. Brunet, CA*

**00:04:28**

The name changes quite often.

*James D. Cox, MD*

**00:04:29**

The name changed really just from therapeutic radiology to radiation oncology.

*Lesley W. Brunet, CA*

**00:04:36**

Of course in the old days they called it radiotherapy.

*James D. Cox, MD*

**00:04:42**

That's right. They called it radiotherapy here. That's right. That's right. But the board certification was in therapeutic radiology. You see the second one up there? That was at that time what one became board certified in. That was a time when you could still become board certified in radiology, where you could practice radio diagnosis or radiotherapy. But that disappeared in 1972 or 1973. You had to do one or the other.



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***Lesley W. Brunet, CA***

**0:05:14.8**

Was that a bad—?

***James D. Cox, MD***

**0:05:17.1**

It was old. When you figure the origins of or the beginnings of radiology, it was not without reason that you were using an instrument, and you could use it for diagnosis. Very few people used it for therapy, but over the years that became more prominent, especially as high-energy therapy became available in the forties and fifties.

So the field really took off in the fifties and the sixties, and I was part of a program that was funded by the National Cancer Institute to train people in radiation oncology, because there was a recognized shortage and a need nationwide for people who were so trained. So there were, initially, three centers that were funded by NCI for training: Yale, Stanford, and this Penrose Cancer Hospital in Colorado Springs.

***Lesley W. Brunet, CA***

**00:06:26**

That's surprising, isn't it?

***James D. Cox, MD***

**00:06:27**

The first people that were trained at Yale and Stanford, I believe, were training beginning around 1965 or so, and that was a time, actually, when I began my training. Actually, my internship was in 1965, and then my formal training was in 1966 through '69.  
(Telephone rings. Interruption.)

***James D. Cox, MD***

**0:06:52.1**

We were talking about Penrose and the whole field of training and so on.

***Lesley W. Brunet, CA***

**0:06:56.8**

I did want to ask you, before you get too far, what triggered your interest in cancer?

***James D. Cox, MD***

**0:07:02.0**

Actually, doing autopsies as a second-year medical student. Don't ask me why. There was no personal connection. It was purely intellectual. I was fascinated by the disease and how it behaved. I found that when I was a second-year student and then in my third and fourth year, as I learned more about cancer and took care of cancer patients, it was just a constant source of interest to me. I was intrigued. Some people get into cardiology and some people get into

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rheumatology and, in fact, I got into oncology before I knew what I was going to do as a specialist. So I became a cancer student long before I became radiation oriented.

*Lesley W. Brunet, CA*

**00:08:02**

So you had a different viewpoint, then, than other people.

*James D. Cox, MD*

**00:08:06**

Yes.

*Lesley W. Brunet, CA*

**00:08:08**

So then you did your residency, and then you went to France.

*James D. Cox, MD*

**00:08:13**

Spent at year at France's largest cancer hospital, the [Gustave Roussy Institute](#)—which was in a suburb right outside of Paris—and had a great experience. The Gustave Roussy is sort of France's version of this; although, well, of course, Anderson was much smaller at the time. But it was a very, very busy place with a lot of breadth and depth, and I learned a great deal. I had been in a very small hospital with a cancer program, so my training was sort of intensive but not broad. Then I went to Gustave Roussy, and it just broadened it enormously.

During the time I was in France, I did go to a couple other of the major cancer centers in Europe, especially [The Royal Marsden Hospital](#) in London and [The Christie Hospital](#) in Manchester and then also in Sweden.

*Lesley W. Brunet, CA*

**00:09:26**

Historically, Europe was so much ahead of us in terms of radiology. Was that still the case when you went?

*James D. Cox, MD*

**00:09:40**

No, but it was very much the case where my mentor, Dr. del Regato, came from. He trained at the University of Paris and then the Radium Institute of the University of Paris. He was a Cuban sort of expatriate who had to go to France. He was given the opportunity to go to France for training because they closed the University of Havana Medical School because of a political crisis in the early twenties. That was in the early twenties. So there was an organization—actually a cancer organization—that helped some of the Cuban medical students go on and get training in Europe. He went to the University of Paris, learned French, became a French scholar, and did his medical school and then his specialty training. But unlike the vast majority of people

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who trained at that time, he too was cancer oriented, so he only did the therapeutic part of radiology, even from the thirties.

***Lesley W. Brunet, CA***

**00:11:04**

That was very early.

