The University of Texas M. D. Anderson Cancer Center

Making Cancer History® Voices Project

Interview Session 2 - March 7, 2002

Interviewer: Lesley W. Brunet
Date: March 7, 2002
Place: Dr. Dodd’s office, University of Texas MD Anderson Cancer Center, Houston, Texas

Lesley Williams Brunet

This is Leslie Williams Brunet, about to record an oral history interview with Dr. Gerald Dodd. This is interview 2 of a series of interviews with Dr. Dodd. The date is March 7, 2002. This interview is being recorded in Dr. Dodd's office, in the eastern main building of the University of Texas MD Anderson Cancer Center in Houston, Texas.

In our first interview, we sort of closed with the -- just before you arrived at MD Anderson. You had told me about your decision. And I'd like you, if you could, to describe the situation in radiology when you got there.

Gerald D. Dodd, MD
[00:50]
What radiology was like here at MD Anderson?

Lesley Williams Brunet
[00:54]
Here. Right. You came in 1955, right?
Chapter: Early work in MD Anderson Radiology Dept and establishment of Diagnostic Radiology section

Gerald D. Dodd, MD
[00:57]
Yeah. Well, the chairman of the department in 1955 was Dr. Gilbert Fletcher, who was a radiotherapist, actually. And he wasn't very interested in diagnostic radiology, except as it impacted on his own service. There were certain types of studies that he required to set his patients up properly and give him the information that he needed about the fields that they were going to use and so on. He cared about it as long as he got those particular procedures promptly and so forth. So I have almost had to start from scratch. Most of the equipment was brand-new, and approximately half of it hadn't been installed yet. It was sitting in crates and so forth on the floor of the diagnostics section. There had been two pieces of old equipment from when the previous temporary quarters moved to MD Anderson's new quarters, but aside from that, there really wasn't much operative. And there was no full-time diagnostic radiologist. I was the first - -

Lesley Williams Brunet
[2:45]
At all?

Gerald D. Dodd, MD
[2:49]
The only people who were working in the apartment were Dr. John McGraw, who was part-time -- he had a private practice as well. And he was head of the section. And Dr. Lois Collins.

Lesley Williams Brunet
[3:11]
Lois Collins?

Gerald D. Dodd, MD
[3:13]
Collins. Who was also part-time. Her husband was chairman of the department of radiology at Baylor, and he also was a radiotherapist. And Lois divided her time between MD Anderson and Baylor. And they were the only two staff people, but there were a couple of fellows, primarily foreign graduates, who helped with the work. I brought with me Robert Egan, who was a resident at Jefferson. He had completed two years at Jefferson. And mainly what he required to finish his training and be eligible for the American Board of Radiology was training in radiotherapy, which -- you couldn't find any better place to do that than MD Anderson.
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**Gerald D. Dodd, MD**
[5:57]
And there just weren't enough staff people for them to take care of business.

**Lesley Williams Brunet**
[6:06]
Why were there not more staff people?

**Gerald D. Dodd, MD**
[6:08]
Well, in 1955 -- this was in August of 1955, and the hospital had only opened in March of 1954. And while it was at the old Baker estate, there really wasn't enough diagnostic radiology to keep one individual busy. And that's how they made -- they just made do with the part-time people.

**Lesley Williams Brunet**
[6:47]
Were they doing some of that work at Herman? Since I know they had patients there.

**Gerald D. Dodd, MD**
[6:51]
No. Originally, when they were the Baker Estate before the estate was remodeled and some temporary buildings were erected, they used to have some beds at Herman that they could use, primarily for surgical patients. But that era had passed.

**Lesley Williams Brunet**
[7:16]
Oh, OK. I thought they still had patients there until '54.

**Gerald D. Dodd, MD**
[7:22]
No. Herman would be quite happy to do certain diagnostic procedures over there that we were not equipped for at MD Anderson, but that was few and far between.

**Lesley Williams Brunet**
[7:37]
OK. So it was just a matter of gearing up... I didn't know whether it was difficult to find diagnostic radiologists, where there was a scarcity of them.

**Gerald D. Dodd, MD**
[7:45]
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[10:20]  
A thousand? (inaudible)  

Gerald D. Dodd, MD  
[10:22]  
Yeah, so it...  

Lesley Williams Brunet  
[10:25]  
My goodness. It did seem like the patient load increased dramatically by, say, '59. At least, that was the impression in the correspondence.  

Gerald D. Dodd, MD  
[10:38]  
It did in the hospital overall, with the total number of patients. In radiology, the increase was a little slow until, I guess, the late '70s, when all of a sudden it just took off. And there are now -- I pointed out the way that there were two of us and one resident, and one of myself: I was really the only full-time staff. There are now something on the order of 75 diagnostic radiologists. And, you know, 15 of that 75 -- approximately 15, I don't remember the exact figure -- but about 15 of them are basic scientists in various research capacities and so on. And so there are somewhere between 55 and 60 radiologists.  

