

# **Dr. Norman Jaffe, M.D.**

Interview #13

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## **Dr. Norman Jaffe, M.D.**

Interview #13

### **Interview Profile**

#### **Interview Information:**

Three interview sessions: 20 April 2012, 17 August 2012, 31 August 2012  
Total approximate duration: 3 hours 30 minutes  
Interviewer: Tacey A. Rosolowski, Ph.D.

For a CV, biosketch, and other support materials, contact:

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

Dr. Norman Jaffe (b. 25 September 1933, Johannesburg, South Africa) came to MD Anderson in 1978 to become Chief of the Section of Solid Tumors in the Department of Pediatrics. His research has focused on clinical treatments for solid tumors, the long-term effects of chemotherapy and radiation therapy on developing bodies, and the psychosocial challenges of long-term survivors. From 1992-'94 he served as Chief of the Pediatric Outpatient Clinic and from 1996-2000 he was Chief of the Long Term Surveillance Clinic for Pediatric Patients Cured of Cancer. Dr. Jaffe retired in 2006 and holds the title of Professor Emeritus of Children's Cancer Hospital at MD Anderson Cancer Center.

#### **Major Topics Covered:**

Personal and educational background

Working with Dr. Sidney Farber at the Sidney Farber Cancer Institute in Boston

Cancer in pediatric patients; "total care" of pediatric patients; special challenges

Research: solid tumors, osteosarcoma, eradicating metastasis with methotrexate

The Department of Pediatric Oncology: history and evolution

Pediatrics and survivorship

Long-Term Surveillance Clinic

Ski Rehabilitation Program

International collaborations

**University of Texas MD Anderson Cancer Center  
Making Cancer History Voices® Oral History Project**

**Research Medical Library: Historical Resources Center**

ORIGINAL Interview Profile: Dr. Norman Jaffe, M.D.  
Submitted by: Tacey A. Rosolowski, Ph.D.  
Date: 7 September 2012

This interview with Dr. Norman Jaffe (b. 25 September 1933, Johannesburg, South Africa) takes place over three sessions in 2012 for a total of 3 hours and thirty minutes. Dr. Jaffe is a hematologist oncologist and a specialist in pediatric cancer and today hold the title of Professor Emeritus (Pediatrics) of Children's Cancer Hospital at MD Anderson Cancer Center in Houston, Texas. Dr. Jaffe joined MD Anderson in 1978 as a Professor of Pediatrics in the Department of Pediatrics. He also served as Chief of the Solid Tumor Service; prior to his retirement he was also Chief of the Long Term Surveillance Clinic for Pediatric Patients Cured of Cancer. He retired in 2006. This interview takes place in the Historical Resources Center Reading Room in Pickens Tower on the main campus of MD Anderson. Tacey A. Rosolowski, Ph.D. is the interviewer.

Dr. Jaffe received his M.D. (MBCCh) in 1956 from the University of the Witwatersrand Medical School, in Johannesburg, South Africa. He interned Coronation Hospital, Johannesburg ('57) and did his residency ('58) at Baragwanath Hospital, where he went on to work as teaching resident from 1959-'61. From 1966-'67 he was a Fellow in Tumor Therapy at the Sidney Farber Cancer Institute in the Harvard Medical School and also a Fellow in Pediatrics at the Children's Cancer Research Foundation and Harvard Medical School ('66-'71). In 1971 he became an Assistant Prof of Pediatrics at that institution, advancing to Associate Profess in 1974. He became Chief of the Pediatric Solid Tumor Service at the SFCl in 1976. In 1978 Dr. Jaffe left Harvard to become Chief of the Section of Solid Tumors in the Department of Pediatrics at MD Anderson. From 1992-'94 he served as Chief of the Pediatric Outpatient Clinic and from 1996-2000 he was Chief of the Long Term Surveillance Clinic for Pediatric Patients Cured of Cancer.

In this interview, Dr. Jaffe traces his lifelong work with the "total care" of pediatric cancer patients: he has focused broadly on research to find clinical treatments for solid tumors, to investigate the long-term effects of chemotherapy and radiation therapy on developing bodies, and to address the psychosocial challenges that long-term survivors face. He has nurtured connections with physicians globally in order to ensure that his discoveries benefit the treatment of children in many nations. This interview offers a wide ranging history of Dr. Jaffe's career and commitment. It also offers a portrait of his relationship with Dr. Sidney Farber during the time he worked at the Sidney Farber Cancer Institute in Boston. Dr. Jaffe offers insights into the history of the Department of Pediatrics at MD Anderson and offers observations on the first three presidents of the institution, with whom he worked fairly closely. Dr. Jaffe also discusses how treating cancer in children is both very gratifying and devastating: the loss of a life just beginning is always tragic, and a severe illness always has long-term effects on the child who survives, as well as his/her family.

## **Dr. Norman Jaffe, M.D.**

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## Dr. Norman Jaffe, M.D.

Interview #13

### Segment Summaries

Session One: 20 April 2012

Segment 00A  
*Interview Identifier*

Segment 01  
*Cancer in Pediatric Patients*  
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Story Codes  
A: The Clinician  
A: Overview  
A: Definitions, Explanations, Translations  
C: Human Stories  
C: Patients  
C: The Professional at Work  
C: Offering Care, Compassion, Help  
D: The Life and Dedication of Clinicians and Researchers

In this segment, Dr. Jaffe provides sketches the problem of treating cancer in children, a disease with dramatic effects on all family members. He concludes this brief (seven-minute) section with the statement that cancer in children is tragic because “children are our most precious commodity.”

Segment 02  
*A Clinician Who Seeks Broad Knowledge and Connections with Patients*  
A: Personal Background

Story Codes  
A: Character, Values, Beliefs, Talents  
A: Personal Background  
A: Inspirations to Practice Science/Medicine  
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C: Faith, Values, Beliefs  
C: Evolution of Career  
C: Formative Experiences  
C: Experiences of Injustice, Bias  
C: Faith, Values, Beliefs

C: Offering Care, Compassion, Help  
C: Patients  
A: The Clinician  
C: Funny Stories

In this segment, Dr. Jaffe describes his family life and education in Johannesburg, South Africa. He expresses his gratitude to his parents, who ensured that he (and five siblings) got a good education, despite the family's modest means. He also speculates that his caretaking role as the oldest child pointed him toward pediatrics, though he took the opportunity to rotate through all four specialties to round out his experience once he qualified as a physician. He talks about his roles (residency and Chief of Pediatrics) at Bagwanath Hospital for Black South Africans, where he had broad experience of diseases. When asked, Dr. Jaffe confirms that he was deeply affected by Apartheid in South Africa, noting that as a Jew, he felt compassion for the persecuted Black South Africans. He also briefly describes how other Jewish doctors were involved in anti-Apartheid activism. Dr. Jaffe next describes his commitment to working with his patients, noting his insistence over the years that he be called anytime a patient died so he might comfort the parents and assure them they could not blame themselves for their child's death. Medicine, he notes, is "a hard mistress."

#### Segment 03

##### *Working for Sidney Farber*

A: Professional Path

##### Story Codes

A: Professional Path  
C: Funny Stories  
C: Evolution of Career  
D: Understanding Cancer, the History of Science, Cancer Research  
C: Portraits  
A: Influences from People and Life Experiences  
A: The Administrator

In this segment, Dr. Jaffe discusses his move to the U.S. and his roles at the Stanley Farber Cancer Institute (Fellow in Tumor Therapy) and the Children's Cancer Research Foundation (Fellow in Pediatrics). Dr. Jaffe was disappointed to discover no real fellowship program under Stanley Farber. He was also distressed by the state of treatment for cancer and had not desire to treat dying children. He tells an anecdote about Farber blocking him from resigning his fellowship. He describes Stanley Farber's character and his strategy of moving Dr. Jaffe into administration. Dr. Jaffe very candidly says that Farber "took advantage" of him and he felt locked in the "vice" of the job, though he and Farber became close over the years. This section closes with his recollections of testifying in the House and Senate on behalf of funding for the Children's Cancer Research Foundation on Farber's death.

#### Segment 04

##### *An Important Contribution to Treatment: Eradicating Metastasis with Methotrexate*

A: The Researcher

##### Story Codes

A: The Researcher

A: The Clinician  
A: Influences from People and Life Experiences  
A: Professional Path  
C: Formative Experiences  
C: Discovery, Creativity and Innovation  
C: Discovery and Success  
C: Professional Practice  
C: The Professional at Work

In this segment, Dr. Jaffe talks about building upon Dr. Farber's work with methotrexate to treat pulmonary metastases from osteosarcoma. He first reviews Dr. Farber's work with Wilms' Tumor and the discoveries that led him to his own research on treating metastasis. He also reveals that he went into oncology because he had no choice at the time, working with Dr. Farber. Next Dr. Jaffe talks about osteosarcoma. At the time there was no treatment for osteosarcoma but amputation. Dr. Jaffe describes the process of discovering how to eradicate the metastasis with high doses of methotrexate combined with leukovorin to mitigate high-dose toxicity –still a recognized treatment. Dr. Jaffe asserts that this work represents his greatest contribution to the treatment of pediatric cancers.

Segment 05

*MD Anderson and The Department of Pediatric Oncology in the Late Seventies*

B: MD Anderson Past

Story Codes

A: Professional Path  
A: Personal Background  
B: MD Anderson History  
C: Portraits  
A: The Leader  
D: On Leadership  
B: MD Anderson Culture

In the last twenty minutes of this session, Dr. Jaffe talks about his decision to leave the Farber Institute and his recruitment to MD Anderson in 1978 to replace Wataru Walter Sutow, who was retiring as Chief of the Section of Solid Tumors. He was also to step in as a new Chief of the Long Term Surveillance Clinic for Pediatric Patients Cured of Cancer and to develop the service along the lines of a similar program created at the Farber Institute. (He describes how he maintained an enduring relationship with the latter service's Chief at the time, Dr. Hugh Ried.) In this section Dr. Jaffe tells some funny anecdotes about the people he met at MD Anderson; he comments on the leadership styles of Dr. Charles LeMaistre and Dr. John Mendelsohn.

Interview Session Two: 17 August 2012

Segment 00B

*Interview Identifier*

Segment 06

*Survivorship: A New Section of Pediatrics I*

B: Building the Institution

Story Codes

A: The Clinician

A: Joining MD Anderson

A: Influences from People and Life Experiences

A: The Researcher

A: The Clinician

A: Contributions

B: Building/Transforming the Institution

A: Definitions, Explanations, Translations

In this segment Dr. Jaffe explains that he was recruited to MD Anderson to replace Dr. Wataru Walter Sutow because of his deep experience in pediatric oncology. He also notes that he left Harvard because of the limited opportunities for promotion.

Segment 07

*Survivorship: A New Section of Pediatrics II*

A: Contributions to MD Anderson

Story Codes

A: Joining MD Anderson

A: Influences from People and Life Experiences

A: The Researcher

A: The Clinician

A: Contributions

B: Building/Transforming the Institution

A: Definitions, Explanations, Translations

Dr. Jaffe explains that he was recruited to MD Anderson to expand the solid tumor section in the Department of Pediatrics and to develop new initiatives to work with survivors of childhood cancer, based on his previous work at the Dana-Farber Institute. He lists complications that patients develop after cancer treatment: reproductive issues, effects on growth and cognitive function (for children given head and neck treatments). He notes that the new survivorship initiative at MD Anderson produced twenty publications, and that it was a unique entity, an entirely new section of pediatrics.

Segment 08

*Solid Tumors and the TIOS Protocols (Treatment and Investigation of Osteosarcoma)*

A: The Researcher

Story Codes

A: The Researcher

A: Definitions, Explanations, Translations

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

C: Discovery and Success

## C: Healing, Hope, and the Promise of Research

In this segment, Dr. Jaffe describes one of his major roles as Chief of the Solid Tumor section in Pediatrics: establish new protocols for treatment of cancers in children. He notes that this was an assignment he was given by the Department, but also one he assigned to himself. His main work was in the treatment of osteosarcoma. He named his series of protocols TIOS (Treatment and Investigation of Osteosarcoma), and developed three protocols before shifting focus to support a colleague's study of a promising drug. He then goes on to give more details on the TIOS protocols, which used three main drugs for treating osteosarcoma. The first protocol used high-dose methotrexate, and Dr. Jaffe explains that the treatment—and its results—were not accepted at first. He says that “it is almost as if doctors couldn't accept that osteosarcoma could be cured.” With the protocols he has designed, he explains, survivorship has increased from about 20% to 65%, and when his protocols are combined with multidisciplinary interventions the survivorship increases to 75-80%. He explains why no progress has been made beyond that point. Dr. Jaffe gives more detail on his procedure: they rely on intra-arterial drug delivery to destroy the sarcoma at its site—an essential step in limb salvage procedures.

### Segment 09

#### *The Chiefs of Pediatrics at MD Anderson*

#### B: An Institutional Unit, Program

#### Story Codes

C: MD Anderson Past

A: The Administrator

B: Institutional Politics

B: MD Anderson and Government

B: Critical Perspectives on MD Anderson

At the beginning of this segment, Dr. Jaffe explains that when he began as Chief of the Solid Tumors section, he had responsibility for musculoskeletal tumors, Wilm's tumors and a number of others, including neuroblastoma, which he eventually ceded to a colleague. As a leader, he notes, he believes that “if you are doing a good job, continue,” and he is very proud that the Solid Tumor section “ran like a well-oiled machine.”

Dr. Jaffe then describes the sequence of Chiefs of Pediatrics, beginning with the first chief, Grant Taylor, who developed a comprehensive pediatric department, focusing on clinical initiatives and benchwork. He continued to check in on the progress of the Department after he retired and Dr. Jordan (Dan) Wilbur took over. Dr. Jordan is known for the VAC (vincristine, actinomycin, cyclophosphamide) chemotherapy protocol for soft tumors in children that has not changed in the past forty years. Dr. Jan Van Eys took over from Dr. Wilbur and brought a different outlook. This was when Dr. Jaffe was recruited: Dr. Van Eys enhanced the solid tumor section. He also focused on the psychosocial and religious aspects of patient care. He believed religion was a major mechanism of support for patients. Dr. Pat Sullivan was Chief for one year, then Dr. Ka Wa Chan served as interim director for 5 years, until Dr. Archie Bleyer took over and attempted to change the department in ways that Dr. Jaffe feels were not well received. Dr. Eugenie S. Kleinerman then assumed the position of Chief of Pediatrics and enhanced investigation of sarcoma. Dr. Jaffe notes Dr. Kleinerman's laissez-faire approach toward department members who are performing well. He then talks about the areas in which

the Department of Pediatrics has made particular contributions to pediatric oncology, going into particular detail about value of conventional therapeutic therapies and the rapid, intra-arterial deliver of chemotherapy developed by the Department.

Segment 10

*The Ski Rehabilitation Program*

B: Building the Institution

Story Codes

A: The Clinician

A: The Administrator

A: Contributions

B: Building/Transforming the Institution

C: Offering Care, Compassion, Help

C: Patients

C: Human Stories

In this segment Dr. Jaffe speaks in detail about MD Anderson's Ski Rehabilitation Program, an innovative initiative run yearly in Winter Park, Colorado, to build the long-term confidence and competence of amputees. He describes criteria for selecting the patients for the first week-long program (health mattered more than age), as well as the decision to have a parent accompany each child. Parent participated in conferences during the week, providing MD Anderson staff with their evaluation of their child's treatment. The main problems mentioned were communication and the timing of treatments, and Dr. Jaffe notes that this information was valuable in improving patient care. The costs of the trip for the children and parents were funded by MD Anderson. Later the trips were funded by the Children's Art Project. Dr. Jaffe notes that there are not enough funds for the 2013 trip, but many parents and children are paying their own way, because the trip is so important for them. Dr. Jaffe also describes the effects of the week long experience on the children –notably a dramatic increase in their sense of "prowess." He also goes into detail about the activities provided and how these have changed over the years to include one-on-one training, races, and prizes. He reports that children who have participated in this program mainstream easily, and have gone on to become very successful. (Ten have become physicians.)

Segment 11

*A Satisfying Career and Children who are Physicians*

A: View of Career and Accomplishments

Story Codes

A: Career and Accomplishments

A: Personal Background

D: The Life and Dedication of Clinicians and Researchers

C: Patients

Dr. Jaffe looks back at a very satisfying career at MD Anderson (though he originally wanted to be a surgeon). He explains why his sons and his daughter chose not to go onto oncology. He expresses his deep regret at the patients he lost over the years.

Session Three: 31 August 2012

Segment 00B

*Interview Identifier*

Segment 12

*The Long-Term Surveillance Clinic*

B: An Institutional Unit

Story Codes

B: Building/Transforming the Institution

C: Patients

C: Professional Practice

C: The Professional at Work

D: The History of Health Care, Patient Care

B: MD Anderson History

B: MD Anderson Snapshot

B: Institutional Mission and Values

B: MD Anderson Culture

In this segment, Dr. Jaffe talks about his work with MD Anderson's Long Term Surveillance Clinic. The Clinic was already in existence when he came to MD Anderson in 1978, however he was recruited in part to expand the Clinic, based on his experience with a similar unit at the Dana-Farber Cancer Institute (established in '72/'73). (Dr. Jaffe wrote the first paper on radiation and survivorship [published in '75] and he suspects this was instrumental in the creation of a number of survivorship clinics.) He notes that with the use of radiation and chemotherapy, the numbers of pediatric cancer survivors grew exponentially, and they also exhibited many complications from their treatments. The Clinic monitored all the complications and referred patients to the service that could address them. Dr. Jaffe then talks about the many people involved in the Clinic. When Dr. Jaffe arrived, Dr. Hubert Ried directed the Clinic with the assistance of nurse practitioner, Hallie Zietz (whom he describes as "the heart and soul" of the Clinic). The three of them worked together to expand services and write papers. Dr. Jan Van Eys, he explains, was an advocate of monitoring nutrition in survivorship. He explains why nutrition is an issue and how his experience with patients with such afflictions as kwashiorkor in South Africa sensitized him to malnutrition in cancer patients. Dr. Jaffe also credits Dr. Van Eys with establishing psychosocial support as a key element in the survivorship clinic. Donna Copeland was Chief of Psychosocial Services. Dr. Jaffe gives several examples of the kinds of challenges children face. He also explains that Dr. Van Eys developed the position of the Child Life Worker to help children adjust. He describes the role of the Child Life Worker—who might, for example, go to a child's school to sensitize other children to why a cancer survivor might not look like other children or might have some kind of disability. This kind of support role owes a great deal, Dr. Jaffe explains, to Dr. Sidney Farber's concept of total care. He talks about how pediatric patients are dealt with differently now than in the past: for example, efforts have to be made now to obtain a child's permission for treatment, and he gives examples of how a procedure might be explained to a very small child of four or five. He also returns to the example of the Ski Program, run through the Survivorship Clinic, and notes that

the video, *Amputation is no Barrier*, was produced to showcase the Ski Program and the activities it offered to survivors.

### Segment 13

#### *Building Collaborations and Treating Patients from Around the Globe*

B: Beyond the Institution

#### Story Codes

B: Beyond the Institution

A: The Clinician

A: The Administrator

C: Professional Practice

C: The Professional at Work

C: Collaborations

C: Leadership

C: Patients, Treatment, Survivors

Dr. Jaffe quips that when he realized he wasn't going to win the Nobel Prize he began to turn his mind to how to ensure that what he had learned about treating pediatric sarcoma and survivorship would be passed on. In this segment he speaks about the many collaborations he has sustained with physicians internationally over the last fifteen or twenty years. For the past ten years, for example, he has helped physicians in many cities in Mexico establish programs for solid tumors and survivors. Many hospital programs in different nations in South America have requested his expertise. He has many contacts across Europe, has been involved in EURAMOS, the European and American Osteosarcoma Study group, and for the past fifteen years has sustained contacts in Germany, Norway and Sweden. He tells an interesting anecdote about hosting several doctors from Slovenia who contacted him about coming to observe practices at MD Anderson. Dr. Jaffe hosted them at his home during their visit of 6-8 weeks. One physician noticed how many surgical instruments MD Anderson discarded, and it was arranged that she could take home a crate of instruments for use in their hospital. In another anecdote, Dr. Jaffe describes he was invited to Egypt several times and then asked by an ambassador to write a report about the poor treatment for cancer in that country. That document resulted in the creation of the Friends of Egyptian Children with Cancer group, which hosts various fundraisers to provide children with improved care. [redacted] In another anecdote, Dr. Jaffe talks about his hesitancy to accept an invitation to Saudi Arabia because of his (Jewish) faith. He was very impressed at his treatment, however, and surprised that they offered him a position.