***James D. Cox, MD***

**00:11:06**

Which was very early. So when he came and established training in the United States, it was training in radiation oncology. The first people he trained were people at the Ellis Fischel Cancer Hospital in Columbia, Missouri, and then in 1949 he went to the Penrose Hospital in Colorado Springs and started a cancer program and was there for twenty-four years until he retired in 1973.

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## ***Chapter 02: Appreciation for Surgeons and Surgery in Collaboration with Radiology***

A: Overview;

Codes

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D: The History of Health Care, Patient Care;

B: The MD Anderson Brand, Reputation;

B: Multi-disciplinary Approaches;

***Lesley W. Brunet, CA***

**00:11:48**

Were there other people during your medical school and postgraduate work that were large influences the way he was?

***James D. Cox, MD***

**00:11:59**

I think Charles Sherman, a surgeon who kind of opened the door to these various cancer hospitals, also was a good example of a cancer surgeon. He was trained at Memorial Hospital in New York and was a really good cancer surgeon, gave me my first understanding of the difference between cancer surgery and general surgery as it was practiced around the world. The general surgeons learned an operation and applied it, and the people who were really trained in cancer surgery sort of understood the disease and went after it in whatever manifestation it had. So they were very skilled and very, very able to do things.

To this day, I have such enormous respect for cancer surgery. One of my greatest, most delightful experiences in coming to MD Anderson was I had not appreciated how terrific the cancer surgery was. I should have known, but I just didn't appreciate fully how good the surgery was here until I came in 1988. It's fantastic.

***Lesley W. Brunet, CA***

**00:13:18**

It seemed unusual, when I started researching you, that you worked so closely with surgery. I was a little surprised by it, and among your accomplishments was the way surgery had been raised to a certain level. I'm looking for my quote. "Surgery has achieved academic stature without peer." And you'd only been here for a couple years, and you had contributed to that.

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***James D. Cox, MD***

**0:13:59.6**

Yes.

***Lesley W. Brunet, CA***

**0:14:01.8**

I don't remember seeing that about [Gilbert H.] Fletcher. Let's put it that way.

***James D. Cox, MD***

**00:14:06**

Fletcher worked very closely and wonderfully with the surgeons. I mean, what he did, actually, he fought them, he and Bill [William S.] MacComb. MacComb was trained at Memorial also, in an era where there were phenomenal cancer surgeons that were trained in the late, late thirties, except possibly for the Mayo Clinic, but for cancer per se there was no training ground like the Memorial Hospital of New York. The surgeons, they didn't know anything about radiation oncology, so they were really naïve and they were often super opinionated and they thought surgery was the only thing. But they were really skilled, and once they did learn about good practice of radiotherapy, they became real converts.

So over time, Fletcher was ornery and MacComb was ornery, and they fought each other and gradually came to working together. Then when Dick [Richard H.] Jesse succeeded MacComb, he and Fletcher worked wonderfully together and set the example, in fact, for multidisciplinary collaboration that has been the example for the institution ever since. The other person, of course, was Felix [N.] Rutledge, who worked with Fletcher, and that combination was incredibly successful. So GYN and Head and Neck have always been the examples of multidisciplinary care in the institution. Then with Eleanor Montague and Norah [D.] Tapley and the people who interacted with especially the breast cancer team—and Fletcher was involved with that as well—there was the sort of general surgery or breast cancer surgery part of it as well.

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### **Chapter 03: *Military Experience***

A: Professional Path;

Codes

A: Military Experience;

A: Professional Path;

C: Evolution of Career;

***Lesley W. Brunet, CA***

**0:16:15.1**

I'm going to back up just a little.

***James D. Cox, MD***

**0:16:22.3**

I got way ahead.

***Lesley W. Brunet, CA***

**0:16:22.9**

No, that's okay. You were in the service?

***James D. Cox, MD***

**0:16:26.8**

Yes.

***Lesley W. Brunet, CA***

**0:16:28.2**

That was after France? You were working in Wisconsin?

***James D. Cox, MD***

**0:16:33.9**

In 1965, I was an intern at the University of Chicago, and the Vietnam War was just building, and the draft was there. It was clear that every physician, he or she was going to go into the military one way or the other.

***Lesley W. Brunet, CA***

**0:17:00.7**

Did they have the physician draft then? They drafted everybody.

***James D. Cox, MD***

**0:17:05.5**

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They drafted everybody, but virtually every physician because they needed them. So in 1965, I volunteered for the draft.

***Lesley W. Brunet, CA***

**0:17:16.3**

Get it over with.