Lesley Williams Brunet  
[11:42]  
And of course radiology has -- diagnostic radiology has really changed also, and --  

Gerald D. Dodd, MD  
[11:47]  
Oh, yes. Yeah. Yeah.  

Lesley Williams Brunet  
[11:49]  
And gotten...  

Gerald D. Dodd, MD  
[11:52]  
No question about that, yeah.  

Lesley Williams Brunet  
[11:54]
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And I'd like you, if you could, to maybe talk about the kind of... the kind of diagnostic tools you were changing -- you were using then. And keeping in mind that some people who read this transcript are not going to be physicians or scientists and might not have a full understanding.
Chapter: Introduction of tomography, new diagnostic tools and procedures

Gerald D. Dodd, MD
[12:16]
Well, when we first arrived, they were equipped to do only what you might call routine examinations: chest, abdomen, bones, and so on. And studies had been done in any hospital for years and years and years. The character of those studies improved, from a technical standpoint, as years passed, in all hospitals. But the basic examination remained the same -- it's just the quality improved. Anderson was different -- only a little bit different in one respect -- and that was the fact that we had a dedicated tomographic unit in the department. With all the special things that might be there, it was sort of an anomaly to see one room occupied by this tomogram alone. Well, that was due to Dr. Fletcher. And he brought with him from France the concept of using tomography extensively in the head and neck areas, and in just about the lungs and so forth. And it was -- it's an examination that requires a little more time than a chest film or a lateral soft tissue film of the neck, which is what most people use for pre-treatment purposes. But the amount of information that you get is far greater and more precise than you get with the conventional films. So a great deal of that was done here at MD Anderson.

Lesley Williams Brunet
[14:20]
And what exactly is tomography?

Gerald D. Dodd, MD
[14:23]
It's simply a method by which the structures overlying and behind an area of interest -- let's see a mass in the lung or a suspected mass. That's the focal point, and the tube revolves around that focal point, which simply means that the area of interest, the focal point, is the only thing that is really focused, and the rest of it is blurred by the motion.

Lesley Williams Brunet
[14:57]
Oh, I see.

Gerald D. Dodd, MD
[14:58]
A radiologic study of the body is, at least at that time, is a two-dimensional representation of a three-dimensional object. And you really can't clearly see many things, because there are all these normal structures that are superimposed on the shadow or point of interest. And that tomographic movement blurs all of that information and just leaves the point of interest much more clearly than you would see it on the conventional film. And we hadn't, at that time, when I came to MD Anderson, there were no facilities at all for doing what were at that time called
special procedures. And that referred mainly to cardiovascular studies, the demonstration of the blood supply of tumors, some actual interventional procedures: by that I mean procedures in which, for example, the blood supply of the tumor was interrupted to allow it to -- it couldn't grow, it would get smaller, and so on. And they also could infuse chemotherapeutic agents through the vessels, so the concentration of the chemotherapy was more directly delivered and the total amount that the tumor received was greater.

Lesley Williams Brunet
[17:00]
And you're using diagnostic tools to pinpoint while they're doing these procedures?

Gerald D. Dodd, MD
[17:03]
Yeah. We would introduce a catheter into the blood vessel, for example, and inject dye which would outline the blood vessel and the ramifications of the blood vessel that supplied the tumor. That was one type of so-called special procedure. Other types were the demonstration of aneurysms, bulges, and the major vessels that needed to be buttressed so they wouldn't blow out or replaced, depending on where they were. The same thing was true for the head, where the intercranial arteries were opacified. And you could tell from the alteration of the position of the vessels in one area or the appearance of a blush, tumor blush which resulted from the dye being within the fine tumor vessels, you could localize tumors and determine whether or not they were operable and where the surgeon would have to operate, so. Some of that was being done, particularly in the head area at that time, by single films. They would inject dye and take a film, let us say, in a lateral projection, or in the (inaudible) projection and so on. But the (serial stud?) is multiple exposures following injection of the material, were not done. And as a matter of fact, during the time that I was first at MD Anderson, we had difficulty in convincing people that those types of examinations had application in the tumor institute. And, of course, funds were at a premium during those days. The equipment to do things like that was expensive. The staff as a whole was not familiar with these type of procedures, didn't really see that they would have any use that warranted spending -- diverting from other places, actually, a lot of money on them. And we finally got what is known as a film-changer, which was a rapid exposure of films, and if I remember correctly, the first change we had was anywhere from one to six exposures per second. And that was fine, but we really didn't have the output, the type of generators and so on, necessary to produce the types of films that we wanted. And above all, we didn't have something that was becoming very, very necessary in the department of radiology, and that was image intensifiers.