### Segment 14

#### *Healing Children: An Emotionally Complicated Task*

A: View on Career and Accomplishments

#### Story Codes

A: Character, Values, Beliefs, Talents

A: Faith

A: The Clinician

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients

In this segment, Dr. Jaffe reflects on the fact that he has practiced medicine for fifty years, finding the career both enjoyable and devastating. He reflects on the opportunities he has had to train many talented individuals, most of whom have succeeded in their fields. He explains that his own faith has been important in shaping his attitudes toward his work, citing the sanctity of life in the Jewish faith. He ends this segment by paraphrasing a Talmudic expression that counsels never to deprive any individual of mercy.

## Norman Jaffe, MD

Interview Session 1— April 20, 2012

### **About transcription and the transcript**

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language.

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

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

### **Chapter 00A**

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

***Tacey Ann Rosolowski, PhD***

**0:00:00.0**

This is Tacey Ann Rosolowski interviewing Dr. Norman Jaffe whose specialty is pediatric—I should say this a little different—who is a pediatric hematologist oncologist and a specialist in pediatric cancer. Dr. Jaffe is Professor Emeritus of Children’s Cancer Hospital at the University of Texas MD Anderson Cancer Center in Houston, Texas. He was a professor of pediatrics in the Department of Pediatrics from 1978 until his retirement in 2006. Prior to his retirement, he was [served as chief of the solid tumor service and] also the chief of the long-term surveillance clinic for pediatric patients cured of [the] cancer. This interview is being conducted for the “Making Cancer History Voices” Oral History Project run by the Historical Resources Center at MD Anderson, and the interview is taking place in the Reading Room of the Research Medical Library in the Pickens Academic Tower on the main campus of MD Anderson. This is the first of our planned sessions together. Today is the 20th of April, 2012, and the time is 10:40. Thank you, Dr. Jaffe, for devoting your time to this interview and to the oral history project. We really appreciate it.

***Norman Jaffe, MD***

**0:01:15.3**

My pleasure.

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## **Chapter 01**

### **A: Overview**

#### ***Cancer in Pediatric Patients***

#### Story Codes

- A: The Clinician
- A: Overview
- A: Definitions, Explanations, Translations
- C: Human Stories
- C: Patients
- C: The Professional at Work
- C: Offering Care, Compassion, Help
- D: The Life and Dedication of Clinicians and Researchers

***Tacey Ann Rosolowski, PhD***

**0:01:16.8**

As I mentioned before I turned on the recorder, because you're the first pediatric specialist that we've been interviewing for this—we will be interviewing for this project—I wanted to start with some general issues about cancer in children. I wanted to ask the most general question. What is the percentage of children who develop cancer today, and how does that compare with the rates when your career began?

***Norman Jaffe, MD***

**0:01:46.6**

Let me put it to you this way. Cancer is the second most common cause of deaths in children. The first most common cause is accidents, but it is the most common disease cause of death in children, and the incidence is probably of the order of about four or five per 100,000 a year. When I started the outlook for most children with cancer—and I'm talking about approximately fifty years ago—the outlook was extremely grave. Very few children survived. It was only children with so-called localized disease in the solid tumor section that had a possibility of good survival, and very few children with leukemia and lymphoma survived the disease. Possibly some children with [Hodgkin's disease](#) had a better chance of survival, but otherwise the outlook for most children with cancer was extremely grave.

***Tacey Ann Rosolowski, PhD***

**0:02:46.3**

And today, the outlooks?

***Norman Jaffe, MD***

**0:02:47.5**

Today it is a complete reversal of the situation. Approximately eighty percent of children with

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leukemia can now be cured of disease, and a similar figure, probably of the order of sixty to eighty percent, in the solid tumor section. There is a complete reversal of the outlook in the modern era.

*Tacey Ann Rosolowski, PhD*

**0:03:08.9**

How do the survivorship rates among children compare to those of adults?

*Norman Jaffe, MD*

**0:03:14.9**

They [the statistics for children] are much improved as compared to the adults. In fact, I will put it to you this way: [] we are the pioneers and the guiding light for the treatment and strategies of cancer, and many of the treatments that have been adopted by the adult service were in fact originally devised by the pediatric oncologists.

*Tacey Ann Rosolowski, PhD*

**0:03:35.6**

Really? For some reason I had assumed that the reverse would be true.

*Norman Jaffe, MD*

**0:03:39.6**

No, it certainly was not so.

*Tacey Ann Rosolowski, PhD*

**0:03:41.0**

Interesting. What are some of the special issues and challenges that you face in working with childhood cancer?

*Norman Jaffe, MD*

**0:03:48.6**

Well, cancer is an enigmatic disease. It affects not only the child, but the entire family is affected, and by the entire family, I mean not only the mother and father and siblings but the grandparents, the aunts, the uncles and so on and so forth. It is a dishonest disease and at the same time has many ramifications. It's a devastating disease, and in fact, can destroy families if it is not handled appropriately and with hope and courage.

*Tacey Ann Rosolowski, PhD*

**0:04:24.7**

Why do you call it a dishonest disease?

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*Norman Jaffe, MD*

**0:04:27.3**

It is a dishonest disease, because when it first rear[s] [] its ugly head, you may think you have in fact eradicated the disease only for it to occur later in a very, very subtle way and then to become devastating to the individual like a wildfire.

*Tacey Ann Rosolowski, PhD*

**0:04:47.0**

What are some of the—? How does cancer destroy a family? How can it happen?

*Norman Jaffe, MD*

**0:04:53.1**

Well, it can destroy the family simply by the child being affected, and this can affect the child in many, many ways[:] pain, discomfort, irritability, anemia, loss of general ability to play and interact with his siblings, surroundings, and things of that nature, which in turn affects the parents. They become concerned and in fact even devastated at times when they see the child suffering to such an extent.

*Tacey Ann Rosolowski, PhD*

**0:05:25.4** What are some of the physical dimensions? How is cancer physically different in children than in adults? I was just thinking that—

*Norman Jaffe, MD*

**0:05:32.9**

It's not really different in children compared to adults. It still presents in children in the form of lumps and bumps, in the form of general illness and [the like] []. The signs that we are aware of in adults are also applicable to children, but a child may complain of pain and not be able to express the discomfort as well as an adult, so it's a more challenging disease for a doctor [to diagnose] in a child as compared to an adult.

*Tacey Ann Rosolowski, PhD*

**0:06:04.3**

Is there anything about the processes of the child's growing body that changes the way you deal with cancer?

*Norman Jaffe, MD*

**0:06:12.5**

Not that we know [of], except that I'll put it to you this way. It is ludicrous and disastrous to treat an adult like a child, but it is in fact, I think, even inconceivable to treat a child like an adult. Children require specific treatment. We adopt our strategies and tactics in such a way that we tailor our treatment specifically for the disease and for the age of the child.

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***Tacey Ann Rosolowski, PhD***

**0:06:43.6**

Would now be the time to ask you for an example, or would you like to wait until we're talking more about your research?

***Norman Jaffe, MD***

**0:06:48.9**

No, I think this will come out in the course of the interview.

***Tacey Ann Rosolowski, PhD***

**0:06:50.9**

Okay. I wasn't even quite sure how to ask this question, but I'll give it a shot. Cancer seems to be more poignant or more tragic when it occurs in a child, and I was wondering what your view is about that.

***Norman Jaffe, MD***

**0:07:08.1**

Oh, I completely concur. Our most precious commodity in this world is our children, and we need to fix any child. It is devastating. It is devastating from every aspect you'd wish to consider, and those people, those parents who have lost children, remember it for the rest of their lives. I think that it is correct to say that to me it is one of the most devastating causes of destruction in family life [that] [] one could consider in the entire world.

***Tacey Ann Rosolowski, PhD***

**0:07:53.2**

Thank you for that overview, and I'm sure we'll be revisiting many of these points over the course of the interview.

***Norman Jaffe, MD***

**0:07:58.5**

Sure, we'll bring them up as we come along with the different diseases and things of that nature.

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## **Chapter 02**

### **A: Personal Background**

#### *A Clinician Who Seeks Broad Knowledge and Connections with Patients*

#### Story Codes

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

C: Faith, Values, Beliefs

C: Evolution of Career

C: Formative Experiences

C: Experiences of Injustice, Bias

C: Faith, Values, Beliefs

C: Offering Care, Compassion, Help

C: Patients

A: The Clinician

C: Funny Stories;

#### *Tacey Ann Rosolowski, PhD*

**0:08:02.3**

Absolutely. I wanted to start at the more usual starting place, which is with some of the personal background. If you could tell me where you were born and when and where you grew up.

#### *Norman Jaffe, MD*

**0:08:15.7**

Sure. I was born in Johannesburg, South Africa. That was 78 years ago, and I knew from the very beginning that I wanted to be a physician. I don't know why. Perhaps it's engendered in some of the families. I'm Jewish, and my parents had a high regard for a physician. I think this possibly infiltrated into my concept of life.

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***Tacey Ann Rosolowski, PhD***

**0:08:41.3**

What did your parents do?

***Norman Jaffe, MD***

**0:08:43.2**

My father was a general storekeeper, and my mother was a teacher. She taught Hebrew extremely well and was very well educated in Hebrew. In fact, she came from [Kovno](#), which is in Lithuania, and there was a very vibrant Jewish community in Lithuania [which] spoke Hebrew extremely well. I have great difficulty now in accepting the fact that I did not exploit her talents more effectively when I reconsider the situation at the present time. My father also appreciated her, though he wasn't as well educated as my mother. He was an extremely good father and taught—I'm sorry—and did everything he could for his family, and he gave me certain ideals and concepts to follow, which I hope I, in fact, adhere[d] to in the course of my life.

***Tacey Ann Rosolowski, PhD***

**0:09:38.1**

What are some of those ideals that you learned from him?

***Norman Jaffe, MD***

**0:09:40.7**

That family is the most important thing[:] to be honest, conscientious, and hardworking, and he was that way. He worked extremely hard. He made a reasonable living but not an outstanding living, and he did everything he could to educate his children. I'm one of six children. I'm the oldest. I know how difficult it was for him and how hard he worked in order to ensure that his children would be educated. In fact, he often made the statement, "They can take many things away from you, but they will not take away your education." He went out of his way to ensure that we had an adequate and appropriate education.

***Tacey Ann Rosolowski, PhD***

**0:10:22.6**

And your parents' names?

***([PhMD])^13(\[[0-9][0-9]:[0-9][0-9]:[0-9][0-9]\])^13***

***Tacey Ann Rosolowski, PhD***

**0:12:07.5**

When did you know that you were gifted in the sciences?

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*Norman Jaffe, MD*

**0:12:11.5**

I think it came naturally. I was always interested in that. In fact, I remember even in what we call Standard 8 or Standard 7 [which is equivalent] to the fourth or fifth grade in American standards—I became interested in [van Leeuwenhoek's](#) discovery of the microscope,. [] I remember taking a book out of the library called *The Microbe Hunters*. [] That had a major impact on me on how he was able to identify [] the bacteria []. And from there it followed almost automatically that I gravitated to many medical texts and books for the appropriate age at that particular time. I was a voracious reader at that stage as well.

*Tacey Ann Rosolowski, PhD*

**0:13:06.3**

Were there other books that really affected you at that young age?

*Norman Jaffe, MD*

**0:13:09.1**

Yes, I liked detective novels, and I liked novels of medicine.

*Tacey Ann Rosolowski, PhD*

**0:13:15.5**

And working with cancer is kind of being a detective, I think.

*Norman Jaffe, MD*

**0:13:18.8**

That's absolutely right. I still like them []. Incidentally, I would draw your attention [to the fact that] I'm currently reading *The Leopard* [by] an author in Norway. I can't remember his name now at the moment [Jo Nesbo], but it's quite a nice, interesting story, and he's equated to the books that came out of Sweden recently, [for example,] the girl with the tattoo on her—

*Tacey Ann Rosolowski, PhD*

**0:13:43.7**

*The [Girl with the] Dragon Tattoo*, yeah.

*Norman Jaffe, MD*

**0:13:45.4**

That's right [ ]. Those are very, very exciting and interesting books. They hold one's attention, and I absorb them very well. Incidentally, just on a sideline and in passing, I'm grateful to my wife, who also reads novels of that nature, and we often have long discussions about [them].

*Tacey Ann Rosolowski, PhD*

**0:14:04.0**

And her name?

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*Norman Jaffe, MD*

**0:14:05.2**

Her name is Louise, Louise Jaffe. Well, originally her maiden name was Louise Carr.

*Tacey Ann Rosolowski, PhD*

**0:14:10.9**

Carr?

*Norman Jaffe, MD*

**0:14:12.0**

C-A-R-R.

*Tacey Ann Rosolowski, PhD*

**0:14:15.8**

Thank you. Tell me about going to medical school. Where did you go?

*Norman Jaffe, MD*

**0:14:19.6**

I went to the [University of Witwatersrand](#). Now, that is difficult to pronounce. It is actually an [Afrikaans](#) name. It should really be pronounced "Vit-vaters-rand," which is Afrikaans. I was schooled in both English and Afrikaans. Afrikaans was [a] bilingual language of South Africa at that particular time, so I became fluent in both English and Afrikaans, and I did fairly well in medical school. I didn't get top marks, but I was in the upper echelon among the first ten or fifteen at the top, and I thoroughly enjoyed medical school. It was a six-year program, and at the very end of it I knew that I wanted to do pediatric oncology. Not really oncology, I'm sorry, but pediatrics.

*Tacey Ann Rosolowski, PhD*

**0:15:07.9**

Why?

*Norman Jaffe, MD*

**0:15:09.0**

Because I was one of six children, and I liked children because of my siblings. I guided my siblings, so much so that I induced my brother also to enter into medicine. I couldn't induce my four sisters to do that. They became schoolteachers and nursery school teachers and the like, but they also had the same ideas and concepts that I was raised with, and each one of them, fortunately, got higher educations and so [forth].

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*Tacey Ann Rosolowski, PhD*

**0:15:42.1**

I was going to ask you if being the first child had an effect, because often you're kind of a substitute parent in some ways.

*Norman Jaffe, MD*

**0:15:51.8**

I think it did[.] My wife tells me that I know how to handle people because of the way I handled my siblings. I didn't do that deliberately. I think it was imposed upon me, but that's the way it was. I was the first one, so I think I even taught my parents how to be parents.

*Tacey Ann Rosolowski, PhD*

**0:16:14.7**

I always feel like the first child gets practiced on, and they help the others.

*Norman Jaffe, MD*

**0:16:18.7**

Yeah, it can also be a reversal situation as well.

*Tacey Ann Rosolowski, PhD*

**0:16:22.0**

Yeah, that's true. That is true. Tell me about your residencies, and just kind of take me through the whole professional training track.

*Norman Jaffe, MD*

**0:16:30.10**

After I had qualified as a doctor, I decided that to be fair to myself and to others and particularly to my patients, even though I had the qualities to become a general practitioner and to decide on becoming a specialist in one field or another, it would be appropriate for me to do specialty services in the four major specialties. I had six months of pediatrics, six months of medicine, six months of surgery, and six months of obstetrics and gynecology.

*Tacey Ann Rosolowski, PhD*

**0:17:07.2**

I noticed that on your CV, and I thought that looked unusual. That was not—did most people do that?

*Norman Jaffe, MD*

**0:17:13.9**

Many of them did, not most, but many of them did, and I think that was a reasonable way of solidifying your ultimate choice. And having done that, I decided that pediatrics was indeed the specialty that I should undertake.

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*Tacey Ann Rosolowski, PhD*

**0:17:30.8**

Now, I noticed that there were several hospitals that you went to and I'm wondering if any of— what they were. There was [Coronation Hospital](#).

*Norman Jaffe, MD*

**0:17:43.4**

That's where I did my internship in medicine and surgery.

*Tacey Ann Rosolowski, PhD*

**0:17:47.7**

In 1957.

*Norman Jaffe, MD*

**0:17:49.3**

That's correct, and then I also did pediatrics in Coronation Hospital.

*Tacey Ann Rosolowski, PhD*

**0:17:56.9**

And then you went to—?

*Norman Jaffe, MD*

**0:17:59.6**

Baragwanath. That hospital has now changed its name to the [Chris Hani Hospital](#). Chris Hani was one of the individuals in the [apartheid](#) system who was killed in his attempts to overcome the system, and in recognition of his valiant attempts they named the hospital after him. I think Baragwanath derives from the Welsh word which means "bread" or something of that nature. I'm not quite sure. But it was a very good hospital for training.

*Tacey Ann Rosolowski, PhD*

**0:18:36.0**

But was this an apartheid hospital that—

*Norman Jaffe, MD*

**0:18:38.8**

It was only for blacks.

*Tacey Ann Rosolowski, PhD*

**0:18:40.0**

Only for blacks. That's what I thought. Now what—? Did you see a difference—? How did you—?

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*Norman Jaffe, MD*

**0:18:45.6**

That affected me greatly, incidentally. It affected me because as a Jew whose people had undergone discrimination and difficulties in their lives, I felt it was entirely wrong to subject a black person to similar situations, particularly for Jews to do that, and I think that it was also possible that I might have landed up in jail because of my activities associated in the anti-apartheid system. That was one of the motivating factors, incidentally, which induced me to leave South Africa and come to the United States at a subsequent time.

*Tacey Ann Rosolowski, PhD*

**0:19:29.3**

Did you take part in activist activities there?

*Norman Jaffe, MD*

**0:19:31.4**

No, not as much as the others did, and many of my colleagues who did were whisked away overnight by their parents to Israel, to the United Kingdom, to Canada, and some even to Australia because they were in danger of being locked up and sent to jail for their activities. I remember one friend. I saw him in the morning, and he wasn't there the next morning, and after inquiry, it was revealed that he's gone on vacation. I subsequently learned that he was taken by his parents to Israel because he was in danger of being prosecuted for his anti-apartheid activities. There were many such young Jews who did that sort of thing, and I do admire them and sometimes envy them because I wasn't as active as they were.

*Tacey Ann Rosolowski, PhD*

**0:20:32.1**

What were you noticing at Baragwanath Hospital? I'm asking because when I interviewed Ralph Freedman, who also worked at some black hospitals, he said that because the level of care was so low for black South Africans he saw a wide range of diseases and I'm wondering if you—

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*Norman Jaffe, MD*

**0:20:50.9**

Oh, I did the same, but they were mainly diseases of malnutrition and of poverty, diseases of severe gastroenteritis, diarrhea and things of that nature. I became an expert, incidentally, in putting up intravenous therapy in little children who were dehydrated and needed urgent intravenous fluid. I think the experiences had a great effect upon me not only from a social point of view but also from a medical point of view. I saw many diseases which no one has seen over here. I saw diphtheria, for example, that I don't think anyone [here] has seen, those membranes, whitish-bluish membranes on the throat. I also saw diphtheria, for example, causing heart failure, which very few know about []. I saw smallpox affecting the skin. In fact, in one of the recent meetings that I attended, a patient with smallpox on his skin was flashed out on the [screen], and no one knew the diagnosis except myself. It wasn't a touch of genius. It was because I had seen it before. One saw many, many diseases which one doesn't see over here. These are diseases that are still prevalent, incidentally, in underdeveloped countries, particularly in Africa.