***James D. Cox, MD***

**0:17:17.3**

And that permitted me to be a candidate for what was called the Berry Plan. The Berry plan was a way of deferring active duty in areas where the army had a shortage of specialists, and it was only for a certain list of specialists, one of which was therapeutic radiology. So I volunteered for the draft, which was the first thing and a risky thing in its own right, and then I did apply for this Berry Plan and was able to get deferred through my whole training, including France. Then I went on active duty as soon as I came back from France, and I was on active duty from July of 1970 until June or July of 1972.

***Lesley W. Brunet, CA***

**0:18:29.2**

Where did you serve?

***James D. Cox, MD***

**0:18:34.4**

I was stationed at Walter Reed Army Medical Center [Bethesda, Maryland].

***Lesley W. Brunet, CA***

**0:18:35.4**

So you didn't have to go overseas?

***James D. Cox, MD***

**0:18:36.7**

I didn't have to go overseas. Right.

***Lesley W. Brunet, CA***

**0:18:41.1**

Was that a useful—?

***James D. Cox, MD***

**0:18:44.5**

It was a very good experience. I mean, Walter Reed was the major place for cancer treatment in the United States. There were three million active-duty men in the army, and almost everybody with cancer was funneled to Walter Reed. Some went to Fitzsimons Army [Medical Center] Hospital in Denver, some went to [Camp] Letterman [General Hospital] in San Francisco, and some went to [Tripler](#) [Hospital]. But only the ones in the Far East went to Tripler Hospital in

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Hawaii, in Honolulu. But those were the four major hospitals, and Walter Reed was far and away the main source. We saw very large numbers of young men with Hodgkin's disease and testicular cancer, and women who were dependents of active-duty army personnel, with cancer of the cervix, breast, and so on.

So it was a good experience, and I did some stuff academically. Walter Reed was right next to the Armed Forces Institute of Pathology, so I did work with the pathologists and wrote a few papers.

***Lesley W. Brunet, CA***

**0:20:12.8**

That was a good time then?

***James D. Cox, MD***

**0:20:16.7**

That was a good time. I tried to make maximum use out of it. The hours were pretty good, relative to what I'm used to doing, and so I had time to do some retrospective studies of patients that had been treated there and to interact with the pathologists and try to learn stuff about the natural history, especially of lymphomas.

***Lesley W. Brunet, CA***

**0:20:45.8**

You studied a lot of different kinds of cancer.

***James D. Cox, MD***

**0:20:50.8**

Well, yes, but probably the main areas of focus have been lymphomas and cancer of the lung and, to a lesser degree, cancer of the prostate. I've done a few studies in other areas, head and neck, but that's most of it.



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## ***Chapter 04: Responsibilities at MD Anderson and Discovering the Limits of Leadership Roles***

A: Overview;

Codes

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C: Professional Practice;

C: The Professional at Work;

B: Institutional Politics;

C: Understanding the Institution;

***Lesley W. Brunet, CA***

**0:21:17.0**

Let's go forward a little bit. I don't want to skip over this, but I do want to get to your coming down here. I guess when I first started looking at this I thought, why would anyone leave Columbia for Houston?

***James D. Cox, MD***

**0:21:33.7**

There were reasons. One was the attraction, and the other one was that the economic environment in New York City went bad around that time. Columbia Presbyterian Hospital, that had made a commitment—a major commitment—to improve the department, suddenly found that it was losing a couple million dollars a month. They couldn't do anything, any of the stuff that they said they were going to do and wanted to do, and the picture looked pretty bleak pretty far out. So when this opportunity presented itself, even though I worked incredibly hard for three years at Columbia Presbyterian, I didn't have very much to show for it.

***Lesley W. Brunet, CA***

**0:22:35.3**

Who first approached you about coming down here?

***James D. Cox, MD***

**0:22:37.4**

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Actually, I was on the Board of Chancellors of the College of Radiology, and one of the people who was a chancellor at that time, or maybe somehow he was involved, was Gerald [D.] Dodd, [Jr.], who at that time was the head of Radiology here. Gerry said, "You know, they've got a position at MD Anderson for a physician-in-chief." He said, "I think you'd be good, a good candidate for that. Would you be willing to look at it?"

And I said yes. That was in 1987, because I guess I had just become a chancellor. I think I was a chancellor from '87 to '93. Anyhow, I was in the leadership of the college somehow. Before that, I'd been on the steering committee of the Council of the College.