Lesley Williams Brunet
[20:43]
Is that -- an image amplifier, is that the same thing? I was going to ask you about that.
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**Gerald D. Dodd, MD**

[20:45]  
That's right.

**Lesley Williams Brunet**

[20:46]  
I was going to ask you about that.

**Gerald D. Dodd, MD**

[20:47]  
And what it simply was, you know, you take a -- you look in a fluoroscope, which is a fluorescent plate that takes a relatively low dose of X-ray, and you can watch movement of organs and dye through blood vessels and so on, and bury them in the stomach, in the colon and whatnot. You can watch those fluoroscopically, but you had to wear dark glasses before you went into the room to adapt your eyes, as they were done --

**Lesley Williams Brunet**

[21:25]  
Oh, for the light.

**Gerald D. Dodd, MD**

[21:26]  
-- in a dark room. And it was still a fairly indistinct image. In fact, residents nowadays, when they see an older radiologist such as myself doing fluoroscopy, they wonder "how does he see anything on that?" Because they really haven't been trained in that particular type of work. But there wasn't any of that amplification equipment available, and finally, I think after I had been here for about five years, we managed to get one five-inch image intensifier that was about that big.

**Lesley Williams Brunet**

[22:10]  
I saw some correspondence on that, and how you were trying to get it, and Dr. Clark suggested that you try for an NCI grant -- a research grant.

**Gerald D. Dodd, MD**

[22:25]  
Yes, he did. And I said that that was standard equipment at NCI: unless we had a particular project that was going to require image intensification used in a unique way, the NCI wouldn't fund it because they expected people to have that type of equipment. And that was a going disagreement between Dr. Clark and myself. He was always very good to talk to. He would listen to you and he understood a great deal about radiology, for example. He understood a great
deal about many things, but he also had financial problems. And they didn't always materialize after he explained what was needed, and to get a grant for that particular thing, whatever it happened to be, might not be too easy. Because before that, it had come into the realm of being expected equipment. So you had to dream up some type of program that would require that particular type of equipment, and you didn't have any interest in that particular program. And you didn't want to be bogged down with it, and so on. But we finally got one.

Lesley Williams Brunet
[23:44]
Is that how you got it, through a grant, or through founda-- or institutional funds?

Gerald D. Dodd, MD
[23:49]
We purchased it just because it was radiologic equipment that was necessary. What we didn't have was a unit to put it on to produce the X-rays that would activate it. And we finally got an old fluoroscopic and radiographic unit from the Air Force surplus. And it worked. It produced X-rays. But it was soon very clear to us why it was surplus. (laughter) And it wasn't very useful at all. And we didn't have any of the ancillary equipment that went with it or anything. And to make a long story short, after I was here for about six years, I said "this is a waste of time," and I said "I can't seem to make people understand what we need and why we need it, and if they do understand, the wherewithal to get it isn't available." And about that time Philip (Protese?), who was a chairman at Thomas Jefferson University, came by for a visit and asked me if I would like to come back to Philadelphia and be chief of diagnosis and head of the resident training program there. And that, of course, was my alma mater and my home and so forth. And that's the way I went, so. And what really occasioned it -- my wife didn't really want to leave. She liked it here in Houston, and part of her family had come from here, as I told you, I think. And she didn't want to go --

Lesley Williams Brunet
[25:51]
It was 1961, right.

Gerald D. Dodd, MD
[25:51]
-- but she was aware of the problems that I had and so on. So we went. And I -- all things being considered, if we had had the type of equipment that we needed, I think I probably would have stayed, but I just got tired of trying to get (inaudible).

Lesley Williams Brunet
[26:15]
Well, I don't -- I have a few questions for before we get to that period, if that's OK.
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Gerald D. Dodd, MD
[26:21]
Mm-hmm.

Lesley Williams Brunet
[26:26]
Along with the imaging application that you just talked about was the high-speed radiographic equipment. What exactly is that? Is this --?

Gerald D. Dodd, MD
[26:40]
Well, in order to get the ultra-short exposures that we needed, we'd have to have equipment that had a high milli-amperage and a high kilo-voltage capability. And that requires pretty potent generators, and we didn't have any of those.

Lesley Williams Brunet
[27:00]
Oh, those were the generators? OK.

Gerald D. Dodd, MD
[27:02]
Maybe you had to leave to get -- come back to get the equipment. Sometimes happens. Just a few other questions before we get to that: obviously, equipment -- the competition for resources for equipment was always tough. What about space?