*Tacey Ann Rosolowski, PhD*

**0:22:16.3**

What about the next phase? Because I notice you were registrar and is that—

*Norman Jaffe, MD*

**0:22:22.5**

Yeah, "Registrar" is very similar to a "Fellow[ship]" to get one's higher degree. I did become a Registrar. I did my time, and then I got my higher degree. Now, there is a system in South Africa that once you have your higher degree, in preparation for registration as a specialist, you must leave your specialty for one year. The idea is that you would not be able to talk to doctors to refer patients to you, but you should also get a rounded experience in an allied discipline to the one you have chosen. I chose to do internal medicine to complement this. I hoped that I would at least get some experience with the adolescent and older population similar to those in pediatrics or allied to the pediatric problems. I chose to do this extra year of specialty in a hospital staffed by missionary nuns because I wanted to get experience on how they treated and handled patients and the patients that they saw. This was called Edenvale Hospital. I think it's in my curriculum vitae. You may see it over there.

This was a hospital in Edenvale, which was an allied suburb to Johannesburg. I was given a contract for one year.

When I came to that hospital, it was in dire straits. Things were not going well. It was disorganized []. I managed to get some of the problems sorted out and put order into chaos, but it still was not right, so I approached the superintendent, and I told him that I would resign unless certain factors were implemented. I was able to get them implemented. The nuns were very grateful, and they approached me, and they said, "We are grateful for what you have done, and

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we would like to reward you.” And I said, “You are very kind, but I want to say something to you,” and they said, “By all means.” I said, “You know, Sisters”—we called the nuns sisters—I said, “I’m a Jew, and I’m a little unhappy.” They said, “Why?” And I said, “Because I see you walk around every morning, and you talk a certain language, and perhaps you’re talking about me. I’m sure you’re not, but I still feel uncomfortable. What are you talking about?” They said, “We’re talking Gaelic.” I said, “Teach me Gaelic.” Their eyes lit up, and they said, “By all means.”

I would intervene for one moment and say that if I am ever seriously ill I want to be nursed by Irish nuns. They are devoted people. They will do whatever they can for you. They taught me Gaelic.

We used to go around in the morning, and I would say, “Dea Is Muraguth,” (God and Mary be with you), and they would respond, “Dea Is Muragath is Patrick,” (God and Mary and Patrick be with you), and things of that nature.<sup>1</sup> In fact, we conducted a good deal of the ward rounds at a later stage in Gaelic. I thoroughly enjoyed the experience.

At the end of the one year, when my contract was up, they approached me and said, “What do you want to do?” and I said, “Well, Sisters, quite frankly, I want to go to the United States to expand my knowledge on pediatric neonatology. I’m a pediatrician, and I like doing very early pediatrics, which is neonatology, but I have some difficulty in getting in over there, so I’m not quite sure what I’ll do.” In the interim, I was awarded a contract to be a chief at Baragwanath Hospital, and they said, “Do us a favor. Stay an extra year in Edenvale Hospital, and we will pray to Father Lieberman. Father Lieberman [was] a converted Jew, and we’ll ask him to intervene on your behalf to get you into the United States.” I accepted another year to stay on at Edenvale Hospital and continued my studies in Gaelic and to help out with the nuns [].

At the end of the year, I got a note from Dr. [Charles] Janeway, and he said, “I have your application to come to the United States to do pediatric neonatology, but unfortunately, my sponsorship for Americans is oversubscribed. Your mother, who[] you described was born in Lithuania, can get into the United States quicker than you can even though she’s not a doctor.” But he said, “I will hand over your papers to Dr. Sidney Farber, who is a hematology oncologist specialist, particularly [in] oncology. I understand that he’s looking for someone to run his clinic, and since you are now also being given a chief’s post at Baragwanath, he may be interested in you.” I thanked him for it, and I approached the sisters, and I said, “Sisters, look, this is what has happened, and my contract here is over. I am going to become a chief at Baragwanath Hospital, and I will accept it until further developments.” And they said, “Doctor, we have been praying continually to Father Lieberman. We will now write to the Pope in order to proceed further to

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<sup>1</sup> The transcription service provided the following transliterations, respectively: “Dia is Muire dhuit,” “Dia is Muire dhuit agus Padraig.” The transliteration in the text proper was provided by the interview subject.

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ask that he [Father Lieberman] be made a saint.” I’m not sure Father Lieberman was ever made a saint, but here is a Jewish boy who [may be] responsible for someone being a saint.

Whatever the circumstances, I accepted my post at Baragwanath Hospital as a chief, and three months after accepting the post I got a letter from Sidney Farber to say, “Dr. Janeway has sent me your curriculum vitae, has sent me your applications and things of that nature. I note that you are a chief at Baragwanath Hospital, that you’re doing neonatology, but I need someone to run my clinic, and I’m prepared to sponsor you as an immigrant into the United States.” [Thus] Dr. Farber said he would sponsor me to the United States, and that’s how I landed up in the United States.

*Tacey Ann Rosolowski, PhD*

**0:29:07.2**

And so you were a fellow in tumor therapy?

*Norman Jaffe, MD*

**0:29:09.6**

He gave me a fellow in tumor therapy. That was the position that he awarded to me.

*Tacey Ann Rosolowski, PhD*

**0:29:15.7**

And that was 1966 to '67.

*Norman Jaffe, MD*

**0:29:17.9**

That’s correct.

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***Tacey Ann Rosolowski, PhD***

**0:29:19.0**

Can I ask you a couple of questions just going back a little bit? This is normally a question that I ask at the end of the interview, but it seems appropriate to ask it now given your relationship with the nuns and some of the comments you've made. To what extent is your faith and sense of spirituality part of what you do?

***Norman Jaffe, MD***

**0:29:40.8**

I don't say that I'm extremely religious, but I do go to synagogue, to [shul](#), every week. I put on what are called [phylacteries](#) and so on whenever I can, and my wife runs a kosher home and has brought our children up as such. We believe very deeply in our faith. I feel I get spiritual satisfaction from my faith. In fact, I will tell you something. I lost a child at the age of twelve. She had a congenital heart, and I was advised to take her to the Mayo Clinic, where an operation was performed. The operation was a magnificent success, and she died two days later. I know how people feel when they lose a child. I'll tell you something: no matter what the psychiatrists and psychologists and everyone tell you that you'll overcome the problem, you never do. It's always with you, and when I've lost a patient, I know how my parents feel. We're deviating somewhat, but I'll tell you this much, [] I [] insisted, while I was in practice, that any patient of mine who dies, even in the middle of the night, I must be summoned to that patient's bedside. I've risen from my bed in the middle of the night, 3 o'clock in the morning [at times], to [drive] to the hospital for a dead child so that I can sit and talk to the parents and comfort them and tell them that, above all everything that could be done was done for their child, that they must not feel in any way guilty, or have any other feelings about that situation. I think that it has been of some service to them. And this is not only because of my own personal loss. I think my religious experiences have stimulated me and induced me to do that as well.

***Tacey Ann Rosolowski, PhD***

**0:31:42.9**

I'm sure that's enormous comfort. My sister almost died when she was under a year old. My parents were just—they were beside themselves, and they didn't really get a lot of good support from some of the medical staff, and it was very hard. It made things very hard, so I'm sure your patients have been comforted.

***([PhMD])^13(\\[[0-9][0-9]:[0-9][0-9]:[0-9][0-9]])^13***

***Tacey Ann Rosolowski, PhD***

**0:33:05.6**

That's a wonderful testament to a life's work.

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*Norman Jaffe, MD*

**0:33:09.0**

Well, I think so, and I hope so, but I will tell you another secret. I could not do the work that I did without my bride, without my wife. We've been married fifty years, and she has told me she knows that I have another mistress [medicine]. She has encouraged me when my mistress has called in the middle of the night to go and attend to my mistress, which is medicine. She says, "Your mistress is a hard mistress, but I will support her." It's a difficult situation, but I could not do it without her. She is a wonderful woman. There's a story or an aphorism that behind every famous man there's a woman pushing. I don't think I've been pushed. I've been supported.

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## **Chapter 03**

### **A: Professional Path**

#### ***Working for Sidney Farber***

#### Story Codes

A: Professional Path

C: Funny Stories

C: Evolution of Career

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

C: Portraits

A: Influences from People and Life Experiences

A: The Administrator

***Tacey Ann Rosolowski, PhD***

**0:34:00.1**

That's great. Would you tell me about going to Boston and Sidney Farber?

***Norman Jaffe, MD***

**0:34:07.9**

Well, I accepted my post in Baragwanath Hospital as a chief, and I enjoyed it. I was chief mainly of Neonatology, and then Sidney Farber wrote to me approximately three and a half months after I'd accepted the post that he was somewhat desperate, and he wished me to come as a Fellow, initially because he wanted to make sure that I was appropriate for this particular position. He said he will in fact support my application for an immigrant's visa, which gave me carte blanche to do what I wanted really in the United States. He indicated that the Fellowship would be available in June of '66. I felt a little uncomfortable and embarrassed after I had in fact signed a contract at Baragwanath Hospital to be a chief, one of the chiefs that were available there, to do work in pediatrics. After being there for three and a half months I [renege]d on my contract. I'm not sure how happy they were with me, but that doesn't matter. And I then left the South African shores by air on BOAC. I remember the actual airline. And I came to the United States with a wife, a child, and two suitcases. One of the suitcases was half packed with cloth diapers.

***Tacey Ann Rosolowski, PhD***

**0:35:42.0**

How old was your child?

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***Norman Jaffe, MD***

**0:35:43.4**

He was three years old, and those cloth diapers were examined meticulously by the customs [officials] in case I was bringing drugs in. I had to unpack each diaper to show them that there were no drugs concealed in the diapers. In this country, you [didn't] have diapers. You have regular diapers that [are made] with paper and things of that nature. But that's the way it was in my time.

Incidentally, there is a little story attached to this pediatrics. When I was trying to make up my mind what I wanted to do, I approached our practitioner, our family doctor, and I asked him what he [thought] I should do at that particular time, because I was interested in all parts of medicine, but I was gravitating to pediatrics, and he said, "Listen, my friend, sit down," so I sat down. He said, "Go into pediatrics as you wish to do." I said, "Thank you. Why?" He said, "The secret of pediatrics is to keep the mother occupied." I said, "What do you mean?" He said, "Most children happily get cured, get well on their own. Just don't be overzealous." And he said, "And when you're called to a child who is ill, tell the mother to take a huge pot"—he spoke to me in Yiddish, *Nem a teppel*. "Take a huge pot, and tell her to put in three-fourths of a pot filled with water and a pinch of salt and to put it on the stove and run it at a particular temperature and to stir it every fifteen minutes. Tell her to do it three times a day, because that's what she will be feeding the child, and [] to add [a certain] amount of milk. But keep her occupied." And he said, "And that is the secret of pediatrics." I was thinking, "Oh, that's not a bad idea," so I entered pediatrics in the hope that I would keep the mothers occupied. And what happened? Immediately thereafter, the cloth diapers disappeared, Similac was introduced, there was no stove, there was no hot water, there was no added pinch of salt, there was no milk, there was no stirring of the pot, and the parents could go and purchase Similac and so on. I could no longer keep them occupied. That's what happened in pediatrics.

***Tacey Ann Rosolowski, PhD***

**0:38:21.7**

So you never found another way to keep the mother occupied.

***Norman Jaffe, MD***

**0:38:24.4**

No, but that was originally the secret of pediatrics.

***Tacey Ann Rosolowski, PhD***

**0:38:29.7**

That's funny. Did you ever make that prescription for the [mixture]?

***Norman Jaffe, MD***

**0:38:32.10**

Oh, no.

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***Tacey Ann Rosolowski, PhD***

**0:38:34.7**

It's a good story, though. It really is.

***Norman Jaffe, MD***

**0:38:36.2**

But it's true, and I remember the name of the doctor [Dr. Witkin]. I have it written down somewhere, but he was a congenial, nice old man, and the way he said to me, "Sit down," and he spoke to me half in Yiddish, as if I was his son. He said, "I've known you since you were a very small boy, and I kept your mother occupied."

***Tacey Ann Rosolowski, PhD***

**0:39:02.5**

What did you discover after the customs officers went through all the diapers and when you got to see Stanley Farber?

***Norman Jaffe, MD***

**0:39:10.0**

Sidney Farber. I was disappointed. I was devastated. I came there— Well, I knew that the oncology was not the best [choice], but I didn't expect so many children to be dying. But strangely, there were a few who were living, and I got interested in that. And Sidney Farber had a very, very well-established organization called the [Children's Cancer Research Foundation](#) in Boston. Are you familiar with Boston?

***Tacey Ann Rosolowski, PhD***

**0:39:44.1**

Not terribly, no.

***Norman Jaffe, MD***

**0:39:44.8**

There is a book written by a man called [Siddhartha] Mukherjee, *The Emperor of All Maladies*. I think you should read it. It's not accurate in certain aspects because I was Sidney Farber's administrator for about seven years, and I ran the clinic for him, and I know what [happened]. But in general, it's a reasonably good read, and it does give you some insight into the problems that existed.

Well, Sidney Farber invited me to come there, and I expected to learn about pediatric oncology. I did. I learned entirely on my own. There was no real Fellowship program, but I began to absorb things and notice how one treated them. I read many publications and books and so on. I was entirely self-taught at that particular time.

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At the end of one year, I said, “That is enough. All the children are dying. This is not a position for me. I did not enter pediatrics to treat dying children.” I wrote a memo to Sidney Farber. You never spoke to him directly. You always communicated by memo, and I sent a memo to him saying, “I thank you for sponsoring me into this country. It’s been an interesting experience, but I feel that I am not cut out for this particular type of pediatrics. I really want to do neonatology, as you will see from my curriculum vitae, and as you will see, I was a Chief of Neonatology in Baragwanath Hospital, and as such, am making arrangements with Clement Smith, who is a neonatologist at the Beth Israel Hospital across the road, to enter into neonatology with Clement Smith for one year.” In fact, I’d already seen Clement Smith, and it was almost a sealed deal. [However,] he made a statement to me which I now understand in retrospect. He said, “Look, Dr. Jaffe, I’m impressed with your curriculum vitae. I’m impressed with what you’ve done. You want a job with me, I will give you the job, but you go to Sidney Farber and tell him that you are taking this job. I am not going to communicate with Sidney Farber.” I said, “Sure,” and then I communicated with him by memo.

The day before I was due to start, I received a telephone call from Sidney Farber’s secretary—her name was Mrs. McGeichie—who, incidentally, had her own secretary to do some of the work. That was how busy they were. Her name was Dorothy Witkin, the same name as the doctor who told me to keep the mothers occupied. Witkin was her name. Mrs. McGeichie said, “Dr. Farber would like to talk to you,” and I said, “Fine, I have no problem with that,” and he was a very charismatic, avuncular man. You have no idea how you fell into his grasp, but you felt so good about things. He knew how to talk. He was a master of the English language and with such confidence. You really had to have a great deal of respect for him. The telephone conversation went more or less like this: “Dr. Jaffe.” And I said, “Yes, sir.” “What is this piece of paper I have in front of me?” I said, “Sir, I have no idea what piece of paper you are referring to.” He said, “Apparently”—and I remember this very well—“apparently it is a memo from you to me advising me that you’re leaving my service,” and I said, “Yes, sir. I am making arrangements with Clement Smith to take a job in Pediatric Neonatology.” There was a significant pause. It was deafening, that pause, and then he said, “Do you know who I am?” and I said, “Yes, sir.” And he said, “Do you know how powerful I am?” and I said, “Yes, sir.” And he said, “You will never receive a job anywhere in this country unless I sanction it, and I do not sanction this job. I did not bring you over from South Africa for you to desert me at the last minute and work for Clement Smith.” It may be that he had some problems with Clement Smith and was going to spite him or something of that nature, but I don’t know. He said, “You are hereby appointed the administrator of my clinic. I will escalate your salary from \$2,000 to \$16,000, and I will discuss your Harvard appointment next week,” and he put the phone down, and that was it.

I walked home—please note that I walked home. I could not afford an automobile. When I left South Africa, I could not take much money out, so I walked home, and I said to my bride, “Do you know where I’m working tomorrow?” and she said, “Yes, Clement Smith.” I said, “Listen, this is what happened.” The next day I duly reported. I was ecstatic. I had the same office, the

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same place and so on, but a new sign went up, and it said *Administrator*. I was doing the same work I was doing before, but I was now administrator. And I said, “Well, if I’m going to do this, I’ve got to get things straightened out over here. I may as well do something.” If I’m locked in for a while, I’ll do that, and so I became the administrator of the clinic, which I did for seven years.

There was an interesting point about that as well. I came in as a [South African] citizen. Not [as]—an American []. I could therefore get a job anywhere because I had this immigrant’s visa, and as such, I was also liable for the draft in Vietnam. And approximately two or three months after becoming the administrator, I got a letter from the draft offices saying that “you are here on an immigrant’s visa. Please report for possible recruitment to Vietnam.” I said, “Is this part of the system as well? I’m an American? I’m not even an American! I’m a South African, and I haven’t even sworn allegiance to this country.” And they wrote back to me and said, “All immigrants are liable to the draft, and therefore, you will report.”

I discussed this with my wife. I discussed it [also] with Sidney Farber, and his response to me was very clear. “Let us hope wisdom will prevail.” That’s all he said to me, and I duly reported to the draft office. They said, “Appear for a [medical] examination,” [for] which I had to come back a week later.

They did it very, very efficiently. I do congratulate them on that. They had stations. You went from one station to the other, and this station did the rectal examination, this station did that and so on and so forth. You went right through, and I was impressed with that more than anything else. This one listened to the heart, this one listened to the chest, this one did that, and so on and so forth. It was efficient right through, and at the end of that I said, “Listen, I had rheumatic fever as a youngster, and perhaps there’s something wrong with my heart,” and they listened again. They said, “No, there’s nothing wrong with your heart.” [] “You are now classified as A1. Be prepared to be called up and [keep] this [draft card]”—they gave me a “ticket” to hold in my wallet for the future, in case I’m asked about the draft. I [decided], “There’s no option now. I’m not going back to South Africa, and if I have to go to Vietnam, we’ll discuss the situation at that [stage].” I remained in anxiety and almost in fear until the age of thirty-five, and after the age of thirty-five. After the age of thirty-five, they would not call you up. At the age of thirty-six, I became an official American citizen, [and there was no possibility] of conscripting me to the draft because of my age, although I was [possibly] eligible from other aspects. That was an interesting experience as well.

***Tacey Ann Rosolowski, PhD***

**0:48:17.2**

It must have been really stressful.

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*Norman Jaffe, MD*

**0:48:18.4**

Oh, yes, because I didn't want to leave my wife, and we had another child at that stage and things of that nature.

*Tacey Ann Rosolowski, PhD*

**0:48:25.3**

And just putting yourself in serious harm's way.

*Norman Jaffe, MD*

**0:48:27.7**

That's right, but it was interesting that I could be called up [into] the draft even though I was not an American citizen.

*Tacey Ann Rosolowski, PhD*

**0:48:34.2**

I had no idea.

*Norman Jaffe, MD*

**0:48:35.6**

[ ] One of my colleagues, Jeffrey Maisels—you may know him—who incidentally became a good neonatologist, he was with me at Baragwanath Hospital, was in fact drafted and fortunately didn't have to go to Vietnam. He was in the Army for a period of two years. There were several South Africans who were drafted in that particular situation even though they were not American citizens, but that was the law, the system, and we came here. We enjoyed the fruits of the United States. I can understand it from that point of view, but it becomes very difficult [to understand]. Even though one may not agree with some of the things and even particularly because one is not an American citizen yet [they could] still ask me to fight for the United States. But that's the way it was. I then continued [my employment] under Sidney Farber. I began to organize the conferences [and] take a more active role. I said, "I cannot move now. I know where I stand." He really exploited me. He took great advantage of me. He insisted that I run the clinic efficiently and I report to him daily. The reporting daily to him—I think I should send you a copy of the letter that I sent to Dr. Mukherjee indicating some of [these] aspects that he omitted to put in his book, *The Emperor of All Maladies*. If you give me your email, I could send it to you. [Note: The relevant correspondence is included beginning on page 107 of this transcript.]

*Tacey Ann Rosolowski, PhD*

**0:50:13.9**

I would like to have that. Yes, I will.