So Gerry came back, apparently, and talked to people here. I got a call from Dr. [Charles A.] LeMaistre's [oral history interview] office and I was invited to come and interview. First, he was in New York City. I remember meeting Dr. LeMaistre for the first time at a hotel—I can't remember the name—in New York City. We had lunch together and talked, and I guess he seemed to be interested after our talk. So I came and visited, and I met with the then division heads of the institution, including John Batsakis and Dodd and Jose [M.] Trujillo and Charles [M.] Balch [oral history interview], Irv [Irwin H.] Krakoff.

***Lesley W. Brunet, CA***

**0:25:08.1**

Pediatrics. Van Eys?

***James D. Cox, MD***

**0:25:17.2**

Jan van Eys. I think that gets all of them. Maybe not.

I interviewed with them, and apparently that went all right, so sometime soon after that they made an offer. I said okay, and I said I couldn't leave too quickly because I was head of the department there and I had to keep my responsibilities to the people for some period of time. Anyhow, I came here, started officially August 1; although, we were working on plans for renovating the office and so on before that. I started on August 1, 1988.

***Lesley W. Brunet, CA***

**0:26:08.4**

There were several things you wanted. As a matter of fact, I have your acceptance letter. I don't know if you want to look at that.

***James D. Cox, MD***

**0:26:17.5**

[laughs] Oh my.

***Lesley W. Brunet, CA***

**0:26:20.2**

See, the correspondence—it's always in the correspondence.

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***James D. Cox, MD***

**0:26:22.5**

That's fascinating. Oh, yes.

***Lesley W. Brunet, CA***

**0:26:24.6**

Then I actually have a response to that from LeMaistre. There were several issues that you were concerned about. I'll give you a few minutes to look that over.

***James D. Cox, MD***

**0:26:50.9**

Wow. [Reads documentation.] I was smarter than I thought. Yes, I said I would plan to spend some portion of my time continuing as chairman of the Radiation Therapy Oncology Group. This would require my traveling to Philadelphia at least once each month, and I would have to go to Bethesda with somewhat regularity for meetings with the chairman of cooperative groups. I asked them to accept the RTOG as a responsibility in the Division of Radiotherapy but more widely. And I was right in spelling that out, although they were wrong, or it turned out that they were very uncomfortable with my being away that much, which was one of the sources of dissatisfaction that evolved.

***Lesley W. Brunet, CA***

**0:28:42.5**

I got the impression they expected you to be on call around the clock.

***James D. Cox, MD***

**0:28:46.9**

All the time. And not only on call for the president, but on call for the division heads, an impossible task. As I've told people since—I don't know if this has been quoted elsewhere—but I said, "It was a great title and a bad job."

***Lesley W. Brunet, CA***

**0:29:07.8**

Certainly a difficult, difficult job. You mean the title of Physician-in-Chief or the Vice President for Patient Care?

***James D. Cox, MD***

**0:29:15.0**

Vice President for Patient Care and Physician-in-Chief, that whole title was a great title and it was a bad job, for me. In fact, they never really replicated it in that form quite again.

David Hohn took it over, and he did a very good job. I mean he was really committed, and he was especially gifted in his interest in facilities and having them evolve. I think almost to a surprise I supported him very strongly in that position, and he was always most appreciative of that, but I was happy he had it, because I didn't want it.

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*Lesley W. Brunet, CA*

**0:30:03.4**

How soon did you realize you didn't want it?

*James D. Cox, MD*

**0:30:08.5**

Well, no. I mean, after. Actually, I did my best until '92, so more or less four years. And two things happened. LeMaistre called me in and said he wanted David Hohn to do this instead of me. Lillian Fuller was scheduled for retirement in the Department of Radiotherapy, and they needed a person to take over from her the very considerable responsibility of the practice for lymphoma. That was sort of my first love, as I indicated, some of the early research that I did, so I was very pleased to do that.

So I was happy to go back to being a practicing radiation oncologist and to take care of the lymphoma service and the lymphoma patients and be doing research in that area. And I worked very well with Fernando [F.] Cabanillas. Through the whole thing, I was running the RTOG nationally, which was sort of my anchor and my source in a—

[break in audio tape]

*Lesley W. Brunet, CA*

**0:00:00.8**

You were saying that RTOG was your personal—

*James D. Cox, MD*

**0:00:02.8**

It was my professional validation, because I did not get satisfaction from what I was doing day in and day out.

But I learned a lesson, you know. As I said, for me that was not a good job, and after I was no longer in that position, I was offered the opportunity to become chancellor, vice chancellor, dean, so on and so forth. And I'd learned my lesson. That was a kind of administration I didn't want to do and didn't feel that I was good at. I didn't find the kinds of gratifications that made me happiest.