Lesley Williams Brunet
[27:29]
Essentially, there wasn't any. When we came, the diagnostic department consisted of a section -- it wasn't a department -- shared the second floor of the new building with radiation therapy. And in the center of the department was a reception area that was used both for therapy and diagnostic patients. And one-half of the floor had the diagnostic equipment; the other half had the radiotherapy equipment -- the conventional radiotherapy equipment. The super-voltage equipment, the linear accelerators and the cobalt radiators and so on, they were in the basement downstairs. And they -- but the bulk of the work was done on three corridors that they had there, with two units in each corridor as well as two additional rooms that had superficial therapy units in them. I guess they had a total of eight units on that floor. And that's where most people retreated. They -- across the corridor from the treatment or examining areas were offices. And on the therapy side, there was Dr. Fletcher's office and two areas where he had his secretary and typist. And then there was a next -- another room which was used as a residence. Fellows' headquarters, where they had their mailboxes and some work tables and whatnot. And that
ended the -- that was at the end of the radiotherapy section. There was a corridor that led off into the basic science division, where the physics department was located. And then there were, let's see, one, two, three offices at the opposite end where the diagnostic section was. Three individual offices, a typists' area, and then a double office. And then a small office which is used for the chief technician. So we had the capacity for five radiologists, except that there wasn't any chief technician in that office, there was a therapeutic radiologist and then in the double office there were two therapeutic radiologists. (laughter)

Lesley Williams Brunet
[30:40]
Well, I was going to ask you about this.

Gerald D. Dodd, MD
[30:43]
So that was it. We had three offices, plus a typing area.

Lesley Williams Brunet
[30:46]
Let me just stop this so I can flip the tape.
END OF FILE 1

Lesley Williams Brunet
[00:00]
I was going to ask you about the position of diagnostic in comparison with radiology within the whole department, because just in the correspondence with -- the director's office correspondence with Dr. Clark, certainly Fletcher's predominates. And I just wondered if you had concerns: did everything have to go through Fletcher?

Gerald D. Dodd, MD
[0:32]
Oh, yes. He was chairman of the department.

Lesley Williams Brunet
[0:34]
But you -- but occasionally you seem to deal with Dr. Fletcher directly.

Gerald D. Dodd, MD
[0:42]
Well, Dr. Fletcher, as I pointed out, was interested primarily in radiotherapy. He had been trained in diagnostic radiology as well, but except for the examinations that he needed, he had no
interest in it at all. And he made that perfectly plain to me. And the more that I ran it as a separate department rather than the section, the happier he was.

*Lesley Williams Brunet*
[1:03]
Oh, OK. So he didn't -- he didn't have a problem with that, then.

*Gerald D. Dodd, MD*
[1:07]
No, I hadn't -- in fact, our relationship with Dr. Fletcher was excellent. I liked him and respected him. He was a very, very capable man. But I couldn't ask him -- I could ask him, but nothing much would happen -- to intercede to get us equipment that we needed, or new additional faculty spaces and so on. He had no animus against the diagnostic section; he just was not interested, and he had enough problems of his own and he really didn't want to be bothered. And if he could help without getting embroiled in some sort of complicated case that would take too much time, he would try to be as helpful as he could, but he really didn't know anything about the newer forms of diagnostic equipment and so forth that were required, and just was not interested. So it was pretty much a case of we were on our own without the title.

*Lesley Williams Brunet*
[2:30]
(laughter) Without the title. Something else... You mentioned that you provided diagnostic radiology services at -- well, I don't know if you were the provider, but something about St. Joe's and Herman. How did this work? Were these residents? I mean, what kind of affiliation was it?

*Gerald D. Dodd, MD*
[3:01]
Well, initially -- and I had nothing to do with this; this was in effect before I arrived -- Herman Hospital had its own residency program.

*Lesley Williams Brunet*
[3:11]
That was my understanding.

*Gerald D. Dodd, MD*
[3:12]
And St. Joseph's had their own residency program.

*Lesley Williams Brunet*
[3:15]
Oh, I see.
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**Gerald D. Dodd, MD**
[3:17]
And the residents from both of those institutions rotated through MD Anderson for all or part of their therapeutic radiology training.