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*Norman Jaffe, MD*

**0:50:18.3**

And the point is this: [ ] I revamped the entire system over there. I became the real administrator now because I was given the power to do that. He relied heavily on me. I almost became his confidant; in fact, so much so that he would take me to Washington. Sidney Farber would take me to Washington with him where he would go and talk to the Senate and [other committees]. I remember one occasion. He called me up to his office, and he said, "Norman"—sometimes he'd call me Norman. Sometimes he would call me Dr. Jaffe. This time he was very, very approachable, and he said, "Norman, I've just spoken to Dick." I said, "Yes, sir." I didn't know who Dick was. And he said, "You have a great future in pediatric oncology. We will move forward. We will advance." He had great vision, and he said, "I want to go to Washington next week, and you will come with me, and we will discuss this further. But meanwhile, prepare a report on how far we have advanced in pediatric oncology at the present time and what your actions [and activities] are in my clinic." I said, "Yes, sir," and there were discussions about a few other things [ ]. I went out from his office on the eighth floor, and I said to Mrs. McGehre his secretary, "Who is Dick?" And she said, "Dick is the president. Didn't you know that?" I said, "No." She said, "It's Richard Nixon." I didn't know. I [assessed the situation and thought], "What a great man. He's just spoken to the president, and now he's speaking to me." This [was] Sidney Farber!

We went there, but he wouldn't let me see Dick, or perhaps Dick didn't want to see me. He kept me in the hotel, and anytime he had a problem he would phone me, and then he would ask me about things and [ ] go and speak to Dick [ ]. I'd go to Washington on occasion [ ].

Sidney Farber, incidentally, was also a Jew, but he didn't have much understanding [and] experience in Jewish affairs. I think he felt a little bit disturbed about that, so much so that he was invited to [ ] the Board of Governors of [Brandeis University](#). He accepted with great pleasure to show his Judaism [ ]. He would discuss some aspects of it with me as well. When we used to travel to Washington in the car, he would ask me about [ ] Judaism, [ ] the Talmud and things of that nature. I [spent] a great deal of time with Sidney, and I enjoyed my association with him, even though he kept a vise on me. I couldn't move. I knew that he had great power, and the only time the power was dissipated or even eradicated completely and the shackles were severed was when he died.

When he died, I was in Mexico, and I received an urgent call to return [ ] to Boston because they wanted to reassure the staff that I looked after that there would be no change in the situation, their jobs were guaranteed [ ]...[ ]

He had me well trained. I had to report to [ ] Farber every evening. I never knew when I would return home. At 5 o'clock, after all the doctors had left [ ] and [I'd report] [ ]. I would sit in my office and wait for a telephone call from Mrs. McGehre to come up to Sidney Farber. The call would be received sometimes at 5:30, sometimes at 6:00, sometimes at 8:00, and so on [ ]. My

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bride knew that she would have to come [to] fetch me at different times [ ]. That was the way it worked, and I accepted it. I'd go up there at 8 o'clock at night and he'd say, "Give me the report on the clinic. Give me the report on this, give me the report on that." The report would take about twenty minutes. It wasn't long. "And how is the staff reacting, and what are they doing?"

He had his finger on the pulse of [things]. He knew exactly what was happening, so I do give him credit for that, that he took a great deal of interest [in the clinic operations], but he never did ward rounds. I would do the ward rounds.

He may have done them before my arrival, but he never did it while I was there. For seven years that I was the administrator and for many years prior to that, apparently, he never did any ward rounds, although in [Mukherjee's] book it says he did ward rounds. I don't think that's correct. [ ] I really got a good grounding on my own, and because I was given the liberty to do things and he trusted me, I think I was able to advance the situation at the Children's Cancer Research Foundation [in] Boston.

[ ] [W]hen Sidney Farber died, they wanted to start a new building, but they didn't have the money, and the new chief, Tom Frei, who came originally here from MD Anderson, was my new chief. I had a great relationship with him, and he sent me down to Washington, where I testified and asked for funds for [the building. The testimony] is available in the Congressional Records. I testified before the House, and I testified before the Senate. I think the reason why he really did that was I treated Ted Kennedy for [osteosarcoma](#). After I had testified [( ) Kennedy had recused himself from the meeting because, he said, "You have treated my son" ( )], [Emil] Tom Frei [ ] told me, "You went down and you asked for \$10 million to start the building, and we're getting that \$10 million!" Whenever I go past [the building] in Boston, I say, "That building belongs to me," for what it's worth. I put the foundations in.

***Tacey Ann Rosolowski, PhD***

**0:56:45.7**

I'm wondering about something else too, because when you went to Washington with Sidney Farber and he was talking to President Nixon, do you know the substance of that? Because that was just prior to the cancer plan.

***Norman Jaffe, MD***

**0:56:58.4**

He was responsible for initiating that cancer plan. Nixon relied heavily on Farber to do that. I think they called it *The Conquest of Cancer* or something of that nature. I can't remember, but it's in that book *The Emperor of All Maladies*. It's worthwhile reading.

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## **Chapter 04**

### **A: The Researcher**

#### ***An Important Contribution to Treatment: Eradicating Metastasis with Methotrexate***

#### Story Codes

A: The Researcher

A: The Clinician

A: Influences from People and Life Experiences

A: Professional Path

C: Formative Experiences

C: Discovery, Creativity and Innovation

C: Discovery and Success

C: Professional Practice

C: The Professional at Work

***Tacey Ann Rosolowski, PhD***

**0:57:23.3**

I know we have a lot of different positions to cover before you even get to MD Anderson, but you had mentioned that the seven years under Sidney Farber was such good training, and you were able to accomplish certain things. Maybe you could give me a couple of examples of some things that you accomplished that you really learned something from.

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*Norman Jaffe, MD*

**0:57:44.3**

Okay, I'll tell you. When I was there, I noticed that Farber had a specific way of treating solid tumors, in particular, [Wilms' tumor](#). He had originally done some work with a person called Guilio J. D'Angio who we called Dan D'Angio. Dan D'Angio was a radiation therapist. And a problem in cancer existed at that particular time in relation to the kidney. Cancer of the kidney in children is generally Wilms' tumor. That's the type of tumor that the kidney develops in children. There are others, but that's the main one, and the kidney metastasizes—the cancer metastasizes to the lungs, and that eventually causes the demise of the child. Experiments and investigations done by Sidney Farber with a substance called [actinomycin D](#), which he acquired from [Selwyn Waksman](#), who was a friend of his, revealed that the combination of actinomycin D and radiation therapy could destroy the metastases in the lungs. You could destroy metastases in the lungs also with radiation therapy [alone], but the amount of radiation therapy that one had to deliver to the lungs to destroy these metastases was such that you not only destroyed the metastases, but you destroyed a major part of the lungs [as well]. When combined in association with actinomycin D, you could reduce the quantity of radiation therapy and not destroy the lungs. Farber did major investigations in this, so much so that he was able to convert the survival rate of children with Wilms' tumor from --in optimum circumstances-- under approximately forty percent to close to eighty percent. He had doubled the survival rate. I learned that from Farber. He introduced the concept of [delivery of] radiation therapy plus actinomycin D. That [ ] was also exploited further in some of the solid tumors in [rhabdomyosarcoma](#). That was a major saltation in the treatment of solid tumors and cancers, and it was entirely due to Farber's investigations. So one had to give him great credit for that. He was a brilliant pathologist, incidentally. I enjoyed listening to him describe the tumors. Every Wednesday afternoon when we would have tumor board, Farber would sit and describe the pathology as it was flashed on the board. This information, incidentally, is available in the letter that I sent to Mukherjee, and I will send it to you.

*Tacey Ann Rosolowski, PhD*

**1:00:58.9**

Yeah, I'd appreciate that.

*Norman Jaffe, MD*

**1:01:00.1**

And I think you'll learn about it in greater detail. Farber did a great service to the children by describing an excellent method, which is still used today, incidentally, in the treatment of Wilms' tumor. That is cancer of the kidney of children, and it has been extended further to other solid tumors as well, particularly rhabdomyosarcoma.

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***Tacey Ann Rosolowski, PhD***

**1:01:27.7**

Along the way, as we've been talking, we kind of moved seamlessly from your interest in pediatrics to oncology, and I'm wondering when was the point that you really made the decision that you wanted to focus on oncology?

***Norman Jaffe, MD***

**1:01:40.3**

Well, it was after Farber told me that I would not get a job elsewhere. I had no option. It was not my decision. And in the United States, after a while, if you do well and you show exceptional talent, things like that, then they'll push you as well. And Farber pushed me, and I think he knew that he had—as I heard one of my colleagues say, “He knew he had a gem in you, and he wouldn't let you go.” That was the reason. As I said, originally I was not interested in oncology, but I had no option at that stage. At '66 I came to this country. I would say it was '69-'70, particularly after I had made a huge saltation in the treatment of bone tumors, osteosarcoma, that I said, “Listen, this is the way I've got to go now.” And Farber wouldn't let me turn back.

***Tacey Ann Rosolowski, PhD***

**1:02:37.8**

Can you tell me about that discovery?

***Norman Jaffe, MD***

**1:02:40.1**

What happened was the most common bone tumor in a human being, and particularly in children, is called osteosarcoma. It particularly affects the pre-teenage and teenage individual, and until the beginning of the 1970s there was no chemotherapeutic agent that could destroy osteosarcoma. Osteosarcoma develops in the bone, and if it is untreated it continues to metastasize to the lungs. Initially the metastases are not visible on x-ray in the lungs, but they are there because we know that since there [was] no major treatment for osteosarcoma except amputation at that particular time, and even if you amputate, nine months later, these micro metastases in the lungs will appear [visibly] and be responsible for the demise of the patient. Now, Farber, as you may or may not know, was responsible for the discovery of [methotrexate](#), which is used in leukemia. I refer you again to the book *The Emperor of All Maladies*, which discusses his approach to this particular problem.

In '66, there was no effective treatment for osteosarcoma, but a man called Isaac Djerassi was aware of investigations performed in mice by an investigator called Abraham Golden at the National Cancer Institute. Abraham Golden took massive doses of the methotrexate, which Farber had discovered for the treatment of leukemia, and treated mice with leukemia, and after several hours of administering these massive doses—I call them industrial doses—he would give the antidote to methotrexate, and the mice would not die from toxicity. Djerassi used that approach in children with leukemia and found it to be highly successful. Djerassi had trained at

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one stage with Sidney Farber but then moved to Philadelphia. We invited Djerassi—well, I invited him because I was in charge of the tumor board—to discuss his investigations and his treatment approach to leukemia with these massive doses of methotrexate. I used to have tumor board every Wednesday afternoon with Sidney Farber. Djerassi was invited and presented the information on the treatment of resistant leukemia with massive doses of methotrexate followed by the antidote [leucovorin](#) or [ ] citrovorum factor, but it's called leucovorin [today]. As I described to you, massive doses, and then after an interval, the antidote—and the patient or mice did not succumb, and the patient also responded.

And after hearing his presentation, I approached Sidney Farber a day or two later, and I indicated to him, “Dr. Farber, we have no treatment for osteosarcoma. I would like to treat patients with this particular therapeutic branch.” At that stage, there were no surveillance boards. There were no institutional review boards. You simply had to get permission from the chief, and I remember his words so clearly. “Proceed, young man.”

I found a patient who had developed pulmonary metastases, osteosarcoma in the lungs, after she had undergone a hemipelvectomy. We removed half her pelvis from the osteosarcoma. I discussed this with the patient and her mother. I said, “Listen, I have nothing really to offer you, but I've heard of a treatment that has been highly successful in leukemia, and I would like to investigate this treatment in your particular situation.” And they said, “Since you tell us there is nothing further, by all means, proceed.”

[Redacted]

Incidentally, just in passing, the chief of Pediatric Hematology at Texas Children's Hospital is David Poplack, and David Poplack was my house officer at that particular time. I told David Poplack, “We are going to treat this patient in this particular manner.” We gave the patient the treatment. It did not succeed. I telephoned Djerassi, and I remember his words particularly clear. He said, “Double the dose.” I doubled the dose, and indeed, after doubling the dose, complete disappearance of metastases was achieved, and this is a phenomenon that had never before been seen. I continued on this particular approach because I was afraid [that] cancer, being a dishonest disease, it would recur. It did not recur, but she developed severe toxicity, and I give tribute to David Poplack, who as I say, is chief across the road, for looking after this patient and rescuing her from the toxicity.

***Tacey Ann Rosolowski, PhD***

**1:08:54.9**

What were the symptoms of the toxicity?

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*Norman Jaffe, MD*

**1:08:58.0**

Severe mouth ulcers, kidney failure, liver failure, the works. She had it very, very severely, but we brought her round, and we continued treatment after that, and there were no problems. She completed two years of treatment. To my knowledge, [redacted] is alive and well and kicking, and she gave birth to two normal, healthy children, and that set the ball rolling for the use of high dose methotrexate with leucovorin in osteosarcoma, which is still used today. It is one of the major achievements that I consider to have accomplished in pediatric oncology, high dose methotrexate with leucovorin factor, and if you look at my CV, you'll see many of the publications in this regard. The point about telling this story is that I would not be able to accomplish this particular approach at the present time. There are so many regulatory agencies. It has to go through this agency and that agency and this committee and this surveillance and so on and so forth that by the time one finishes with the committees the patient is dead, and you are tired. It could not be done now, but it certainly was done then, and all I needed was permission from Sidney Farber, which is a tribute to him, because I say he had confidence in me. I'm not sure that was appropriate, but nonetheless, as I say, "Proceed, young man." At least he had the confidence in me to go ahead, because I think he realized that I would not approach him had not the circumstances been so dire and had [there] not been the possibility of accomplishing something without severe toxicity, which did occur. We know now some of the reasons why toxicity occurs, and we can avoid it, but not always. Nonetheless, it's still an established and recognized form of treatment for osteosarcoma, and in passing, the survival of osteosarcoma was at the order of five to ten percent [at that time]. Now it is of the order of sixty-five to seventy-five percent, utilizing this approach and other agents in addition.

*Tacey Ann Rosolowski, PhD*

**1:11:20.0**

It's really landmark.

*Norman Jaffe, MD*

**1:11:21.3**

Tremendous, and I think Farber was very appreciative of it because he had originally discovered methotrexate, although [had] not discovered this approach, but he was very proud of it. And I used to send him memos more or less on a weekly basis. So-and-so has been treated, so-and-so had a response, so-and-so has had this, this, that and the other. Anyone who has access to Farber's private papers, if they're still in existence, will find my memos over there, which I had to send him once a week and to tell him and keep him informed of the situation not only of the high dose methotrexate situation but the clinic and things in general.

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## **Chapter 05**

### **B: MD Anderson Past**

#### ***MD Anderson and The Department of Pediatric Oncology in the Late Seventies***

##### Story Codes

A: Professional Path  
A: Personal Background  
B: MD Anderson History  
C: Portraits  
A: The Leader  
D: On Leadership  
B: MD Anderson Culture

***Tacey Ann Rosolowski, PhD***

**1:12:08.0**

How did it happen, your move to Harvard?

***Norman Jaffe, MD***

**1:12:14.4**

From Harvard to [MD Anderson?]

***Tacey Ann Rosolowski, PhD***

**1:12:16.0**

Yes talking about—because I was looking—because you went from the institute to—oh, I see. I'm sorry. We hadn't talked about the fact that the Children's Cancer Research Foundation is actually part of—

***Norman Jaffe, MD***

**1:12:33.3**

It's part of Harvard and part of the Children's Hospital and Medical Center. It was a combined institution.

***Tacey Ann Rosolowski, PhD***

**1:12:40.4**

A combined institution. My mistake. My apologies. And so would you like to talk now about how you made the move to MD Anderson?

***Norman Jaffe, MD***

**1:12:50.4**

Well, there were several factors involved. Firstly, I had reached what I think was the limits of my utility at Harvard. I couldn't go any further. Secondly, Harvard is a great place, but it is also a

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place full of politics, and I was getting a little tired of the politics. I mean, you make the statement in jest, but I say that at times I wondered when they said “Good morning” to you, I should go outside and see if it’s not “good evening.” But that was the situation, and there were some problems in that regard. I was getting a little tired of the problems, and life is too short to drink bad wine. You drink good wine. And it’s too short to fight problems of that nature. And more importantly, I was Farber’s bright little boy, and when Farber died, he had many enemies, and the enemies said, “It is time.” I was caught in the crossfire. I said, “Listen, I don’t need this.” I was not responsible for certain factors, but they certainly [felt] justified in saying, “We are now going to take things over.”

But more importantly, my daughter, who had a congenital heart, couldn’t take the cold, the snow, and things of that nature. And one of the more important factors as well was that [Wataru Sutow](#), who was employed in this institution—and we can talk about this institution in a short while about how it developed—was retiring. I got a personal telephone call from Wataru Sutow saying, “Norman, I have seen your work. I know you. I know what you’ve done, and I am retiring. You would do me a great favor if you came and took my position at this hospital.” Now, that was a personal call from Wataru Sutow. He was not a very great personal friend of mine, but I used to meet him at meetings and so on and discuss things with him. He, incidentally, taught me a lot, although he doesn’t admit it. Of course, now he’s dead. Although he didn’t admit it and although he didn’t recognize it in his mind, I believe that he did. I met him through his writings before I met him personally. I used to read his publications with avarice, and I thought he had a good mind, and as a consequence, when I say I was well taught, I was well taught because I was self-taught through publications by Wataru Sutow, by Donald Pinkel and things of that nature. That’s how I met him, and I think he must have realized [that] I had a great deal of respect for him, and that’s why he phoned me and said, “I’m retiring. I would like you to come down and consider a position,” and that’s when I came down here.

My daughter with a congenital heart, Wataru Sutow, factors at Harvard and so on, I said it was time to make a move. I’d been at the Farber Center for twelve years, seven of those under Sidney Farber, five under the new chief, Tom Frei, with whom I had a great relationship. I was really sorry to leave Harvard, but other factors were of more pressing problems to me, and I said it was time. That’s why I left and came to this institution.

When we talk about this institution, it was originally established—and we can talk about it now for that matter—it was originally established by Grant Taylor. I don’t know if you know that. He was the chief over here, and he started Pediatric Oncology at this time. I didn’t know him very well, but there is a story attached to him as well. He was always dressed in a suit. He retired after a period of time, but he always came to see what was happening over here, and he felt a great deal about the integrity of the environment. At one stage, we used to take our Coca-Cola cans and put them into the garbage and things of that nature. But he didn’t like it, so when I came here, he had adopted a practice of going to the various garbage cans and pulling out Coca-Cola cans and putting them into a plastic bag and carrying the plastic bag. My bride, who came

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to fetch me one evening, saw him walking out—he always wore a suit—with a bag on his shoulder and my bride said, “You have come to a very, very impressive institution. Even the janitor wears a suit!” That’s a true story. But she used to see him walking around with his suit, and every evening he would collect the cans.

*Tacey Ann Rosolowski, PhD*

**1:18:10.7**

What was he doing with the cans?

*Norman Jaffe, MD*

**1:18:12.5**

I think he was disposing of them appropriately, and if you see separate garbage pails now for cans, that’s because of Grant Taylor.

*Tacey Ann Rosolowski, PhD*

**1:18:25.0**

That’s so funny. People make their marks on institutions in all kinds of ways.

*Norman Jaffe, MD*

**1:18:28.7**

I don’t know if anyone knows that, but that’s what he used to do.

*Tacey Ann Rosolowski, PhD*

**1:18:32.7**

That’s a great story.

*Norman Jaffe, MD*

**1:18:34.6**

Grant Taylor established Pediatric Oncology at MD Anderson. He invited two people to assist him over the course of time. One was Wataru Sutow, [to] whom I referred, and the other was Margaret Pat Sullivan. I think one or both worked in the Marshall Islands investigating the effect of the atomic radiation in the Marshall Islands at that time. So both of them came over here and started Pediatric Oncology, and they remained here until their retirement or until their death.

*Tacey Ann Rosolowski, PhD*

**1:19:14.3**

When was that department established?