So I'm very happy being a radiation oncologist practicing here. I came to appreciate the institution far, far more once I was in the trenches, as it were, instead of looking at it from outside or from above, or however you want to characterize it. So I was really very much happier. Then totally to a surprise, when Dr. [Lester] Peters decided to go back to Australia and this position opened up—you know—I thought briefly about whether I should do that. I said, "Well, wait a minute. That's the kind of administration I've always done, I've always been good at."

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Go back in time. When I was at Walter Reed for two years, the second of those two years all of the regular army therapeutic radiologists had left, so by default I became head of the radiotherapy service at Walter Reed.

***Lesley W. Brunet, CA***

**0:02:02.2**

Pretty good training ground.

***James D. Cox, MD***

**0:02:03.0**

They had recruited one of my commanding officers to become the head of the section of radiotherapy at Georgetown [University Hospital]. He took the job and at the last minute backed out just as I got out of the army, and they offered me that job, so I became the head of the section of radiotherapy at Georgetown. Then I went to the Medical College of Wisconsin as head of the Division of Radiotherapy there and then made it into a department. Then I headed a department at Columbia, the first new department at Columbia University College of Physicians and Surgeons in thirty-two years.

So I had done that kind of administration and enjoyed it, was good at it, and so I thought, “Well, if I have an opportunity to do that again, I would like to do it.” And I do, and over the course of the last however many years it’s been, seven years or so, eight years almost. It will be eight years, more than eight, because it was late 1995 when I took over. It’s been the happiest professional time in my life. I love what I do.

***Lesley W. Brunet, CA***

**0:03:31.2**

And the department or the division, it’s—

***James D. Cox, MD***

**0:03:33.5**

It’s flourished.

***Lesley W. Brunet, CA***

**0:03:36.9**

It really has. It’s got quite a reputation.

***James D. Cox, MD***

**0:03:38.8**

It’s flourished, yes, and I’m very proud of it. I’m proud of what we’ve done with the training program, which was to make it more and more and more academic all the time. The people who are going to start with us in July are phenomenal—our residents in training. The people we just matched with earlier this week who will become our PG-1 trainees and then who will start with us full-time in residency in 2005 are incredible. I mean, they are fantastic scientists, they are outstanding clinicians, they are really wonderful people, and we are just ever more excited about

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the people that are coming in for training, the research we've produced, the productivity of the place.

I feel very fortunate to have the opportunity, and I feel very proud with what we've been able to accomplish. I'm surrounded by fantastic people. So what can I say?

***Lesley W. Brunet, CA***

**0:04:57.9**

So it's worked out well.

***James D. Cox, MD***

**0:04:58.8**

It's worked out well.

***Lesley W. Brunet, CA***

**0:05:01.0**

Do you mind discussing the earlier period just a little while longer?

***James D. Cox, MD***

**0:05:05.6**

No, I don't mind.

***Lesley W. Brunet, CA***

**0:05:07.4**

One of the things that you talked about or you wrote in your acceptance letter or in the negotiation process was about having a Vice President for Patient Care and then a Vice President for Patient Affairs. What was the issue here?

***James D. Cox, MD***

**0:05:33.3**

The Vice President for Patient Affairs was a physician very close to Dr. LeMaistre, so the degree of access, influence, and balance was always with that person. But Dr. [Charles] McCall, with all due respect, was not a cancer person, didn't know much about cancer, and so in the context of trying to make a cancer hospital work well, oftentimes was sort of—I don't want to be unfair—but oftentimes put an emphasis on areas that seemed to me other than what was really best for the cancer patient, best for the faculty.

See, my set of priorities from the day I came in—and to this day, as far as that's concerned—was the most important people in this institution are the people who work here, with one exception; the exception being the patients are even more important. But, I mean, the people are so important and their ability to care for the patients then is so important that in a setting of a cancer hospital, it seemed like that balance wasn't always a very good one.

Now, Dr. LeMaistre himself was not an oncologist, and so I think a perception that was arguably different from Dr. [R. Lee] Clark's and different from mine was the dominant influence in the

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institution. It was far more political than it seemed to me was advantageous. Not to say that every institution isn't political, but it seemed like the emphasis in the decisions and even the representation of the priorities of the institution sometimes got, if not subverted, at least tangential to what I thought were the top priorities in the institution.