**Lesley Williams Brunet**
[3:32]
Just for therapeutic? Not anything for diagnostic?

**Gerald D. Dodd, MD**
[3:34]
That's right. And there was, at St. Joseph's, a radiologist called James Keegan who was one of the senior partners. And it just so happened that Dr. Keegan and I were friends from way back when we were both in the East. And I got together with him, and we arranged for the St. Joe's residents, in addition to their therapy rotations, to take an -- I'm not sure exactly the period; I think it was a three months' rotation in the diagnostic section at MD Anderson. And we also actually made a similar arrangement with Herman with Dr. Luther Vaughn, who was the chairman over there. And we did not have a diagnostic residency as such at MD Anderson, simply because of the type of patients that we had. The diversity of cases was not great enough to train residents. They simply didn't see some things that they must have in order to be fully trained in diagnostic radiology. So we just took these individuals on a residency. Plus the fact that we accepted some people as fellows for a year's training in diagnostic radiology, and in fact that program is still in effect. And I wonder if you'll excuse me for just a moment; I have to take care of something. (break in audio)
Chapter: Early research at MD Anderson and resulting diagnostic procedures

Lesley Williams Brunet
[5:42]
Were you doing research during your first period at Anderson?

Gerald D. Dodd, MD
[5:53]
Clinical research, yes. Not anything that could be termed basic research, no.

Lesley Williams Brunet
[5:57]
What kind of things were you doing -- were you studying? Do you remember?

Gerald D. Dodd, MD
[06:03]
Well, we did a fair amount of work with the tomograph, applying it to things that were particularly necessary in this hospital but had not been explored to any great extent. And then we gradually got into some other clinical studies. There were things called lymphocysts that began to appear in patients who had so-called pelvic exenterations: in other words, radical removal of the pelvic organs, including the lymph nodes. And they would get big collections of lymphs, some of them, in the pelvis. And those collections would obstruct the ureters, for example, or compress the bladder to the point that the patient had considerable difficulty, or the rectum -- whatever other structures that were still there in the pelvis. And we were interested in how they could be diagnosed radiologically. And we did some work on secondary manifestations: in other words, the pressure on the ureters, the pressure on the bladder, and so forth and so on, which was not a direct visualization of them -- it was just inferential. Later on, when we came back, we explored them using an opacification of the lymphatic channels, and we were able to distinguish just exactly what the problem was and how it could be avoided in the future. We also did a series of examinations on jaundiced patients, where rather than -- see, you can't use dye injected intravenously in patients who have liver damage, because that dye is excreted by the liver. It has to be to give a clear picture of the duct system in the liver. And with the liver impaired, the excretion of the dye was so slow that you never got enough opacification to see the ducts. So there was always -- the only way that it could be done satisfactorily at that time was surgically. At surgery they'd put a catheter in and inject the dye and so on. We -- as a result of an article that was published in the American Journal of Surgery, I think it was; it was by two gentlemen from South America, who reported on a series of 35 patients in whom they put a needle into the liver and aspirated until they got bile back, and then they would inject dye. And that outlined the ducts and gave them a great deal of information. And so we thought, well, we might as well try that ourselves. So Melvin Samuels, who was a classmate of mine from Jefferson and a member of the medical staff here at the department of medicine, he and I started
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to see whether we could duplicate this. And we wound up doing some 35 or 40 cases that it turned out was the first series that was ever done in this country. And we reported at the American (inaudible) Society in 1957. We actually didn't give a paper -- we just made an exhibit. And I can remember people looking at me and looking at that exhibit and shaking their heads and whatnot.

Lesley Williams Brunet
[10:48]
(laughter) Yeah, you were smiling as you were telling this story, so I had to wonder. Because they thought it was unusual and didn't...

Gerald D. Dodd, MD
[10:56]
They thought we were going to do somebody in. (laughter)

Lesley Williams Brunet
[10:58]
Yeah, well, I wondered that. (laughter) And...

Gerald D. Dodd, MD
[11:05]
It worked very well.

Lesley Williams Brunet
[11:09]
And did people then start using it more, or...?

Gerald D. Dodd, MD
[11:11]
Oh, it's become a very common procedure, you know? It's been more or less supplanted now, because you can visualize the ductile system of the liver with magnetic-resonance imaging, without any dye and so forth. (coughs) Excuse me, I'm sorry.

Lesley Williams Brunet
[11:36]
It's hard to talk -- (inaudible) bring you some water.

Gerald D. Dodd, MD
[11:42]
But it is -- it's still in the armamentarium of radiologists, and is used sometimes.
Lesley Williams Brunet
[11:50]
Well, I was going to ask you about what were your successes for this period. So it sounds like this would be one of your successes for the six years you're...