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***Norman Jaffe, MD***

**1:19:18.7**

Now, that I don't know. I came here when it was already established. The heads of the department were the following: First it was Grant Taylor. When Taylor retired, Dan Wilbur took over for a limited period of time. Dan Wilbur is currently in San Francisco. I think he's also retired now, but he was in charge of Pediatric Oncology in one of the hospitals in San Francisco. After Dan Wilbur retired—or didn't retire but moved to San Francisco—Jan van Eys took over. Jan van Eys is originally from Holland. He's still alive, incidentally, in Tennessee, and since I had been raised in an Afrikaans environment and spoke Afrikaans fluently, which is allied to Dutch, he and I often used to speak to one another, he in Dutch and I in Afrikaans (speaking Afrikaans). And Wataru Sutow, who invited me to come and take his position, had Jan van Eys as the chief, and van Eys recruited me.

At that stage, they wanted me very desperately, and I interviewed several people over here. I interviewed, for example, [Dr. Robert] Hickey, over here. I don't remember what his first name is. You've got the Hickey Auditorium named after him, and Hickey even said, "We will give you the same salary as we are giving Jan van Eys because we want you." There's also a story attached to that, incidentally.

I was invited to come down and inspect the facilities and so on and so forth, and I came down with my bride and my children. I had three children at that stage. We had four, because of my daughter with the congenital heart [died]. We stayed at the Anderson Mayfair Hotel. It's no longer in existence. There is the new hotel now, but it used to be the Anderson Mayfair, I think they called it. The president of MD Anderson was Lee Clark, and I was also requested –invited-- to be interviewed by [R.] Lee Clark. Lee Clark stayed at MD Anderson on a permanent basis. I think he had an apartment in the top floor, and I was already in the hospital, but my wife was in the elevator when Lee Clark was also in the elevator, and he had a file in his hand, and the file was marked *Norman Jaffe, MD*, and he was looking at it. I don't know if he had enough time to look at it elsewhere, and he said, "Impressive. Very good." And so my wife related that story to me, and so I had an additional card to play when I interviewed Lee Clark. You mustn't look at files in the elevator!

***Tacey Ann Rosolowski, PhD***

**1:22:34.3**

Especially not in front of an undercover agent.

***Norman Jaffe, MD***

**1:22:36.8**

That's right. He didn't know who she was and so on. That's where they put people up when they came to interview for a position and things of that nature.

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*Tacey Ann Rosolowski, PhD*

**1:22:46.5**

How did your interview with R. Lee Clark go?

*Norman Jaffe, MD*

**1:22:49.8**

It went off very well.

*Tacey Ann Rosolowski, PhD*

**1:22:51.3**

What were your impressions of him?

*Norman Jaffe, MD*

**1:22:53.8**

He was an unusual man, a go-getter. I don't know how much he knew about oncology, but he certainly was an individual who knew what he wanted, and he would do everything possible to get it. I rather liked him. I didn't have any problems with him, and as I say, having the additional card that I knew that he was impressed and so on, that's all I needed. We discussed a lot of things. I can't remember exactly, but I was not unhappy with the interview. Subsequently, in the final analysis, van Eys approached me and he said, "Listen, we are prepared to offer you a professorship here, full privileges"—which I'll enumerate to you in a moment—"a tenured position. You'll be a tenured position." Tenure at that stage was every seven years. I don't know what is the situation now, but I was given a full professorship, tenure, and he said, "I want you here in two positions: one, chief of the solid tumor service, and two, I want you to develop the long-term surveillance clinic, patients who are now survivors of cancer," because I had developed that particular clinic at the Farber Center, and it was called the [Dana-Farber Cancer Center](#) at that stage. I published about it and things of that nature, so I was asked to assume two positions: chief of the solid tumor service and head of the long-term surveillance clinic, which, incidentally, was being run by a man called Dr. Hugh Ried. He's still alive and well, and a reasonably good friend of mine, and one must not take positions away from an individual. One must respect their dignity, so I approached Hugh, and I said, "Listen, Hugh, you are running this clinic. I want to help you. I'm not your chief, I'm your colleague, and we'll do it together."

You can buy a man's soul with kindness. All you've got to do is approach them in the right way, and that's how my attitude has been to many of the positions I've held, and I've got more out of that than anything else. You can get people—More flies are attracted with honey than on a lemon, and just be kind and considerate to people, and you will get really a good friend out of that individual, and you'll get what you want out of that individual.

Hugh Ried and I got together, and we developed this clinic extremely well, to the extent that I wrote some papers and put his name on as the first author, as you may or may not hear, which he

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appreciated, and as I say, we still remain good friends. I was chief of the solid tumor service and chief of the long-term surveillance clinic. That position I held under Dr. van Eys.

When Dr. van Eys retired, Dr. Margaret Sullivan took the position over for about six to nine months, and then they sought another chief, and Ka Wah Chan took that position for a period of time, and eventually Archie Bleyer took the position and he took this position for about—I would say—eight years, ten years. And when he left, they sought another individual for the position, and I nominated Dr. Eugenie Kleinerman, who is head of the position, who is chairlady or chairman or whatever you call it, and head of the department now. In fact, she came to me when I had been at Anderson after about five years. Van Eys introduced her to me. She originally had a position with Isaiah Fidler or Josh Fidler, as he was called, head of the—

*Tacey Ann Rosolowski, PhD*

**1:27:09.0**

Metastasis laboratory.

*Norman Jaffe, MD*

**1:27:11.1**

And she said she was interested in osteosarcoma, and she presented some novel ideas to me, and I encouraged her to develop them, so much so that she's made fantastic discoveries in osteosarcoma. And when the time came for a new chief to assume the position, I think they wanted—and I supported this—a younger person, one who would at least be able to give them a fair amount of time and effort and so on, so I nominated her, and happily, she got the position. I got a call even from Dr. [John] Mendelsohn's office where he asked me what my impressions were of Eugenie Kleinerman, and I gave her a very positive outlook on things. And as I've told her and I've told others, I really have the pleasure of saying that I am supervised by someone whom I trained. I often use that cliché, and I think she likes it, and I certainly like it. Whatever the circumstances, she is currently the chief of Pediatrics, and I think she's doing a reasonably good job. That's where we stand with Eugenie.

*Tacey Ann Rosolowski, PhD*

**1:28:25.7**

You came to MD Anderson in—

*Norman Jaffe, MD*

**1:28:27.4**

In '66 [to the United States]. In '78. That's right.

*Tacey Ann Rosolowski, PhD*

**1:28:30.8**

And what were your impressions of the institution as a whole when you arrived? How did you find it? How did it function?

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*Norman Jaffe, MD*

**1:28:37.6**

I was very impressed with it. I liked it very much, and in general, I believe that they looked after their employees. Listen, there is no utopia. Let's get it straight. There are some problems at Anderson, but there are problems everywhere, and you just have to weigh which are the more major problems, which are the minor problems, which are those that you can live with, which are those which are a constant source of irritation to you, so much so that you cannot live with them. I found that there were problems, but to me, they were minor, and I was prepared to live with them, and in fact, even try and overcome them and things of that nature, and I thoroughly enjoyed my stay at MD Anderson.

*Tacey Ann Rosolowski, PhD*

**1:29:20.1**

What were some of the particular strengths of the institution when you came in 1978, and how did it compare with the situation under Sidney Farber?

*Norman Jaffe, MD*

**1:29:29.5**

It was far superior to the Farber Center. We had good people over here. We had investigative studies [at Anderson] that were not being conducted at Farber. It was an institution that was concentrated on investigation, on new therapeutic approaches. It was indeed at the cutting edge of medicine. I think the Farber Center has changed, but when I was at the Farber Center, there was no comparison [to Anderson]. This was the institution.

*Tacey Ann Rosolowski, PhD*

**1:30:02.7**

To what do you attribute that?

*Norman Jaffe, MD*

**1:30:05.0**

I think the people who were here—[Emil] J Freireich, Tom Frei, Evan Hirsch, Wataru Sutow. We had giants here. It was nothing at the Farber Center, so to speak. I know because I was there for twelve years, and I don't say that I did much for them, but I think I put the Farber Center on a reasonable course. It improved tremendously after Tom Frei, who was originally at MD Anderson, came over there and became my chief. I enjoyed working with Tom Frei, and he and I were sorry to depart, but I felt that it was appropriate to separate for the reasons that I explained—my daughter [with the congenital heart condition], the problems at Harvard and things of that nature, and the call from Wataru Sutow over here. And particularly when I had looked at this place and saw the facilities, the enthusiasm, what was being done and things of that nature, I said, "This is really at the forefront of cancer work now." I was very happy to come here.

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*Tacey Ann Rosolowski, PhD*

**1:31:15.5**

Let me just check in with you about the time. It's about ten minutes of 12:00.

*Norman Jaffe, MD*

**1:31:19.4**

I need to go to grand rounds.

*Tacey Ann Rosolowski, PhD*

**1:31:21.5**

Okay. What time do you need to leave?

*Norman Jaffe, MD*

**1:31:24.0**

In about five minutes.

*Tacey Ann Rosolowski, PhD*

**1:31:25.1**

In about five minutes, okay. Let me ask you one additional question, and then we can terminate the interview, and maybe we can make an appointment for another time. You've served under three MD Anderson presidents and sort of observed perhaps something about—

*Norman Jaffe, MD*

**1:31:45.7**

Actually, it's more accurate to say that I've served under two because Lee Clark was there, but he was retiring. Mickey [Charles A.] LeMaistre came on and then John Mendelsohn.

*Tacey Ann Rosolowski, PhD*

**1:31:59.7**

I was wondering if you could make some observations about their leadership styles and what they contributed to the institution.

*Norman Jaffe, MD*

**1:32:07.7**

I think each one has contributed to the institution in a different way. Lee Clark was responsible for its major initial growth and development, and I think he was very good, more for its growth and development than any scientific aspects. He really didn't put a lot of science into it, but I'm really not in a strong position to comment on that because I didn't work very much under Lee Clark. He more or less retired by the time I came here, and in fact, when Mickey LeMaistre came here, I often said to him, "Mickey, you have one great advantage. You and I came at the same time. That's your claim to fame." It's a joke that he could take. I think he did development, and

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he also introduced scientific aspects. John Mendelsohn was greater, in my judgment, than Mickey LeMaistre. He expanded the development far greater, and he's really a scientist. I don't think he's much of a clinician, incidentally, but I think he's a good scientist. Mickey LeMaistre was not a scientist, more a clinician, but I didn't see him do much clinical work. But each one contributed in the different aspects, and each one to me can be considered a giant in their different fields. As I say, I have worked under three. Well, not really three. It's two, under LeMaistre and John Mendelsohn. I told John that his claim to fame is that he and I were at Harvard at the same time, but we never came across each other. That's how I looked at it, and I have had a great relationship with each one. It's not been a very intimate one, but it's been nice. Take John. I used to speak him, and he said, "Do not call me Dr. Mendelsohn. My name is John." He and I went to the Senate in Austin at one stage to ask for funds and things like that, after I had introduced one of the senators to my ski trip [whom] I found in Utah, and perhaps on another occasion we can talk about that.

*Tacey Ann Rosolowski, PhD*

**1:34:23.3**

Absolutely. Well, why don't we close off the interview for today so that you can make your grand rounds.

*Norman Jaffe, MD*

**1:34:27.8**

It's been a real pleasure. Perhaps I've been rambling a little bit, but I apologize.

*Tacey Ann Rosolowski, PhD*

**1:34:31.8**

No, not at all. I'm turning off the recorder at about 11:54.

**(1:34:41.5 End of Audio Session 1)**

## **Norman Jaffe, MD**

Interview Session 2—August 17, 2012

### **Chapter 00B**

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

*Norman Jaffe, MD*

**0:00:01.3**

No harm in that.

*Tacey Ann Rosolowski, PhD*

**0:00:02.5**

I'm Tacey Ann Rosolowski, and as Dr. Jaffe mentioned, we are sitting here today. This is for our second interview session, and the time is 10:30, and this interview is taking place in the Reading Room of the Research Medical Library.

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## **Chapter 06**

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

#### ***Survivorship: A New Section of Pediatrics I***

Story Codes

A: The Clinician

A: Joining MD Anderson

A: Influences from People and Life Experiences

A: The Researcher

A: The Clinician

A: Contributions

B: Building/Transforming the Institution

A: Definitions, Explanations, Translations

***Tacey Ann Rosolowski, PhD***

**0:00:02.5 +**

Dr. Jaffe, you had mentioned that you would like to sketch the history of the Department of Pediatrics since you arrived at MD Anderson in 1978, so I wonder if you would start however you want with that particular history.

***Norman Jaffe, MD***

**0:00:40.8**

I'm very happy to do that. I was recruited into the MD Anderson Cancer Center in the Department of Pediatrics following Dr. Wataru Sutow's retirement. He actually phoned me and asked me to take his position over here, and since I'd reached what I considered to be the limits of my progression at Harvard Medical School and also at the Dana-Farber Cancer Institute, the opportunity was in fact ideal.

***Tacey Ann Rosolowski, PhD***

**0:01:14.1**

Do you know why he contacted you in particular?

***Norman Jaffe, MD***

**0:01:17.9**

I think that he was very enamored with the research that I was doing at the MD Anderson Cancer Center [corrected to: Sidney Farber Cancer Center]. In fact, he frequently contacted me. He always used to call me. "Young man, what are you doing now?" and so on.

***Tacey Ann Rosolowski, PhD***

**0:01:30.1**

And what was the area in particular you were focusing on?

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*Norman Jaffe, MD*

**0:01:32.4**

Solid tumors in pediatrics. He was a very fine gentleman. His interest in conchology—that is the collection of shells—was throughout the world, but in particular he knew I was from South Africa, and he said South African shores had a very rich supply of shells, and he would one day like to go there. And in fact, he often asked me about it. But I think his major interest was in my work in pediatric oncology, so much so that he even asked me to edit a book on his behalf. He had already started the book, but he didn't have sufficient time to complete it, and so I took over the reins and published [the] book. And incidentally, in that book, I dedicated it to Wataru Sutow, and my dedication stated as follows: "To Wataru Sutow, I knew him before I met him. I knew him from his publications."

*Tacey Ann Rosolowski, PhD*

**0:02:28.9**

That's wonderful. What was the name of that book that you edited for him?

*Norman Jaffe, MD*

**0:02:31.8**

I think it's called—I edited several books. I can't remember exactly what the name was, but I think it's called *Solid Tumors in Pediatrics*. And as I say, we continued to discuss things [ ] after eventually I did meet him. I met him at meetings and so on, and then when he was about to retire he phoned me and particularly asked me to step into his shoes because, as he said, he could think of no one else who would be the ideal candidate for this particular position. And for many reasons, in Boston particularly, as I reached the limits of what I considered my academic progression—Harvard is a very difficult situation, and I think you've got to wait for the individual above you to expire [or retire] before you will get his position, if you do in fact get his position. As a consequence and for many other reasons as well, after discussing it with my bride of thirty-two years at that stage, I decided to make the movement, and she was totally supportive. We did move, and it was in fact a very, very ideal situation, something that I've not indeed regretted.

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## **Chapter 07**

### **A: Contributions to MD Anderson**

#### ***Survivorship: A New Section of Pediatrics II***

Story Codes

A: Joining MD Anderson

A: Influences from People and Life Experiences

A: The Researcher

A: The Clinician

A: Contributions

B: Building/Transforming the Institution

A: Definitions, Explanations, Translations

***Tacey Ann Rosolowski, PhD***

**0:03:48.1**

And so you arrived at MD Anderson in 1978.

***Norman Jaffe, MD***

**0:03:50.7**

Correct.

***Tacey Ann Rosolowski, PhD***

**0:03:52.0**

And what did you see yourself setting out to do?

***Norman Jaffe, MD***

**0:03:56.6**

I was recruited to MD Anderson Cancer Center in the pediatric department for two particular reasons. Dr. van Eys wanted me to take over Sutow's positions and to expand the section on solid tumors. In fact, I was given the title Chief of the Solid Tumor Service, and also he asked me to expand the late survivor situation as well. I had already started a late survivor investigation and follow-up clinic at the Dana-Farber Cancer Institute. That clinic was already in existence at the Pediatric Department at the MD Anderson Cancer Center, but it was not very well developed at that time. It was running along quite smoothly, but it required a great deal of effort and industry to expand it and to expand all the aspects of solid tumors rather than just simply to see follow-up patients who were cured of these tumors, because these patients were now developing complications. They were developing problems related to the chemotherapy, problems related to their survival and so on, and it needed to open up a new avenue of research. And in fact, I immediately set upon creating a grant for that particular aspect, which was, incidentally, very well received, but unfortunately, funding at that particular time was at a low ebb, so it could not be funded satisfactorily. But we continued to expand on it, and Dr. Hugh Ried, who was in

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charge of that clinic, was maintained as the individual to be in charge, and I supervised him together with another person, Hallie Zietz, who was a nurse practitioner, a very, very competent woman. And between Dr. Ried, Hallie Zietz, and myself, we expanded that very, very well, to the extent that I think we published approximately twenty publications on our work in the follow-up clinic of long-term survivors. But my main emphasis was on expanding and developing the solid tumor section from Wataru Sutow, which I did.

***Tacey Ann Rosolowski, PhD***

**0:06:19.2**

Just a quick question about that funding for the survivorship initiative—was funding in general difficult to get at that time for all research, or was it survivorship? I was just curious if there was less interest in survivorship for some reason.

***Norman Jaffe, MD***

**0:06:35.0**

There was, actually. That's quite correct. It was only in its embryonic stage at that stage, but I had actually started the first long-term survivor clinic at the Dana-Farber Cancer Institute. In fact, Dr. Fred Li, who unfortunately developed several complications, I think he developed a stroke at some stage in his career and could no longer continue his work, but he and I started the long-term survivor clinic at the Dana-Farber Cancer Institute, and I think one of the first publications, if not the first publication, I published on long-term survivor complications from chemotherapy.

***Tacey Ann Rosolowski, PhD***

**0:07:15.7**

I think it was in 1975, because I noticed how early— It was so early.

***Norman Jaffe, MD***

**0:07:20.4**

But there was no recognition of the problems and difficulties and complications which could occur in long-term survivors at that time because, quite frankly, long-term survivors were a new entity. People did not expect patients to survive to be cured of their cancers, the children, at that particular time.

***Tacey Ann Rosolowski, PhD***

**0:07:38.9**

Now, did you notice that children developed secondary effects or side effects more quickly than adults who were survivors?

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*Norman Jaffe, MD*

**0:07:48.4**

Well, I can't tell you about adults because I didn't treat adults, but I began to recognize these long-term complications quite soon as I saw them in their followup, and as a consequence of that I published—I think it must have been the first paper on long-term effects from chemotherapy and radiation therapy in long-term survivors of childhood cancer.

*Tacey Ann Rosolowski, PhD*

**0:08:10.7**

I'm sure we'll come back to this, but just quickly, so we have an idea right now, what were some of those effects that you saw?

*Norman Jaffe, MD*

**0:08:16.9**

There were problems in growth and development. There were problems in reproductive function. There were problems in intellectual issues, patients who had received radiation to the head. Practically every organ or system in the body could be tainted with a long-term complication. This developed more and more, so much so that when Melissa Hudson, who was my fellow at the MD Anderson Cancer Center some ten or fifteen years later, was doing her fellowship and I interested her in this—and she has made a remarkable development and published numerous publications on the long-term survivor complications in childhood cancer, and it's been recognized now as a unique entity in this. Most of the pediatric publications, journals and so on, talk about quality of life, talk about long-term complications and things of that nature.

*Tacey Ann Rosolowski, PhD*

**0:09:20.6**

So it was really groundbreaking.

*Norman Jaffe, MD*

**0:09:21.8**

Absolutely, it's an entirely new section of pediatrics.

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## **Chapter 08**

### **A: The Researcher**

#### ***Solid Tumors and the TIOS Protocols (Treatment and Investigation of Osteosarcoma)***

#### Story Codes

A: The Researcher;

A: Definitions, Explanations, Translations;

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

C: Discovery and Success;

C: Healing, Hope, and the Promise of Research;

***Tacey Ann Rosolowski, PhD***

**0:09:30.6**

Let's go back to your arrival at MD Anderson.