I think there was and there evolved a disconnect between me and Dr. LeMaistre in that regard, not because of Dr. McCall, but I think the structure of the institution was such that it lent itself to decisions that were governed more by the people who— It was sort of the squeaky wheel gets the grease, and the two squeakiest wheels, naturally, because they had big services, were Dr. Krakoff and Dr. Balch. So Dr. McCall, Krakoff, and Balch had great access to Dr. LeMaistre and great support from him and, I daresay, far greater support than I got from him. Now, that's candor.

*Lesley W. Brunet, CA*

**0:09:32.8**

This probably comes through in the records.

*James D. Cox, MD*

**0:09:39.5**

Sure.

*Lesley W. Brunet, CA*

**0:09:41.6**

Was there also an issue about who headed up clinical research?

*James D. Cox, MD*

**0:09:55.8**

There was some issue on that, and again, I felt that oversight of clinical research, the design and analysis of clinical trials, the administration of clinical research was one of the skills I was bringing to the institution. I was so passionately committed to that, that it seemed unwise to have that in a different office.

Dr. [Frederick F.] Becker [oral history interview], in sort of the Office of Protocol Research, as I recall it, related more to Fred Becker and not very much to the office of the Vice President for Patient Care. So yes, there was some tension there. It was not a huge thing. It didn't dominate what we did, especially since I was doing what I did in the national scene in clinical research. But, still, it seemed that— And in fact, the institution—and with the support of Lester Peters and the support of the faculty within the Division of Radiotherapy—we became a major player in the Radiation Therapy Oncology Group and are to this day.

It becomes a resource for clinical investigations from MD Anderson, because cooperative groups have an ability to do the kinds of clinical research that rarely can be done in a single institution, just because of the numbers of patients involved. So clinical research was something of great

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interest to me, and I did not want that to be entirely in the hands of somebody else. But that worked out, as far as I'm concerned.



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## **Chapter 05**

### ***Inside Institutional Structures: Personalities and Remaking the Division System***

B: Building the Institution;

Codes

B: Building/Transforming the Institution;

C: Leadership;

D: On Leadership;

A: The Administrator;

C: Professional Practice;

C: The Professional at Work;

B: Institutional Politics;

C: Understanding the Institution;

B: Overview;

B: Institutional Processes;

***Lesley W. Brunet, CA***

**0:12:13.6**

I'll try to figure out a nice way to phrase this. It's the personalities. How much is it simply the personalities?

***James D. Cox, MD***

**0:12:28.0**

[Pauses] Well, I'm not sure how to answer that. I don't know what the real question is. There were people with whom I worked easily, and there were people with whom I found it difficult to work, and there were people who, I think, were very unhappy about the way I supported them or didn't support them.

Actually, I think probably Irv Krakoff and Lester Peters were not happy either one about the way I supported them, even though officially I was in Lester's department. But I think Lester was uncomfortable with me, but that's an aside. Put that aside for the moment. I think as far as the others were concerned, I think I worked with some difficulty with Irv Krakoff. I worked okay with Charles Balch. I worked very well with John Batsakis and Trujillo and Dr. Dodd.

***Lesley W. Brunet, CA***

**0:14:49.5**

A couple of big things, it seemed like. I guess we might as well shoot for the biggest.

***James D. Cox, MD***

**0:14:55.3**

Shoot for the biggest.

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*Lesley W. Brunet, CA*

**0:14:56.4**

The dissolution of the divisions.

*James D. Cox, MD*

**0:15:05.5**

What was happening—and this was where probably the greatest problem was—in a few divisions, the divisions and the departments were identical. At that time, there was a Division of Pathology and a separate Division of Laboratory Medicine, so they were that. There was a Division of Diagnostic Imaging or Radiology, as it was called then. That was it. There were no departments. Pediatrics, no departments. Radiotherapy, there was one clinical department and a research department and physics department.

The clinical and the physics departments were not working together very well. And there was a lot of unrest and, I must say, especially in the Division of Surgery, that decisions were being made that were preemptive of the department chairs by the head of the Division of Surgery. And to some degree that was happening also in Medicine. So one could argue whether the divisions were serving a useful structure or whether they were serving as an impediment to the people who really wanted to chart their own course. So I took the position at that time that the divisions were more problematic than they were useful and that it made sense to do away with the divisions.

Now, let me tell you, there're two advantages to the divisions. The one advantage of the division head that has multiple departments is that he or she has greater clout, arguably.

*Lesley W. Brunet, CA*

**0:17:07.4**

You mean the more departments, more money?