Gerald D. Dodd, MD
[12:02]
Oh, yeah. We had -- you know, there are complications that can occur with it, and there are -- we learned as we went along that what we would do if the patient was scheduled for surgery, we would do the procedure immediately before surgery, so that the surgeon had an effective roadmap of what he was going to encounter and what he was going to have to do. That gradually has been supplanted, because we, I think, also were the first ones to do this. We threaded a catheter through the needles and left the catheter in, and there was external drainage in the duct system. And it obviated most of the problems that you would have, which was -- mostly the difficulties would come from bioleakage. And we learned eventually that if we could decompress the duct system, we could probably -- we didn't have to put a catheter in; it would seal itself off before it reached a point of distension where it would be a problem. And the presence of a catheter, of course, did away with that entirely. There could be problems also associated with a catheter. You could get an infection around the catheter if you left it too long, and that applies to virtually any long-positioned catheter. But it... it was a worthwhile procedure, and it just was waiting for someone to do it, and thanks to the two gentlemen in Argentina, I... Actually, the first one that was ever done was at Cornell University Hospital in New York. It was one case, and it was reported in the Journal of the American Medical Association about, oh, 1952 or '53 -- somewhere around there.

Lesley Williams Brunet
[14:12]
But you did a large number, didn't you say?

Gerald D. Dodd, MD
[14:16]
But nobody ever repeated that until these two individuals in Argentina did.

Lesley Williams Brunet
[14:26]
Were there other research or clinical issues that you worked on during that first period that were as successful as that?

Gerald D. Dodd, MD
Oh, sure. Yes. The spread of tumors along the nerve roots: everybody knew that some tumors would spread along the nerves, but there wasn't any way to do a diagnosis other than suspecting
that clinically, because of numbness or pain -- there was no way to tell how extensive it was, and what would be required at surgery would be you'd just have to do serial sections of the nerve until you didn't find any more tumor cells. And we were able to demonstrate that in certain of these, you could detect, diagnose, the presence of tumor within the nerves and get a fair approximation of the amount of involvement that was present by demonstrating erosion of the bone around the -- in the head and neck, this is -- erosion of the bone around the individual nerves. For example, the foramen, and one of them would be enlarged, and fortunately, you have another one to compare it with, so you could do that to make the diagnosis.

Lesley Williams Brunet  
[16:00]  
It sounds like you were working closely with surgeons especially a lot of the time.

Gerald D. Dodd, MD  
[16:05]  
Yup.

Lesley Williams Brunet  
[16:06]  
Is that just standard for that?

Gerald D. Dodd, MD  
[16:06]  
(Overlapping dialogue; inaudible) -- the GYN surgeons for the lymphocysts, and the (transopatical?) angiograms, where, as I said, we worked with Mel Samuels, who was an internist, but the surgeons helped by doing -- scheduling the procedures with respect to when they were going to operate and so forth.

Lesley Williams Brunet  
[16:33]  
I read in... I think it was this short piece on you when you received the Distinguished Physician Award or something... something like that. And it said that initially you specialized in gastrointestinal cancers and stuff like that, and then (inaudible) you moved into breast cancer. What are the origins of that special interest?

Gerald D. Dodd, MD  
[17:02]  
Well, from the GI standpoint, gastrointestinal work... I suppose you could just say we kind of grew into it because our chief at Jefferson when I was a resident was very interested in gastrointestinal work. And just working with him, I got interested in it. And like Topsy, it just rode. (laughter) The breast work was another case entirely, and that's a very long story.
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Lesley Williams Brunet
[17:48]
Do you want to save that until we get to that part in your career?

Gerald D. Dodd, MD
[17:50]
You might as well, because there's a lot of ins and outs with it. (laughter)

Lesley Williams Brunet
[17:56]
Well, there's a lot to talk about there, and I do want to go into it in pretty much detail, and I don't want to take too much time.

Gerald D. Dodd, MD
[18:00]
Sure.
Chapter: Dodd’s Observations of Dr. R. Lee Clark

Lesley Williams Brunet
[18:02]
Let me ask you about some more of the people. I mean, I think we touched on whether you had met Dr. Clark in the first interview, but let's talk a little more about your relationship with Clark or what you observed about Clark in the early years.