***Norman Jaffe, MD***

**0:09:34.9**

Then when I came here, as I say, I was the chief of the Solid Tumor Section and also I had a major part— In fact, I was also responsible for the Long-Term Survivor Clinic. But I concentrated my efforts particularly as chief of the Solid Tumor Section, and the first thing I did was to develop a new protocol in Pediatric Oncology for osteosarcoma. I called this protocol TIOS. TIOS is the acronym for Treatment and Investigation of Osteosarcoma. I published three protocols on the TIOS research in osteosarcoma, TIOS I, II, and III. I was concentrating on TIOS IV when Dr. Eugenie Kleinerman [Oral History Interview], who was appointed head at that particular time, also began investigations in what is known as [liposome MTP-PE](#), liposome muramyl tripeptide phosphatidylethanolamine in osteosarcoma, and she needed patients to test the efficacy of this particular compound in osteosarcoma. So as a consequence, I aborted my investigations on TIOS IV and concentrated then on entering patients into the [2 x 2 factorial design](#) which was created for the investigation of this liposome MTP-PE. In fact, I entered the largest number of patients [from a single institution] into this trial to determine its efficacy in osteosarcoma. I would say that the drug has shown some promise. It is available throughout Europe and in Mexico, but for some reason or other, it has not been accepted by the FDA in the United States. Further discussion on this is in progress.

***Tacey Ann Rosolowski, PhD***

**0:11:42.9**

Let me go back for a moment and ask you about the protocol. Why did you feel that new protocol was needed, and what exactly was the TIOS about?

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*Norman Jaffe, MD*

**0:11:54.1**

We had developed protocols with four major chemotherapeutic agents for the treatment of osteosarcoma. Prior to the development of these agents the survival rate in osteosarcoma was in optimum circumstances ten to twenty percent. It was usually of the order of five percent. Eventually it was concluded that the chemotherapeutic agents which we had discovered were in fact active in osteosarcoma and should be administered to all patients with osteosarcoma. One of the first agents, incidentally, was high dose methotrexate with citrovorum factor, or as it is now known, leucovorin factor or leucovorin in osteosarcoma. This, incidentally, was not initially accepted. It went through a lot of trials and tribulations.

*Tacey Ann Rosolowski, PhD*

**0:12:51.4**

Why?

*Norman Jaffe, MD*

**0:12:53.0**

I have no idea, but it appeared that many physicians could not accept the concept that there was in fact a possible cure for osteosarcoma. Prior to that, the understanding was that if a diagnosis of osteosarcoma was established, one should simply amputate the limb and do nothing further. In fact, there was a British surgeon, Sir Stanford Cade, who was both a surgeon and radiation therapist, and in one meeting on osteosarcoma he made the following statement, and I'm paraphrasing. He said, "Gentleman, if you operate, they die. If you don't operate, they die just the same. This meeting should be concluded with prayers," and he signed off. That was the prevailing attitude at that particular time.

Osteosarcoma was in fact a uniformly fatal disease. With the discovery of high dose methotrexate, which went through a tremendous "birth event" in order to be accepted—it was finally accepted through a randomized, controlled trial—the change in outlook for osteosarcoma was tremendous. Not only was high dose methotrexate effective, but Adriamycin, cyclophosphamide and cisplatin, also known as platin, became effective in osteosarcoma, and combinations of these agents utilized before and after the operation to remove the tumor were administered to the effect that the survival rate now changed from approximately ten to twenty percent to close to sixty-five percent. And with additional multidisciplinary intervention, the survival rate could be escalated even to seventy-five or eighty percent, and that has held true. Unfortunately, it has held true for the past thirty years. We've made no major impact in survival since the past thirty to forty years, and that's our greatest challenge now in osteosarcoma. Notwithstanding, that was the assignment, self-imposed by myself, and for that matter, given to me by Dr. van Eys, to develop a protocol for the treatment of osteosarcoma, and I did so utilizing the TIOS protocol.

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Now, why the TIOS protocol? The TIOS protocol was unusual from the prevailing protocols at that particular time. The protocols extant at that particular time did not use [intra-arterial chemotherapy](#) for osteosarcoma. Dr. Robert Benjamin developed intra-arterial cisplatin for the treatment of osteosarcoma. This enhanced the opportunity to destroy the tumor at the presenting site, so much so that the effects were so great that one could convert most of the patients who were destined for amputation into what is known as a limb salvage procedure, and today at least eighty percent of patients with osteosarcoma undergo limb salvage as opposed to amputation. It was a major milestone in osteosarcoma, and that continued. But as I say, unfortunately, there's been no major improvement in osteosarcoma following these developments approximately thirty to forty years ago.

*Tacey Ann Rosolowski, PhD*

**0:16:25.1**

What is your perspective on why that's the case?

*Norman Jaffe, MD*

**0:16:29.0**

It's because we do not have an effective new agent. We do not have new tactics and strategies to treat this particular tumor, and that is sorely needed. That's our major challenge for the new century.

*Tacey Ann Rosolowski, PhD*

**0:16:47.4**

You said that there were three types of protocols that you developed under—

*Norman Jaffe, MD*

**0:16:51.7**

The TIOS protocols. That's correct, and there was TIOS IV, as I say. I aborted it because I wanted to give Dr. Kleinerman the opportunity to investigate the new biological agent which she had developed in osteosarcoma, liposome MTP-PE.

*Tacey Ann Rosolowski, PhD*

**0:17:15.2**

I wanted to ask you about your collaborators for the TIOS project.

*Norman Jaffe, MD*

**0:17:19.2**

The collaborators were simply all the individuals in my department. Anyone who did even the minutest amount of work which I thought was significant was put on as a co-author in my publications.

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*Tacey Ann Rosolowski, PhD*

**0:17:34.1**

Who were some of the individuals that you—?

*Norman Jaffe, MD*

**0:17:36.1**

Alex Wang, John Murray was the surgeon, Pat Cassidy was the—no, Cassidy was from Dana-Farber. But there were quite a number. They were usually my fellows, and I gave the opportunity for the fellows to have their names on it in order to ensure that their academic positions in the future could be promoted and secured.

*Tacey Ann Rosolowski, PhD*

**0:18:04.1**

What was the next phase of your research? Or would you like to continue with the story of your influence in the department?

*Norman Jaffe, MD*

**0:18:11.0**

The next phase in my research, because we now were concentrating on liposome MTP-PE, was devoted entirely to that until I retired.

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## **Chapter 09**

### **B: An Institutional Unit**

#### *The Chiefs of Pediatrics at MD Anderson*

##### Story Codes

C: MD Anderson Past

A: The Administrator

B: Institutional Politics

B: MD Anderson and Government

B: Critical Perspectives on MD Anderson

*Tacey Ann Rosolowski, PhD*

**0:18:23.4**

Would you like to continue with that story, or would you like to continue with the department?

*Norman Jaffe, MD*

**0:18:27.0**

I think we can return now to the department. I was recruited in 1978, as I say, by Dr. van Eys, but at the instigation of Dr. Sutow. And once I had come over here, then I concentrated on two particular aspects—solid tumors in children and the long-term survivor clinic. With respect to the solid tumors, I was entirely in charge of the musculoskeletal tumors, that is, all the bone tumors and all the muscular tumors, also rhabdomyosarcoma, synovial sarcoma and the like. In addition, I had done a fair amount of work in Wilms' tumor, tumor of the kidneys, so that was given to me as well. I did a little bit of work on [neuroblastoma](#), but Dr. Ayten Cangir, who was responsible for neuroblastoma, was doing a particularly good job, and as head of the solid tumors, I thought it was important for her to maintain her interest and possibly also promote its further development. She was also interested in brain tumors together with Dr. van Eys. I had one policy at that particular time. If you're doing a good job, continue. I think the common expression is "If it ain't broke, don't fix it," so I didn't fix it. I encouraged them. I supported them. I did whatever I could to ensure that there would be further development and expansion, and I think it really came through. The solid tumor section actually was running like a well-oiled machine. I was quite proud of it, and that, incidentally, remained so until Dr. Archie Bleyer came over here, and we can discuss the development and appointments of the new chiefs in the course of time. But Dr. Bleyer felt that he would like to make new changes in the Department of Pediatrics, and he released me from my self-imposed obligations, really, in the [musculoskeletal tumors](#) and told me to concentrate particularly and only, for that matter, on the bone tumors and not on the muscular tumors. He did permit me to continue working on Wilms' tumor.

*Tacey Ann Rosolowski, PhD*

**0:20:58.6**

And about what year was this that you shifted focus?

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***Norman Jaffe, MD***

**0:21:04.2**

I think Dr. Bleyer came here in 1996. I'm not sure of the exact time, but let me give you the sequence of events now of the chiefs who came here in Pediatrics and that will show you how the Department of Pediatrics developed. In fact, we can trace the development of the Department of Pediatrics to the first person who was appointed as the chief of Pediatrics, and that was Grant Taylor. That was many years ago. I was not here, but I was told that he was the first chief, and I met Grant Taylor on a number of occasions. I think I may have said this before, but Grant Taylor retired [and] Dr. Dan Wilbur was appointed the chief. Well, he was appointed the chief when Dr. Grant Taylor retired, and subsequently, Dr. Grant Taylor still came to the MD Anderson Cancer Center to see about its progress, its development. In fact, it was his little baby. He was always dressed in a suit, and he was very conscious of environmental factors. I may have mentioned this to you, but he eventually came to the decision that all the Coca-Cola cans and cans of this nature were in fact going to waste, so he used to go around every night and collect the Coca-Cola cans in a plastic bag and hang it over his shoulder, and once when my wife came to visit me to take me home she said, "You have a wonderful institution. Even the janitor wears a suit." I thought that was very good and very clever. But he was the first chief.

***Tacey Ann Rosolowski, PhD***

**0:22:51.0**

What was his vision for pediatrics, as you understand it?

***Norman Jaffe, MD***

**0:22:54.9**

To develop a complete and comprehensive pediatric department which would encompass not only clinical work but also bench work, research work, and the like. He never quite achieved the bench work, but he did develop a pediatric clinical setup, and that was due entirely to two people, and those two people were Dr. Wataru Sutow, whom he recruited, and Dr. Margaret Patricia Sullivan, who we used to call Pat. It was Wataru Sutow and Pat Sullivan who were responsible for the further development of the pediatric department once it had been developed by Dr. Grant Taylor. When Grant Taylor retired, I don't know what the circumstances were, but Dan Wilbur --Jordan Wilbur-- was recruited as the head of Pediatrics. His name was Jordan, but we called him Dan, and he did some remarkable work. He developed what was known as the [VAC chemotherapy](#) for soft tissue sarcomas in children. VAC comprises three agents: vincristine, actinomycin D and cyclophosphamide. VAC is an acronym for vincristine, actinomycin D, and cyclophosphamide, and that has had a major impact on the treatment of the soft tissue sarcomas in children, and it [also] has not changed over the past forty years. It has been added and modified, but it still remains the cornerstone of treatment. I don't know how long Dan Wilbur was the chief, but when he retired and moved to San Francisco, Dr. Jan van Eys was then appointed Chief of Pediatrics.

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Jan van Eys had a different outlook for it. While he maintained what had been developed in the past and he wished to enhance certain aspects of pediatrics, namely the solid tumor sections in which he appointed me the chief of solid tumors, he concentrated a lot on the psychosocial aspects of patients and also on the religious aspects of patients. He was quite a religious man and used to get our department involved quite frequently in discussing religious matters and so on and so forth, and I think he used religion as a major mechanism of support for patients who were afflicted with cancer. I think it had a very, very profound influence on the patients and supported them. He was the chief of pediatrics for quite some time, and I worked under him for as long as he was here. I think it must have been about fifteen years.

***Tacey Ann Rosolowski, PhD***

**0:25:49.6**

May I ask you how to you spell his last name?

***Norman Jaffe, MD***

**0:25:52.7**

It's actually Dutch, so it's V-A-N, and then it's E-Y-S. The van is a small v, V-A-N and E-Y-S. He spoke Dutch. I spoke Afrikaans. We would often converse in that particular language. It's not the same, but there is a very close relationship and kinship, so much so I would say to you that when the prime minister of South Africa, a great man, Jan Smuts, who was responsible for an important document in the League of Nations in World War I, creating the concept of equality for all nations—when Jan Smuts, the prime minister, visited Holland and spoke to Queen Juliana, he spoke in Afrikaans, and she spoke in Dutch, and they could both understand each other very well. I don't say that I was Jan Smuts and van Eys was Queen Juliana, but we used to speak Afrikaans and Dutch.

***Tacey Ann Rosolowski, PhD***

**0:27:02.7**

It probably offered you a little bit of a home there for the moment.

***Norman Jaffe, MD***

**0:27:05.1**

It did to some extent. We got on extremely well. There was no problem there. But eventually Dr. van Eys, I think, wanted to become head of a department of pediatrics, not just head of a cancer department, so he took over the head of the Department of Pediatrics at the Hermann Hospital in the University of Texas system at Hermann, and when he moved over Pat Sullivan was appointed Chief of Pediatrics. She held that position for approximately a year, and then she resigned or retired. I think she retired, and we were waiting for a new chief to be appointed, and during that interim period Dr. Chan, his name was Ka Wah Chan—C-H-A-N, K-A and W-A-H, two separate words, Ka Wah Chan—was appointed interim chief, pending the appointment of a permanent chief. He held that position for about five years and was quite competent in it, but at

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the end of it, as he explained to me, he was tired, and he felt that he wanted to resign, which he did.

*Tacey Ann Rosolowski, PhD*

**0:28:22.5**

Was it unusual to have an interim chief for so long?

*Norman Jaffe, MD*

**0:28:26.0**

Yes, it was, because they couldn't find anyone. Eventually they appointed Dr. Archie Bleyer as head of pediatrics. I think that could have been in 1995, and he probably accepted that position for eight to ten years, and then eventually he resigned, and Dr. Eugenie Kleinerman was appointed chief, and she's held that position to this day.

*Tacey Ann Rosolowski, PhD*

**0:28:57.7**

What did Dr. Bleyer bring to the department, his perspective and goal?

*Norman Jaffe, MD*

**0:29:03.6**

He tried to change certain aspects. I must tell you that it was not entirely well received. He had major problems here, and people didn't quite accept him as he had hoped that he would be accepted because of his attempt to change things.

*Tacey Ann Rosolowski, PhD*

**0:29:20.1**

What did he try?

*Norman Jaffe, MD*

**0:29:21.7**

For instance, let me give you my own example. He indicated to me that he felt as the chief of the solid tumors I had accepted too much, and therefore I should relinquish my responsibilities in the soft tissue sarcomas entirely to Dr. Beverly Raney. He brought Dr. Beverly Raney into the department as his assistant head of the department. That lasted one year, and Dr. Raney was demoted. And he enticed Dr. David Tubergen to come to the department. He accepted the position, and he became the head of leukemia in this department. That lasted—I don't know—three or four years until Dr. Tubergen retired from that position. He also changed our relationship with the entire pediatric setup in the United States. There were two major cooperative groups in the United States. There was the [Children's Cancer Group](#) and the Pediatric Oncology Group, and we were initially a part of the Pediatric [Oncology] Group. Dr. Bleyer was head of the Children's Cancer Group, so he severed our relationship with our group and joined the MD Anderson Cancer Department with his group.

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***Tacey Ann Rosolowski, PhD***

**0:30:59.6**

With the Pediatric Cancer Group.

***Norman Jaffe, MD***

**0:31:01.1**

And both groups eventually merged, and it is now known as the Pediatric Oncology Group. There was a little bit of resentment of that because we were loyal to the original group. Anyway, a lot of problems, and I think resentment did eventually occur to the extent that Dr. Bleyer felt he would be better off if he retired, which is what he did, and then Dr. Kleinerman took over.

***Tacey Ann Rosolowski, PhD***

**0:31:34.5**

Did he leave a mark in any other way? You've talked about some upheavals that kind of got created. Were there some positive stamps he put on the department?

***Norman Jaffe, MD***

**0:31:45.1**

I don't think so.

***Tacey Ann Rosolowski, PhD***

**0:31:46.8**

That's an unfortunate period of time in the department's history. And so when Dr. Kleinerman took over, what did she bring to the department?

***Norman Jaffe, MD***

**0:31:58.4**

She enhanced the investigative aspects of osteosarcoma. While she's a clinician and an investigator, her efforts now concentrated more on the investigative and bench work in pediatric oncology. She was a good clinician and worked with me. In fact, her interest in osteosarcoma developed as a result of our collaboration. She used to come at least once a week to my rounds and so on and so forth, and I invited her to give talks to our fellows during that particular period once a week as well, and those talks were well received. She did very well from that point of view, and she acquired several patients whom she addressed and tended to and things of that nature. I think that she acquitted herself well in that particular aspect, and I think she was better received than Dr. Bleyer, and so much so that she's remained in that position even today.

***Tacey Ann Rosolowski, PhD***

**0:33:10.6**

It sounds like she probably had a different leadership style.

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*Norman Jaffe, MD*

**0:33:13.4**

A different focus. That's correct.

*Tacey Ann Rosolowski, PhD*

**0:33:14.6**

How would you characterize her style vis-à-vis Dr. Bleyer?

*Norman Jaffe, MD*

**0:33:18.8**

While I was there—I don't know what's happened since I've been retired for the past six years—but while I was there she let people continue in the manner in which they were doing because it was similar to mine, really. If you're doing a good job, carry on. I'm happy to provide some interests and suggestions and guidance and so on if you feel it is required, and I'd like you to talk to me about these things, and meanwhile, if you're doing a good job, carry on. That was the setup over there, and I don't know what has happened since my retirement, but as far as I can see, the department has developed quite nicely, and that's the situation today

[Redacted]

*Tacey Ann Rosolowski, PhD*

**0:34:27.1**

Wow, that's a lot to go through.

*Norman Jaffe, MD*

**0:34:30.5**

As far as I know, everything is in order. That's the setup with Dr. Kleinerman, and those are the number of chiefs we've had in the department. I numbered them out the other day, and there were a total of seven to date.

*Tacey Ann Rosolowski, PhD*

**0:34:46.9**

When you look at the entire scene of the department's development, what are the big points of evolution that you see—the big themes?

*Norman Jaffe, MD*

**0:34:57.7**

We've advanced in major respects in the solid tumors because we have published important articles on the treatment of osteosarcoma, both from the biochemical point of view with Dr. Kleinerman's MTP-PE and also with the conventional forms of chemotherapy. We've also developed the concept of solid tumors because of our ability to destroy the primary tumor with intra-arterial platinum and also now with combination chemotherapy.

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*Tacey Ann Rosolowski, PhD*

**0:35:38.5**

How does that develop the concept of the solid tumor? I mean, I was listening to your phrasing. You said you've developed the concept of the solid tumor. Did I understand you correctly?

*Norman Jaffe, MD*

**0:35:52.5**

It's the concept of continuing and implementing limb salvage procedures. Limb salvage is not new. It has been done before, but it could not be maintained because of local recurrences developing at the site. With the administration of effective chemotherapy, the incidence of local recurrence was tremendously diminished. It's not entirely eliminated, but it has diminished to the extent that now at least 80 percent of patients, instead of undergoing amputation, undergo limb salvage. We save their limbs.

*Tacey Ann Rosolowski, PhD*

**0:36:30.8**

Now, let me understand how that works. When you discover the— There's an initial tumor, and then it's treated.

*Norman Jaffe, MD*

**0:36:39.5**

Then we treat it with chemotherapy. Originally we used to use intra-arterial platinum. Unfortunately, intra-arterial platinum, while extremely good, is labor intensive. It requires a lot of work. It requires an anesthesiologist for doing conscious sedation. It requires the radiology suite to be dedicated to that particular individual for the morning and things of that nature. It's not often and not commonly used [now], but it is used in certain circumstances when you need a rapid, definitive attack on the tumor, when you need a rapid answer for certain things and things of that nature. Now we've switched back to what is known as the conventional combination chemotherapy, which gives you more or less the same result as intra-arterial platinum, but the time taken to get that result is more prolonged. It may take you approximately three to four weeks, whereas with intra-arterial platinum you'll get your answer within a few days.

*Tacey Ann Rosolowski, PhD*

**0:37:41.7**

When do these recurrences emerge?

*Norman Jaffe, MD*

**0:37:46.0**

In the course of treatment.

*Tacey Ann Rosolowski, PhD*

**0:37:47.5**

So it's very rapid.