*James D. Cox, MD*

**0:17:08.6**

More departments, more money, more budget, more resources. But the other thing is that the divisions permit a number of people who would be divisions in other institutions to be called departments, so you have a department chair of this, that, and the other that you would never have in a university medical center. They would all be divisions within a department.

The division structure is not understood outside MD Anderson at all. If you say a Division of Radiotherapy, they say a division of what? They don't think of it as a superstructure; they think of it as a smaller structure, a flip. So there was the external perception. There was all of that. But in retrospect, it was not a battle worth fighting, and I probably should have just said to hell with it and gone on. And would it have made a difference? I don't know. Probably it would have not been good, because I realize all the more that the divisional structure permits a variety of department heads, the head of a Department of Lymphoma Myeloma, that you would never have in a university medical center, a head of a Department of Melanoma, a head of a

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Department of GI Medical Oncology, you would never have. Those would all be small divisions.

Now, Anderson is different, so there's no reason why it shouldn't have a different structure. But anyhow, that was a battle that probably wasn't worth fighting, and it was one of the mistakes I made.

***Lesley W. Brunet, CA***

**0:19:10.8**

I could see it when you were talking about it in the records. You were trying to do away with the layering, and some of the examples were incredible, of the layering.

***James D. Cox, MD***

**0:19:24.4**

Right. It was trying to do away with layers. It was trying to do away with access to people who could make decisions on their behalf.

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## **Chapter 06: *On Executive Leadership Styles within the Division System***

A: Overview;

Codes

A: Overview;

A: Definitions, Explanations, Translations;

C: Discovery, Creativity and Innovation;

C: Discovery and Success;

C: Professional Practice;

B: Multi-disciplinary Approaches;

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

D: The History of Health Care, Patient Care;

D: Technology and R&D;

C: Patients, Treatment, Survivors;

B: Industry Partnerships;

***James D. Cox, MD***

**19:55.4**

I think it's fair to say that Dr. Balch got a lot of satisfaction out of saying what the Department of Head and Neck Surgery what did, the Department of Gynecology, and the Department of Neurology. He loved to control it. Now, it's one thing if the division head is a facilitator and an enabler, and it's another thing if the division head is a controller and micromanager. So on the one hand, it can be very beneficial, and on the other hand, it can get in the way. Under Dr. Balch, it got in the way.

***Lesley W. Brunet, CA***

**0:20:38.5**

How about under Dr. Krakoff?

***James D. Cox, MD***

**0:20:40.2**

It was harder to tell, because the people in the divisions and the department chairs in Cancer Medicine sort of adhered to a party line much more than the ones in Surgery. So I think in general that they felt better supported by Krakoff than the ones in Surgery.

You know, of course, why Krakoff was brought in. I mean, you know. [laughs] Probably from Dr. [Emil J] Freireich you've heard, but—

***Lesley W. Brunet, CA***

**0:21:28.2**

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You mean to get rid of Dr. Freireich?

***James D. Cox, MD***

**0:21:29.9**

No, to get rid of the Developmental Therapeutics.

***Lesley W. Brunet, CA***

**0:21:32.8**

The department. Right.

***James D. Cox, MD***

**0:21:34.9**

And that whole group as a structure and as an influence and as a frame of reference for MD Anderson around the nation—I mean—DT was well known.

***Lesley W. Brunet, CA***

**0:21:49.1**

But why did they want to destroy something that seemed so successful?

***James D. Cox, MD***

**0:21:53.7**

It was successful, but it was like—I'm trying to think of the right word. It was sort of— It will come to me after we're finished. I'll get just the perfect word to characterize it. But absent that word, they were considered kind of wild and crazy and off in their own world, and although they were enormously creative—many of them were enormously creative—they were always a little suspect.

***Lesley W. Brunet, CA***

**0:22:46.1**

And there were some investigations and things.

***James D. Cox, MD***

**0:22:49.4**

Yes, and there were some people who probably deserved to be suspect. [laughs] Without any names. I mean, there were some pretty wild people in that group who did some pretty wild things, in some sense very creative and in other areas maybe dangerous or risky or pushing the envelope too far. So when you looked at the other departments, if you will, of MD Anderson, which had a great deal of credibility throughout the nation, were having a big impact on—I mean, Head and Neck and GYN as two examples. General Surgery, Neurology—these were all departments that had a big influence around the country. There were not parallel influences except in DT, as near as I know, and they were always considered kind of at the fringe, creative but at the fringe.