Gerald D. Dodd, MD
[18:25]
Well, he was very, very much inclined to be down-to-earth, and in discussions get to the point of the matter, and discuss them in a reasonable and intelligent way. He never -- I never had an argument, if you will, with him, or a cross word, for that matter. I enjoyed talking with him. And I was continually impressed by the breadth of his knowledge. He knew what was going on everywhere in this institution. He had a grasp of who was doing what, why they were doing it, and whether or not they were doing anything at all. He was well aware of that, and he would act accordingly. There was one thing about him that you got to realize after you knew him for awhile: he was a very loyal person, as well. And to dismiss somebody from his institution, you really had to do something that was greatly out of line. And if somebody was not really meeting their potential and so on, they may wind up in an insignificant position, but there wouldn't be any real attempt to punish them in any way or get rid of them. I mean, he would just let his displeasure be known by more or less keeping them out of the swing of things until they either decided that they'd better get back to work or they'd best go someplace else. So I said that I gave up trying to get this equipment, and I finally returned to Philadelphia, but that was really in some ways a premature decision on my part. Like many of the newer people at this institution, I had no real appreciation of what Clark and some of the people who were here first had gone through -- the effort that had been made to establish the fact that there was going to be this type of hospital in the University of Texas system. And the difficulties in getting adequate funding, and the difficulties in dealing with the private people in private practice who resented government intrusion; the difficulties in finding people who were competent to head an institution like this, or departments in an institution like this, and who could see beyond what was available at the time, which, of course, was the whole Baker Estate to begin with. And finally when they moved into this beautiful building, nothing was in it in terms of equipment in many places. (laughter) And so I suppose what I'm really saying is that if I had really been more analytical about it and was able to compare what had been accomplished to what was in a relatively short period of time, then his expectations, his castles in the sky, wouldn't have been so and-if-or-butts. They were going to come about, given his continued health and so on. And they did. It was an amazing performance, really. And I have nothing but respect for him. And there's another thing that had always impressed me, and I mentioned in that book I'm working on, is that then and now, there's always friction to some extent between the so-called hospital specialties and the hospital administration. And the reasons for that are varied, but what it all boils down to usually is that
radiology departments, anesthesiology, pathology, and so forth are income-producers, and hospitals are usually operating on a very thin margin. And the income generated by those departments is a very great attraction to those administrators who are looking for money to put into areas of the hospital that are not as profitable as they might be. And radiology, pathologists, and so forth were always resisting that because -- not for personal income, but for expanding and equipping their departments and keeping them up to date and so forth and so on. And I had had several personal experiences with that, when I was at Jefferson and when I was also looking around to decide where I was going to go when I left there. And Dr. Clark and I talked about what was needed -- and particularly when I came back here the second time -- what was needed, what I expected, and what he expected. And we had a very comprehensive, complete understanding, and then we shook hands. And there was not one word put down on paper. And I never had any real complaints about that in the future. If he could possibly do it, he would keep his word.

Lesley Williams Brunet
[25:47] I imagine things have changed -- not just here, but everywhere. That "your word is your bond" doesn't carry the same weight.

Gerald D. Dodd, MD
[26:02] Oh, no. That seems to be a day in the past, yes. Yeah.

Lesley Williams Brunet
[26:10] And how did Dr. Clark get on with Dr. Fletcher?

Gerald D. Dodd, MD
[26:15] Dr. Clark?

Lesley Williams Brunet
[26:18] With Fletcher?

Gerald D. Dodd, MD
[26:20] Oh... Dr. Fletcher came here on his own hook. He had heard about this institution and he had -- he was in the service at the time, and he wanted to work in a cancer hospital. His interests had gravitated completely to radiotherapy, and he, through some connections -- Mrs. Fletcher was from Mississippi, and there was a connection which I don't remember entirely, but they knew
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people in Houston and so on. And they heard about this place, and he just showed up at Clark's office one day and introduced himself. And they got talking, and he impressed Clark with his enthusiasm and with the fact that he felt that the radiotherapy that was being done in Europe, of all places, despite the war, was superior to that being done in the United States. And the end result of all of this was that Fletcher was being made a traveling fellow, and went to Europe for the better part of a year. And went to all of the radiotherapy centers on the Continent and in England and so on. And sent back all of their treatment protocols, all of the plans of the hospitals, their thinking and why they did this, that and the other thing with respect to the physical plant and their treatment policies -- all of which were a great help in the organization and this hospital, specifically to radiotherapy.

Lesley Williams Brunet
[28:26]
I wish we had those records today. I wish we had those papers, those... that would be fascinating.

Gerald D. Dodd, MD
[28:36]
I don't know, by the way -- have you heard of Mary Walker?

Lesley Williams Brunet
[28:43]
Oh... that name does sound familiar.

Gerald D. Dodd, MD
[28:45]
Well, Mary Walker is a radiologic technician who became the chief technician in radiotherapy, and eventually, beyond that. She went to England for the better part of a year as a Fulbright Scholar and came back and established the training program for radiotherapy technicians in this hospital. And she became sort of Dr. Fletcher's right hand. She really took care of the administration of the department and many things like that. And it may be that Mary has some of this material. You might get in touch with her.

Lesley Williams Brunet
[29:43]
So is she still around?

Gerald D. Dodd, MD
[29:45]
Yes, she is.
Lesley Williams Brunet  
[29:46]  
France. I'll try and track her down. I know that there were some Fletcher materials that were lost during the last June flood, because of this radiotherapy flood...

Gerald D. Dodd, MD  
[29:59]  
But she may have them, so you may want to...