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*Norman Jaffe, MD*

**0:37:49.1**

In about six to nine months you'll see a recurrence. It is a different tactic that one employs with intra-arterial as opposed to intravenous, but because it's so labor intensive, it's more involved, and because it is also economically difficult to maintain, people have resorted now to the conventional form of treatment, whereas intra-arterial—although we used intra-arterial quite extensively during my tenure at this time.

*Tacey Ann Rosolowski, PhD*

**0:38:27.1**

What is the difference for the patients? Because your patients are very tiny people. Is one of those easier for the patient to bear?

*Norman Jaffe, MD*

**0:38:39.8**

Yes, I think that the intra-arterial is more difficult.

*Tacey Ann Rosolowski, PhD*

**0:38:41.8**

Really? Why?

*Norman Jaffe, MD*

**0:38:44.4**

You have to pierce the artery. You have to do the administration under conscious sedation. You have to keep the patient quiet for twenty-four hours and things of that nature, whereas with the intravenous form it's done in the hospital ward. The patient has regular chemotherapy like every other patient and things of that nature. There is a tremendous difference, but the major difference between intra-arterial and conventional chemotherapy is that the intra-arterial is very rapid in terms of achieving a response.

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## **Chapter 10**

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

#### ***The Ski Trip Rehabilitation Program***

##### Story Codes

A: The Clinician

A: The Administrator

A: Contributions

B: Building/Transforming the Institution

C: Offering Care, Compassion, Help

C: Patients

C: Human Stories

##### ***Norman Jaffe, MD***

**0:38:44.4+**

Now let me go a little further. Once I had—to my mind at least—created and satisfied the obligations that were imposed—and some of them were self-imposed upon me when I came over here—I began to devote my attention also to the rehabilitation of patients with osteosarcoma, and that was the concept underlying the ski trip, the Ski Rehabilitation Program. I think I may have mentioned it. It was actually introduced to me by Ted Kennedy. I treated young Ted Kennedy, the son of the late senator, when I was in Boston, and he showed me that one could in fact ski even though one had an amputation. When I was at the MD Anderson Cancer Center and I had started the ball rolling in terms of changing things, improving things, developing parts of the long-term survivor clinic and also in the musculoskeletal tumors, there was a patient. Her name was [Redacted], and she had undergone an amputation, and her mother heard about my work with Ted Kennedy. [Redacted] I can't remember her name, but she was incidentally an air hostess—[Redacted] and another woman, Rhoda Tomasco, approached me and said they would like for me to continue the ski program that I had developed at the Dana-Farber Cancer Institute. And we went up to Winter Park, Colorado, and inspected the facilities over there, particularly with a person called [O'Leary]—I can't remember his second name, but it was Howell, and he showed us that he was teaching amputees, particularly veterans, how to ski. And with his blessing and assistance we brought up a contingent of patients and taught them how to ski, and that started the ski program thirty years ago.

##### ***Tacey Ann Rosolowski, PhD***

**0:41:40.8**

How did you select those initial patients?

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*Norman Jaffe, MD*

**0:41:43.3**

Obviously on the basis that they had to be amputees, and secondly, they had to be clinically fit for that particular situation. They could still be undergoing treatment, but as long as they were capable of learning how to ski we permitted them to go.

*Tacey Ann Rosolowski, PhD*

**0:42:01.9**

How old were these kids?

*Norman Jaffe, MD*

**0:42:03.2**

The age did not matter as long as they were secure in what they could do, but there was another point also. I arranged for a single parent to accompany the patient. Now, there was some method in that. I told the hospital that I would convene meetings with the parents at night, and I would discuss with the parents their concept and aspects of the treatment that their child had received while in hospital, and I indicated that this would permit me to make changes to support certain programs and things of that nature at the MD Anderson Cancer Center. At night we used to have meetings around the fireplace, and I would ask the parents what were your problems, what were your difficulties, and so on.

*Tacey Ann Rosolowski, PhD*

**0:42:59.5**

What were some of the things you heard?

*Norman Jaffe, MD*

**0:43:02.2**

There was not enough communication between a nurse and a patient. There was not sufficient time for a procedure to be implemented without forewarning the patient in advance, and things of that nature. I can't remember them all, but they were very valuable pieces of advice, and we did change things. I did that for about four or five years, and because the parents had given me that advice, they were given the opportunity to come free of charge. MD Anderson paid for their trip.

*Tacey Ann Rosolowski, PhD*

**0:43:37.9**

I was going to ask you how it was funded.

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*Norman Jaffe, MD*

**0:43:40.2**

Through MD Anderson. It was very well received. Later the funding came from the art project, the Children's Art Project, which is still done today. There is a problem, however. Next year's trip cannot be funded. We do not have sufficient funds, but we believe that we will be able to continue in 2014. Next year's trip is suspended, but even though it is suspended, the parents of the trips from the past who have been so enamored and so excited with the trip, and the children, have come together and said that they will go on the trip and pay independently to go on the trip and so have asked our advice and guidance. The trip in 2013 will still take place but apparently with a diminished number of patients and also without the staff of the MD Anderson Cancer Center. But we are trying to make arrangements to reinstate the trip for 2014.

*Tacey Ann Rosolowski, PhD*

**0:44:46.1**

What did you observe the first trip that you went on? What impact did you see?

*Norman Jaffe, MD*

**0:44:52.5**

There was a tremendous change in a patient's outlook. Whereas before they were meek and mild, some of them felt that they could not do a thing, at the end of the week when they were showing their prowess, their ability to ski, and even better than I could ski, and so on and to show that they could do things that normal people could do and even better. There was a tremendous change in the psychological attitude of patients, and I think that has held true throughout the period of time that we've held these trips.

*Tacey Ann Rosolowski, PhD*

**0:45:30.6**

How long are the—?

*Norman Jaffe, MD*

**0:45:32.0**

Seven days. Now, let me tell you that on day one they get their gear. On day two they learn to ski. On day three their skiing is improved and so on, and at night we have a dance on one night. Amputees can dance, and I insist on them dancing. On another night we have what is called tubing, take them down to the tube and put them in the tubes, and they go down.

*Tacey Ann Rosolowski, PhD*

**0:46:01.3**

Oh, so like sliding down the hills.

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*Norman Jaffe, MD*

**0:46:04.9**

And we have a child life worker with us, and she keeps them occupied. We have a psychologist and psychiatrist—mainly a psychologist—to come with us and to discuss things with patients and to see what impact it has had. In fact, Dr. Rhonda—what is her name?—Rhonda Roberts can give you more information on what she considers to be the great benefits that have accrued from these children. She's written several papers on it already, and she's going to present some more at some of the cancer meetings. There is tremendous dividend that can occur from these particular trips.

*Tacey Ann Rosolowski, PhD*

**0:46:48.8**

Is it unusual for a cancer center to have this kind of support for patients?

*Norman Jaffe, MD*

**0:46:55.1**

Certainly the ski trip. I don't know. There are one or two centers who have a ski trip, but I have been told by what is called the [National Ability Center](#) in Park City, where we have these trips, that as far as they're concerned, the trip organized by MD Anderson is the best in the world, and we have documents to support that in terms of letters and so on.

*Tacey Ann Rosolowski, PhD*

**0:47:21.3**

What do you think they see in your program that makes it come above the others?

*Norman Jaffe, MD*

**0:47:27.7**

The program didn't develop overnight. It took thirty years to come to its fruition. At the very end of the program we have a race that encourages the children to show what they've done. We have a meeting on the last night where we present the prizes and things of that nature, and each child comes and discusses what he or she has learned from it and things of that nature. The ski instructors talk about how the child has developed over the course of several days, the patient. There is, I think, a different attitude in each child, in each patient, from day one compared to day seven. Incidentally, each patient has a one-on-one ski instructor so that they get the best possible form of teaching in terms of their skiing.

*Tacey Ann Rosolowski, PhD*

**0:48:28.6**

How did the program and what you offer during those seven days evolve over—and why?

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*Norman Jaffe, MD*

**0:48:34.6**

Well, because we saw we needed to do this, we needed to do that, and things of that nature. When we first [started] thirty years ago, well, let the kids ski. That was not good enough after a while. Listen, we've got to do something more. We've got to show the kids that they can do other things, so here is a games night. Here is another night where we take them to the rehabilitation center, and we get them to climb up the mountain, the wall. Now, amputees can climb up those walls, and we show them they can do that. They can ski. They have a night of games like normal children. They have a night where they climb up the wall. They have a night of dancing. They have one free night where we tell them, "Go out with your parents and do what you like." This sort of thing puts them into a normal category of individual.

*Tacey Ann Rosolowski, PhD*

**0:49:27.3**

Have you studied the effects on each of the children who have gone through this program?

*Norman Jaffe, MD*

**0:49:33.2**

Dr. Rhonda Roberts has done that, and I think it may be worthwhile having a chat with her. We have already published several papers on this.

*Tacey Ann Rosolowski, PhD*

**0:49:43.3**

Have you found that these individuals are more successful in adjusting?

*Norman Jaffe, MD*

**0:49:48.4**

They're just as successful in adjusting. I wouldn't say more, but they enter the normal freeway of society. I don't say it's because of the ski trip that they've become doctors and architects and what have you, accountants and things of that nature, but we have many who are in that category. In fact, I have ten doctors [whom] I treated who were amputees in the past. There is a tremendous benefit that has accrued from the ski trip.

*Tacey Ann Rosolowski, PhD*

**0:50:25.8**

Abilifying people.

*Norman Jaffe, MD*

**0:50:26.7**

Absolutely.

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***Tacey Ann Rosolowski, PhD***

**0:50:28.0**

That's pretty amazing. We have about ten minutes left today. What would you like to address now in terms of your role here?

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## **Chapter 11**

### **A: View on Career and Accomplishments;**

#### ***A Satisfying Career and Children who are Physicians***

Story Codes

A: Career and Accomplishments

A: Personal Background

D: The Life and Dedication of Clinicians and Researchers

C: Patients

***Norman Jaffe, MD***

**0:50:40.0**

I'd like to say that I personally have had a very satisfying career at MD Anderson. Look, it's not all been roses. I admit that. But there is no place where there is a utopia. There have been problems. There have been difficulties. But in the total analysis, I have been very satisfied with the career that I've chosen and to continue to develop at the MD Anderson Cancer Center. I really had a wonderful time over here. I cannot say that I am upset that I came to MD Anderson. I enjoy every day of it. Each day is precious to me now as I advance in my years, and I reflect back on my time at MD Anderson, and while there have been many tragedies, many difficulties, I've lost many patients, I've also had major success. And to me, my stay at MD Anderson has been a wonderful experience, and really I give thanks to the Almighty for giving me life, strength, and the ability to continue on this work.

***Tacey Ann Rosolowski, PhD***

**0:51:52.3**

I've heard many people who are reflecting on their careers at MD Anderson and feel that they've been given a very unusual place to do their work, very unusual opportunities to grow and collaborate. I envy that. I really do. It's so wonderful.

***Norman Jaffe, MD***

**0:52:10.1**

It's been a very, very wonderful experience. If I have any regrets, the only regrets I will have is that I did not convince my children to go into my field. Two became doctors, but they did not become oncologists.

***Tacey Ann Rosolowski, PhD***

**0:52:28.1**

Do you know why?

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*Norman Jaffe, MD*

**0:52:29.3**

Yes, I'll give you the example of my son. I approached my son when he was about to make a career choice, and I said, "What about medicine?" He says, "Definitely." I said, "That's nice. What type of doctor do you want to be?" He said, "I will become an ophthalmologist." I said, "Why do you want to do ophthalmology?" "Because," and he looked me straight in the face and said, "I am not like you. I will not wake up in the middle of the night for a dead child. I will not go to the hospital for that. I want a nine-to-five job. I do not believe that you have done your duty properly to our family, although you've been a good father and so on, but I see how you've come back at 5:00 or 6:00 in the morning after that, and it's not fair to you. It is not fair to the family." And he said, "I'll take it nine to five."

*Tacey Ann Rosolowski, PhD*

**0:53:21.9**

I remember last time we spoke you talked about this particular career being, I think you said, "A hard mistress," and that's pretty brutal.

*Norman Jaffe, MD*

**0:53:31.9**

I understand that, and each one has a different attitude toward life. My daughter developed a similar attitude but didn't express it to me. She became a head and neck surgeon, although she gets called in the middle of the night now. One child swallows a peanut and so on and so forth, so it's not so easy. And my other son—well, he said, "I'll not become a doctor. I've seen what happened to you." He became an attorney. Well, I suppose we need an attorney in the family to keep us straight, so that was the setup, but perhaps I'll now tackle my grandchildren.

*Tacey Ann Rosolowski, PhD*

**0:54:10.6**

Is there something as you look back at your time at MD Anderson that you really wish you could have achieved but for some reason were not able to?

*Norman Jaffe, MD*

**0:54:19.8**

No, I have no regrets. I did want to become a surgeon, but I had to be honest with myself. I didn't think I was dexterous enough to become a surgeon, and I think this was better because I had better contact with patients, and they were prolonged contacts. The only regret, if I have any regret, is that I lost patients. These eyes have seen too many tears, and I hope that this will not occur for others in the future.

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*Tacey Ann Rosolowski, PhD*

**0:54:51.8**

I hope that in one of our next meetings we'll be able to talk about your work with psychosocial aspects and with families because it's so important.

*Norman Jaffe, MD*

**0:55:02.6**

Let's see if we can do that. I do have to forewarn you. I have a great program in the next four months. I have to go to London, I have to go to Prague, I have to go to Israel, and I have to, of course, visit my grandchildren to make sure that they're going into medicine.

*Tacey Ann Rosolowski, PhD*

**0:55:24.5**

Maybe this would be a good time to stop and maybe we can chat—

*Norman Jaffe, MD*

**0:55:28.8**

That's fine, and we can get in touch. Sure.

*Tacey Ann Rosolowski, PhD*

**0:55:30.4**

Yes, we can.

*Norman Jaffe, MD*

**0:55:30.5**

Tacey, it was nice to speak with you again, and I hope we'll meet again.

*Tacey Ann Rosolowski, PhD*

**0:55:34.7**

And I'm turning off the recorder at twenty-five minutes after—

**(0:55:37.5** End of Audio Session 2)

## **Norman Jaffe, MD**

Interview Session 3—August 31, 2012

### **Chapter 00C**

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

***Tacey Ann Rosolowski, PhD***

**0:00:03.2**

I'm Tacey Ann Rosolowski, and I'm in the Reading Room of the Historical Resources Center in Pickens Tower, and this is my third session with Dr. Norman Jaffe this morning. It is about 10:39, and it is August 31st, amazingly. Good morning, Dr. Jaffe. Thank you for coming in this morning.

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## **Chapter 12**

### **B: An Institutional Unit**

#### *The Long-Term Surveillance Clinic*

#### Story Codes

B: Building/Transforming the Institution  
C: Patients  
C: Professional Practice  
C: The Professional at Work  
D: The History of Health Care, Patient Care  
B: MD Anderson History  
B: MD Anderson Snapshot  
B: Institutional Mission and Values  
B: MD Anderson Culture

#### *Tacey Ann Rosolowski, PhD*

**0:00:03.2+**

We talked last time about the ski program that you set up, which is obviously for cancer survivors, but we didn't talk about your role as chief of the long-term surveillance clinic for pediatric patients, and you held that role for four years, between 1996 and 2000. Would you explain to me how you came to assume that role and what your goals were in that particular position?

#### *Norman Jaffe, MD*

**0:00:57.3**

When I was at the Dana-Farber Cancer Institute I began to recognize that there were an increasing number of long-term survivors. Not only that, but certain problems and complications occurred in these long-term survivors. I would point out that prior to my advent at the Dana-Farber Cancer Institute, long-term survivors were a rare commodity. In fact, they probably did not exist. But as a consequence of the advances that we had made over the period of time, particularly at the time that I was there, we began to see an increasing number. But in addition to that, I noted that complications occurred as a result of the chemotherapy which had been administered and also in particular as a result of the radiation therapy. I therefore established a long-term surveillance clinic for long-term survivors.

#### *Tacey Ann Rosolowski, PhD*

**0:01:57.0**

And when did that happen at Dana-Farber?

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***Norman Jaffe, MD***

**0:01:59.7**

I came to Dana-Farber in 1966. I would imagine that I started that in 1972-1973. The clinic grew almost exponentially, so much so that I wrote the first paper—I think that would be the first paper—on complications of long-term survivors as a consequence of the administration of chemotherapy and radiation.

***Tacey Ann Rosolowski, PhD***

**0:02:27.3**

I think that was in 1975.

***Norman Jaffe, MD***

**0:02:29.1**

In '75. It appeared in *Radiology*, and prior to that I could not find, as I recall, any particular publication relating to this topic. The clinic developed quite remarkably, and when I was invited to assume the position at the MD Anderson Cancer Center Dr. van Eys asked me not only to be the chief of the solid tumor section but also to expand and improve the clinic that had already been in existence at the MD Anderson Cancer Center. That clinic was under the direction, shall we say, of Dr. Hugh Ried. He did a fine job, but he was only a part-timer. He used to come only twice a week.

***Tacey Ann Rosolowski, PhD***

**0:03:25.3**

That was in existence then in 1978 when you came.

***Norman Jaffe, MD***

**0:03:29.0**

It was. It was in existence. I think it was probably established as a result of the publication and the understanding that I had shown people what could occur from long-term survivors. Of course, as a result of that publication—I'm not sure I can really obtain credit for every clinic that became in existence at that time, but it began to spring up in various clinics now. I think others must also have recognized the problems that had occurred or were developing in long-term survivors, and this clinic now was also in existence at the MD Anderson Cancer Center. Dr. Hubert Ried was joined by a young lady called Hallie Zietz, a remarkable person, who incidentally became the administrator of my ski trip, my Ski Rehabilitation Program. She's a very good skier, and between Dr. Ried, Hallie Zietz and myself, we expanded that clinic and devoted a fair amount of attention to long-term survivors.

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***Tacey Ann Rosolowski, PhD***

**0:04:43.5**

What was the purpose of the clinic at the time, and what did you address?

***Norman Jaffe, MD***

**0:04:47.8**

We addressed all the complications that could occur from long-term survivors, directed them to the appropriate rehabilitative component that would be required and also to the medical and surgical services that were necessary as a result of the findings that we had detected. In fact, we wrote several papers on long-term survivors at that stage. I think we have about ten or fifteen papers arising from that clinic. Hallie Zietz, I think, became the cogwheel of that clinic because she devoted heart and soul to it, and she was supervised by Dr. Hugh Ried and by myself, but I felt that Dr. Ried was doing an extremely good job and left him to do it. When he was away on vacation or could not come because he was only a part-timer I stepped in.

***Tacey Ann Rosolowski, PhD***

**0:05:45.1**

What happened in 1996 when you became chief? How did that happen? He chose to leave? You were chief of the long-term surveillance clinic.

***Norman Jaffe, MD***

**0:06:00.1**

And I remained [as chief].

***Tacey Ann Rosolowski, PhD***

**0:06:01.0**

Okay, so when you came you had involvement from 1978 to 1996, but then you had an official position change, and you were named chief at that time.

***Norman Jaffe, MD***

**0:06:11.1**

I think that was the time that Dr. Archie Bleyer came, and Archie Bleyer rearranged the services.

***Tacey Ann Rosolowski, PhD***

**0:06:19.1**

Okay, so it wasn't really an effective change in your role. It was a nominal change.

***Norman Jaffe, MD***

**0:06:24.1**

That's correct.

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***Tacey Ann Rosolowski, PhD***

**0:06:26.1**

Now, I was really interested at the real array of things that you addressed. Nutrition, for example, and then psychosocial support, and I wonder if you could take me through some of those specific services, because it seemed very comprehensive.

***Norman Jaffe, MD***

**0:06:41.0**

Well, Dr. van Eys was a great advocate of the nutrition factor in cancer survivors, and he asked me also to pay particular attention to that particular problem. Because of my background in South Africa, we had [kwashiorkor](#), and malnutrition was a major problem. I was able to attend to some of these factors.

***Tacey Ann Rosolowski, PhD***

**0:07:07.4**

How do those nutritional problems arise as a result of cancer?