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So you could view it either way. If you were a believer, you thought they were the best thing in the world. If you were a nonbeliever, you thought they were the craziest bunch of people in town. And people usually were on one side or the other. I wasn't. In fact, I have enormous respect for most of the people, certainly all of the people in the department or that are a carryover of that, that are still creative and that have had a great influence. And I think of two. Freireich is one. Michael [J.] Keating [oral history interview] is another. They both know that I have great respect for what they do and what they've accomplished.

But the Leukemia group has still been a little bit at the fringe in terms of some of the clinical research that they've done, and they've gotten into trouble. They've gotten critiqued and so on, and rightly so. But still, a lot of creativity there and a lot of—I mean, I refer my friends to them. I mean, I have great respect for what they do clinical and what they've done investigational.

*Lesley W. Brunet, CA*

**0:25:16.5**

When you decided that you needed to dissolve the divisions, did you talk to LeMaistre before making that announcement?

*James D. Cox, MD*

**0:25:34.8**

Oh, yes. Oh, yes. I talked to him before. Did I talk with him immediately before I sent the memo? No. So he sort of seemed receptive to the idea. He didn't say, "No, that's the craziest idea I've ever heard of. We've got to have it for this, this, and this." He never said anything like that. I was led down the path to believe—Let me step back one minute. I came in to the position of Vice President for Patient Care and Physician-in-Chief thinking it was a leadership position. It was not.

*Lesley W. Brunet, CA*

**0:26:17.8**

It was presented that way.

*James D. Cox, MD*

**0:26:19.0**

It was a manager position. So if one were to take the lead on anything, you would run up almost always against either LeMaistre or the division heads, because, one, they didn't want it to be any different than it was.

I remember sitting in LeMaistre's office on the tenth floor over in HMB when it was still over there. This was probably six months after I was here and long before the letter about the division heads. This is a very interesting place. It's an outstanding place, but it so resistant to change. If you suggested change, people said, "What's wrong?" And instead of saying, "We're good, but we can always be better," which I think is the way people think now—I think John Mendelsohn [oral history interview] has done a fantastic job in that regard, and his whole team. Those of us who just always think that way—no matter how good we are, we can always be better. Why

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not? Take a chance. Do something different. Boy, you could not say words like that within these walls at that time. It was just anathema.

***James D. Cox, MD*** \$\$

**0:26:19.0+**

So to come in, in a leadership position, and to think maybe you wanted to affect change and that change was good, not bad, was just not fitting in with the culture of the place at the time. So my approach and my personality and what I would argue has made Radiation Oncology flourish over the last eight years wasn't possible for them within the institution, not with the current set of players, LeMaistre, and the division heads sort of co-sharing that view.

One of the people who was most resistance, in fact, who whenever I mentioned something about possibly changing it would really always say, "What do you think is wrong with that?" was Lester Peters.

***Lesley W. Brunet, CA***

**0:28:59.1**

Frankly, I was surprised that after you stepped down as vice president— For a long time I was thinking that that's when you became chair, because there were problems.

***James D. Cox, MD***

**0:29:11.1**

I had three years in between.

***Lesley W. Brunet, CA***

**0:29:13.4**

There were problems with Dr. Peters. And maybe everybody has this in their file, and that's just what they say—you know—two sides of things.

***James D. Cox, MD***

**0:29:28.9**

Dr. Peters and I have a fundamentally different style, a very different style. He's a very smart and very talented guy, and what he did personally was really creative and good, but we have a very, very different style. And, again, Lester Peters' style was very much controlling and directing, and my style is really to try to enable people, to try to not tell them where to go, have a vision of where they want to go, and then try to help them fly. And I do that, and I love to do it, and I get satisfaction out of doing it. I don't get any particularly great satisfaction out of saying, "You do this. You do this." And my management style is to bring in people and give them responsibility and let them do the good that they can do and come to me when they've got a problem, but otherwise, kind of not interfere with them. So it's a very different style.

***Lesley W. Brunet, CA***

**0:30:50.6**

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The reason I was asking about LeMaistre and whether you had discussed it with him earlier, I wondered about his management style.

***James D. Cox, MD***

**0:31:02.3**

Oh, do you really want to go there?

***Lesley W. Brunet, CA***

**0:31:05.7**

Yes, I do. [Cox laughs.] Do you want to wait? We're almost out of tape.

***James D. Cox, MD***

**0:31:13.5**

Yes, we ought to wait for another time.

***Lesley W. Brunet, CA***

**0:31:15.9**

We'll pick that up on our next meeting. Thank you for taking this time today.

**0:31:24.7**



*a MDA-RML\_Cox\_James*

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