Lesley Williams Brunet  
[30:01]  
France. Another person I wanted to ask you about was Grimmett.

Gerald D. Dodd, MD  
[30:05]  
Grimmett?
Chapter: Drs. Fletcher and Grimmett and first cobalt irradiator

Lesley Williams Brunet
[30:07]
France hmm.

Gerald D. Dodd, MD
[30:08]
Well, he was a find of Fletcher's while he was on a sabbatical. He was a physicist in Great Britain. I forget where he was at the time that Fletcher was making his tour; he may have met him on the Continent, in France or something like that. But he was from a major radiotherapy center in London. And --

Lesley Williams Brunet
[0:00]
You said Grimmett was working on developing a --

Gerald D. Dodd, MD
[0:04]
A radium irradiator. In other words, to build an irradiation unit that, instead of using X-rays created with generators and Coolidge tubes and all of that, just took a chunk of radium, and that was the source of the beam. And of course, it was an entirely different composition in the X-rays that were generated from the tube, in terms of its -- their penetration ability and so on. He got talking with Fletcher, and they concluded that it would probably be a lot cheaper and more readily obtained if they took some cobalt and did the same thing with it. And he communicated this to Clark and the need for a physicist to help with establishing a proper radiotherapy division, and Clark authorized him to try and recruit Grimmett. And he did, successfully. And they returned here, and Grimmett and Fletcher, between them, designed the first cobalt irradiator. And unfortunately, Dr. Grimmett died prematurely, but he was, no question about it, he was a major cog in that process.

Lesley Williams Brunet
[2:15]
Although they seemed to have a fiery relationship?

Gerald D. Dodd, MD
[2:17]
I can't tell you that. I don't know.

Lesley Williams Brunet
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[2:19]
Oh. Just from the correspondence there seemed to be... and I didn't know what -- you know, I was just wondering what that was.

Gerald D. Dodd, MD
[2:24]
I know of only one thing that they collaborated on, which was -- I mean, aside from the irradiator -- was that Grimmett felt that the radiotherapy department must have a well-developed physics section, and that the physics section must have a well-developed machine laboratory. And he told Fletcher this, and Fletcher said, "Well, just draw up a list of what you need," and he did, which amounted to about $50,000 worth of equipment. Now, this was in 1946, '47, somewhere in there -- dollars, so that was a lot of money. And Clark was really taken aback. In fact, Grimmett decided, after he looked at the list and talked to Fletcher, that maybe Fletcher had better present that to Clark and not himself. And they had some go-rounds about that, but eventually Fletcher convinced Clark, and Clark said "Well, I'll find the money somewhere." And that still exists on the basement floor of the original building here. It's not the original area where it was located, but this extensive machine shop that not only worked with radiotherapy but produced specialized equipment for many departments: they developed, for example, a cardiopulmonary bypass unit for...

Lesley Williams Brunet
[4:13]
Do you want me to stop this?

Gerald D. Dodd, MD
[4:14]
Oh, ask him if he would like to go, yes. (break in audio) We're about done, so.

Lesley Williams Brunet
[4:21]
I'll go ahead and wrap this up. The only other thing I really wanted to talk about before you went off back to Jefferson was the residency program. And I wondered if the problems in developing the residency program was a reason for you returning to Jefferson as well.

Gerald D. Dodd, MD
[04:39]
No, no.

Lesley Williams Brunet
[4:40]
No?
Gerald D. Dodd, MD
[4:40]
No. I had missed the residency, the training; I had always enjoyed it, but that had no great... you know, the lure of being in your own medical school is a very potent thing.

Lesley Williams Brunet
[5:01]
I understand.

Gerald D. Dodd, MD
[5:02]
And I had left Jefferson because Dr. Swenson, my chief, had gotten crosswise with the administration. And, as I think I told you, a whole group of us resigned.

Lesley Williams Brunet
[5:18]
Right. A large group.

Gerald D. Dodd, MD
[5:20]
And actually, I was offered that position about a month after we resigned, and I said absolutely no. In the first place I'm too young, and in the second place, certain people have done certain things and I didn't want to be associated with them. And I tell you that simply because they had gone, and Jefferson had seen the error of its ways, and radiology had a brand-new department and a very, very well-developed residency program. And just the combination of the difficulties I was having here plus the opportunity to go back to Jefferson with so many friends and whatnot, and also the fact that our position had been vindicated by the changes that were made... it was sort of irresistible. So, yeah.

Lesley Williams Brunet
[6:28]
So why don't we stop -- next time we'll talk about why you decided to return to Anderson, and then we have a really big story to tell, because so much has happened.

Gerald D. Dodd, MD
[6:40]
OK. That'll be fine.

Lesley Williams Brunet
[6:41]
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Thank you.

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