***Norman Jaffe, MD***

**0:07:13.2**

Well, in the immediate cancer treatment they arise because patients are subjected to nausea and vomiting and major problems as a result of the chemotherapy that they are being treated with. In addition, they receive radiation therapy to the mouth or the gastrointestinal tract, and they're unable to consume their foods or even to absorb the nutrition of their foods.

***Tacey Ann Rosolowski, PhD***

**0:07:41.1**

What is the approach for treating that problem?

***Norman Jaffe, MD***

**0:07:43.8**

Well, there are various ways. We can give them intravenous therapy, intravenous food. We can also give them different types of enteral feedings, bland feedings and things of that nature. At times they may even require a [gastrostomy](#) or something of that nature.

***Tacey Ann Rosolowski, PhD***

**0:08:01.3**

What is a gastrostomy?

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*Norman Jaffe, MD*

**0:08:02.7**

That is to put a tube into the stomach either by a small operation or through a nasogastric tube.

*Tacey Ann Rosolowski, PhD*

**0:08:13.4**

What about the psychosocial support?

*Norman Jaffe, MD*

**0:08:15.0**

That was a major factor of Dr. van Eys's stewardship at the MD Anderson Cancer Center. He really developed it to a remarkable extent, and I also elicited the services of the psychosocial services that were available at that particular time. I think Donna Copeland was the chief of the psychosocial services, and she assisted us in providing comfort, support, and guidance to our patients.

*Tacey Ann Rosolowski, PhD*

**0:08:49.3**

Can you give me an example of a particular case in which the need for that would arise? I know it sounds kind of obvious because with children it's so complicated, but it would help to make it concrete.

*Norman Jaffe, MD*

**0:09:03.9**

I'm trying to think. Say a youngster of about ten or twelve may have problems in being accepted by his or her peers because of alopecia, loss of hair, because of the different way she looks or he looks and things of that nature, and that child would have to undergo psychosocial treatment in order to understand that hopefully this will be a temporary measure, and in the course of time it would improve. And in addition to that—I don't know if it was through Dr. Copeland or others—but we arranged for our child life worker or various other people to go to the schools and explain to the schools that a child who was being treated with chemotherapy for cancer would hopefully become normal in the course of time.

*Tacey Ann Rosolowski, PhD*

**0:10:01.4**

I've never heard that phrase, child life worker.

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*Norman Jaffe, MD*

**0:10:03.9**

Yes, Dr. van Eys organized child life workers. At the Dana-Farber Cancer Institute we used to call them play ladies, but they were child life workers. They have a degree from the university. They entertain the children in the afternoon. They sit with children. When the child goes for an operation, they may accompany the child to the preoperative room and things of that nature, discuss things with the child, comfort the child, give them strength and support and things of that nature, and they also have a very close relationship with the parents of the child, and this is a recognized entity of the child life worker.

*Tacey Ann Rosolowski, PhD*

**0:10:49.7**

And when did the child life worker become an important part of the treatment team?

*Norman Jaffe, MD*

**0:10:54.3**

It was certainly in existence when I came over here through the efforts of Dr. van Eys who, as I say, was the chief of pediatrics at that particular time.

*Tacey Ann Rosolowski, PhD*

**0:11:03.2**

So you had them at Dana-Farber too?

*Norman Jaffe, MD*

**0:11:06.1**

We had them, but they weren't as well developed at Dana-Farber as they were over here. I was very impressed with what had been established over here.

*Tacey Ann Rosolowski, PhD*

**0:11:14.6**

Dr. van Eys, that was sort of his brainchild, if you will. That's amazing.

*Norman Jaffe, MD*

**0:11:18.4**

In fact, I will tell you that he had about four or five annual meetings on the psychosocial aspects of children with cancer and published books about that. There are books in existence of the meetings that were held. And in passing, I think the books had some catchy titles. One was called *The Normally Sick Child* or *The Truly Cured Child*, another meeting and so on, and it was published as a result. I remember I contributed some chapters to each of these different meetings, and I think they were published.

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***Tacey Ann Rosolowski, PhD***

**0:11:59.0**

Yeah, I can imagine how that would be an enormous help not only to the child but to the parents who I imagine feel tremendously lost dealing with a child in such dire circumstances.

***Norman Jaffe, MD***

**0:12:11.4**

In fact, that was the concept originally advocated and published by my first mentor, Dr. Sidney Farber. In fact, I would say my only mentor. He introduced a concept of what is called total care. That is the care not only of the child in terms of the delivery of chemotherapy, radiation therapy and surgery, but an attention and direct involvement in the psychosocial aspect of the child and to help them in terms of social work, in terms of social welfare and things of that nature. It was a true concept of what he called "Total Care."

***Tacey Ann Rosolowski, PhD***

**0:12:52.8**

Now, how has that idea evolved and expanded during the time when you arrived in '78?

***Norman Jaffe, MD***

**0:13:03.2**

Oh, it has developed tremendously. Today there is a subsection—I'll call it a department—in our Division of Psychosocial Medicine. Dr. Rhonda Roberts is in charge of that.

***Tacey Ann Rosolowski, PhD***

**0:13:26.1**

And in terms of the expansion, there's a subsection which I imagine is responsible for conducting a great deal of research. What are some ways in which this section has changed the way that children are treated over the years with new discoveries?

***Norman Jaffe, MD***

**0:13:45.2**

It has changed tremendously because nowadays we have to obtain informed consent or assent from a child before we start chemotherapy. That child has to have everything explained to him or her. I don't know if they entirely understand it, but we try as much as possible to use simple terms and to advise them of the problem, the treatment, and hopefully the beneficial consequences that can occur as a result of the implication of such treatment.

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***Tacey Ann Rosolowski, PhD***

**0:14:21.8**

Even a tiny child? How old a child would you sit down with?

***Norman Jaffe, MD***

**0:14:26.7**

I would say about— You've got to adjust it according to the age of the child, but a child of even four or five, we'll say, "We are going to give you some medicine. It may be a stick," and so on and so forth. "It will hurt a little bit, but we'll try and make it as little as possible. It may cause some nausea and vomiting, but we're going to try and control that, and the ultimate goal is to cure you completely." And in addition to that, we use the various TV programs that a child can view on TV, to the extent that we will say, "This is what would happen, for example, if so and so were trying to get treatment in this particular thing." But that is the expertise of the child life worker.

***Tacey Ann Rosolowski, PhD***

**0:15:29.5**

I'm just thinking of some people I know who have had childhood cancer and who did not have that kind of service.

***Norman Jaffe, MD***

**0:15:35.4**

It's changed tremendously, and it's still evolving, incidentally.

***Tacey Ann Rosolowski, PhD***

**0:15:39.0**

It's so critical. Are there other areas of activity of the survivorship program that would be worth describing at this point?

***Norman Jaffe, MD***

**0:15:47.9**

As I say, in my particular area I was extremely concerned about the deficits that were imposed upon an amputee, and as a result of that I established the Ski Rehabilitation Program, which incidentally, was not my idea from the beginning. It was because of Ted Kennedy, as I think I explained to you, and we keep in touch every now and again. I think he's very proud of it. I certainly am proud of it, and fortunately, this year, as I said, for the coming year we do not have sufficient funds, but parents have collaborated together, and they are going to have that particular program again next year in the absence of an official doctor, an official sponsorship by MD Anderson. But we hope to continue it the following year, in other words, for 2014.

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***Tacey Ann Rosolowski, PhD***

**0:16:56.0**

I have a note here that you were involved with the rehabilitative care programs at Children's Cancer Hospital. Is that correct?

***Norman Jaffe, MD***

**0:17:06.6**

That's the rehabilitative program we did.

***Tacey Ann Rosolowski, PhD***

**0:17:09.3**

Okay, so we've already covered that adequately. We haven't talked, however, about the video that you were responsible for creating, *Amputation is No Barrier*.

***Norman Jaffe, MD***

**0:17:21.9**

That's part of this, and that video is available to you. I think one of the individuals who run the informational program over here could get it for you, or I have a copy if you need that, but you will have to use the old system. It's not on a DVD.

***Tacey Ann Rosolowski, PhD***

**0:17:42.7**

Yeah, maybe it could be converted.

***Norman Jaffe, MD***

**0:17:44.4**

I'll be happy to give it to you, and if you can get it converted you'll give me a copy of the conversion?

***Tacey Ann Rosolowski, PhD***

**0:17:49.0**

Absolutely. Tell me what the content is and what the purpose of it is.

***Norman Jaffe, MD***

**0:17:54.8**

It tells you exactly what we do on the Ski Rehabilitation Program, and I think it's entitled *Amputation is No Barrier*.

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***Tacey Ann Rosolowski, PhD***

**0:18:07.0**

How do you use it?

***Norman Jaffe, MD***

**0:18:08.7**

We don't use it anymore because everyone knows about this ski program, and when people come along for the ski program and so on we videotape them. We show them all sorts of things, and at the end of every rehabilitation session, in other words, at the end of every ski program, we give them a DVD of the events of that particular time. They can use that, and they are our best ambassadors to show others about the program. Each year the program obviously changes because there are different participants of that particular program.

***Tacey Ann Rosolowski, PhD***

**0:18:51.2**

Why did you decide to document these ski programs visually like that?

***Norman Jaffe, MD***

**0:18:57.1**

Because we thought it would be a good idea to demonstrate to others what we were doing.

***Tacey Ann Rosolowski, PhD***

**0:19:02.5**

And I imagine it would do something kind of neat for the participants, too, to see themselves.

***Norman Jaffe, MD***

**0:19:08.6**

Absolutely. That's exactly the point.

***Tacey Ann Rosolowski, PhD***

**0:19:11.4**

Originally, when you did the *Amputation is No Barrier*, who were the recipients? Who did you send it to?

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*Norman Jaffe, MD*

**0:19:18.7**

MD Anderson has this particular video program for that. They have a staff that will go around. I don't know if they are still in existence, but it was in existence at that particular time, and the entire crew came up with the cameras, their microphones, their photographers and so on and so forth and took pictures of us, took the videos and things of that nature.

*Tacey Ann Rosolowski, PhD*

**0:19:44.1**

It was used pretty much in-house to inform people who might be participating.

*Norman Jaffe, MD*

**0:19:48.6**

And it was also used when I went on talks about our programs.

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## **Chapter 13**

### **B: Beyond the Institution**

#### *Building Collaborations and Treating Patients around the Globe*

#### Story Codes

B: Beyond the Institution  
A: The Clinician  
A: The Administrator  
C: Professional Practice  
C: The Professional at Work  
C: Collaborations  
C: Leadership  
C: Patients, Treatment, Survivors

*Tacey Ann Rosolowski, PhD*

**0:19:56.6**

I was wondering if you could tell me about some of the important collaborations that you set up at MD Anderson.

*Norman Jaffe, MD*

**0:20:04.0**

Sure, I'll be happy to do that.

*Tacey Ann Rosolowski, PhD*

**0:20:04.6**

And I'm thinking here pretty broadly, too, because you've worked administratively as well as in education and then on the research side, clinical, so whatever you feel is really significant.

*Norman Jaffe, MD*

**0:20:18.0**

I reached a stage in my life where I felt it was important to bring the younger people into the program and to teach and train them in order to ensure that whatever I had learned in the past would be maintained and developed and in fact be transmitted to others. And as a consequence, because I was receiving a fair number of inquiries and discussions, consultations and what have you from different parts of the globe, I thought it would be important to establish collaboration with these individuals.

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Let's start with the different parts of the globe. Let's take first the Americas. I developed a very, very strong collaborative effort with doctors in Mexico. I invited doctors, whoever was interested, to come to the MD Anderson Cancer Center and to take them on rounds to show them what I was doing and to establish with them programs in their own hospitals and institutions for the treatment of children with solid tumors and for that matter long-term survivors, and that collaboration has existed. I was invited to go there. It happened almost every year for a period of about ten to fifteen years that they would come here once a year, and I would go to Mexico once a year. And as I say, it still exists. We have a very close friendship, and we've developed close associations to the extent that some of them even consider me as part of their family. They are very competent and very well-trained doctors. I think one must recognize that things can be done in Mexico.

*Tacey Ann Rosolowski, PhD*

**0:22:02.9**

What are the institutions that they represent?

*Norman Jaffe, MD*

**0:22:05.6**

The National Institutes of Health or Child in Mexico. There are several. I can't remember their names offhand, but I have contacts in Guadalajara, contacts in Mazatlan, contacts in several other places in Mexico, particularly Mexico City, where I have three or four hospitals where the contacts are very viable.

From Mexico, let's go down a little bit to Costa Rica. I had patients from Costa Rica, and I developed a close association with one doctor, who unfortunately is now deceased, in Costa Rica, but he was responsible for promoting the welfare and the modern treatment of children with cancer. And I have several patients who are alive and well still in Costa Rica today who keep in touch with me. One I know is married and has a child already. That's Costa Rica.

Then let's go to Brazil. Sorry, let's go to Panama. I have several patients from Panama and several doctors who have kept in touch with me. Then there's Brazil. I invited two doctors from Brazil to come over here as a result of their interest. One doctor is Dr. Sergio Petrilli, P-E-T-R-I-L-L-I, and another is Dr. Sidnei, spelled S-I-D-N-E-I, Epelman, E-P-E-L-M-A-N, who are in charge of very large hospitals for the treatment of childhood cancer, and we still have a very close collaboration. In fact, only two weeks ago I received a paper from Dr. Petrilli indicating that I was part of the program that we had set up for the treatment of cancer, and he was now describing it and the results and so on and asked me if I would join him as a co-author, correct whatever misinformation, if there was any, that I could detect and add to it anything else. I did

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that and sent it back to him. The contact is still viable even though I have been retired for almost six years now.

With Sidnei Epelman it is the same. I heard from him last week, in fact. Unfortunately, his wife had developed a serious problem, but we hope things will improve. He asked me advice of it, and I said, “You must talk to your doctors now.” Whatever the circumstances, that contact remained in very, very close existence for the past—I would say—twenty-five years. We still have very good collaboration.

From Brazil we go to Argentina. There were several doctors over there, and although the contacts are not as strong and as viable as they were in Brazil, we still have some collaboration with them, and one or two of them are still my personal friends. Next to Argentina is Uruguay. There is a doctor in Uruguay who is very, very close to me, and we keep in touch, and he consults with me every now and again, even though I’m supposed to be retired, about problems.

From Uruguay we can go to Chile, and we have a very good doctor in Santiago who I think is supreme in his approach to the problem. They have very good medicine over there, but he still keeps in touch with me as well and uses some of the programs that I advocated with him. There is also a surgeon, Dr. Blanco, I think is his name, who incidentally has thirteen children, and he is very, very good. I think the standard of medicine is excellent. We should not detract from their achievements.

Let’s go to Europe now. I had a very close contact at one stage with doctors from the [Insitut Gustave Roussy](#) in Paris. That has not been viable for the past few years now. I think there’s been a change in leadership and so on and so forth, and the French have their own way of doing things. That’s fine, but we are still good friends.

In England I had several trainees. Unfortunately, one died of a cerebral tumor three years ago, but we had a close collaboration in the United Kingdom as well. That has not been as close now during the past few years, but I think they are very good in any case. They don’t need us, and we do not need them, for that matter, but we have an association through what is called the [EURAMOS](#) study, a study that is investigating—it’s spelled E-U-R-A-M-O-S, EURAMOS—which is the investigation for osteosarcoma in the United States, Europe, and the United Kingdom.

Let’s go from there to Germany. We have a very good relationship with some doctors in Germany, and they are part of the EURAMOS study as well. Norway, a good relationship, and the relationship between Germany and Norway is such that I invited a doctor from Germany and

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a doctor from Norway to assist me as co-editors of a book I published recently on osteosarcoma in the adolescent and child.

*Tacey Ann Rosolowski, PhD*

**0:28:05.4**

I'm really impressed with the international breadth of these connections, and I'm wondering, I imagine it took many years to set this up, and do some of these individuals have contact with one another as well?

*Norman Jaffe, MD*

**0:28:21.2**

Yes, it's all through the Internet.

*Tacey Ann Rosolowski, PhD*

**0:28:24.0**

And how has that facilitated further advances, do you think, in care?

*Norman Jaffe, MD*

**0:28:30.3**

I think it's done a tremendous amount for them and for us. It's a two-way stream, and the one hand washes the other. It's been very, very good.

*Tacey Ann Rosolowski, PhD*

**0:28:40.3**

I'm really struck.

*Norman Jaffe, MD*

**0:28:42.9**

That's Germany and Norway. I had a close contact with a Hans Strander in Sweden, but that has not been viable for the past fifteen years now. I think he's still alive, but he is part of his own institution.

*Tacey Ann Rosolowski, PhD*

**0:29:02.8**

You mentioned that when you were setting up these connections you did so because you got to a point in your career where you wanted to make sure that there were certain things that were passed on. When was that that you decided?

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*Norman Jaffe, MD*

**0:29:13.2**

I would say that was about fifteen years ago when I realized that I would not be a nominee for the Nobel Prize, so I said, "I may as well do something else," and that was fine with me.

*Tacey Ann Rosolowski, PhD*

**0:29:28.3**

And another question I wanted to ask you is you obviously came to MD Anderson because your career had already developed very strongly in these two areas with osteosarcoma and then with survivorship, but I'm wondering how do you feel your perspective and approach evolved during the time that you were here, or did it?

*Norman Jaffe, MD*

**0:29:53.3**

MD Anderson has been very good to me. I was permitted to do mostly whatever I liked. I have no complaints about it. Look, there is no utopia anywhere, but I think that I have had a great opportunity in working here to do what I wanted, to develop, and to be recognized worldwide. I can only give them praise. I know that it's not 100 percent. There are certain things that I may have wanted, but with age and perspective and a year older and a year wiser, I hope I have a better opportunity to reevaluate the situation, and I believe that I have made a contribution in this world, and I hope that contribution has been for the better.

*Tacey Ann Rosolowski, PhD*

**0:30:40.4**

How did you feel that you grew as a clinician?

*Norman Jaffe, MD*

**0:30:43.5**

Very well. I felt that I was given a lot of opportunity to do what I did. They did not interfere with me in many aspects, and I can only sing their praises.

*Tacey Ann Rosolowski, PhD*

**0:30:56.2**

Is that a function of the way the administration is set up? To what do you attribute that?

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*Norman Jaffe, MD*

**0:31:03.3**

No, I think they didn't want to interfere with me. They recognized that I had a very good name worldwide, and I think that if they started doing anything to me or against me it would be counterproductive, so they left me alone.

*Tacey Ann Rosolowski, PhD*

**0:31:18.8**

Who were some individuals here that you felt you had really good working relationships with in forwarding your projects?

*Norman Jaffe, MD*

**0:31:27.7**

They were mainly individuals in the bone tumor service. It was the late Dr. John Murray, Dr. Alberto Ayala, who was the pathologist. Who else could I say? Of course, the latest, Dr. Valerie Lewis and so on, but it was mainly in the beginning Alberto Ayala and John Murray.

*Tacey Ann Rosolowski, PhD*

**0:31:53.8**

And what sort of work did you do with them?

*Norman Jaffe, MD*

**0:31:56.3**

Well, we discussed the problems relating to the treatment of a patient with a particular bone tumor. It was mainly in the bone tumor and musculoskeletal area. They became very close friends, in fact. It was inevitable that that would occur.

*Tacey Ann Rosolowski, PhD*

**0:32:14.3**

What do you feel you learned from them?

*Norman Jaffe, MD*

**0:32:16.3**

A great deal and I'm still learning. In fact, I do not want to say that I know enough. I think the longer I continue to learn the more humility I can inspire in myself and the more I can appreciate the wonders of mankind.

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*Tacey Ann Rosolowski, PhD*

**0:32:34.5**

I notice that though you have mentioned that you retired in '06, it's sort of a theoretical retirement.

*Norman Jaffe, MD*

**0:32:42.6**

Oh, yes. I'm still learning.

*Tacey Ann Rosolowski, PhD*

**0:32:45.0**

What have you been doing since your so-called retirement?

*Norman Jaffe, MD*

**0:32:48.8**

Let's continue this before we get off the theme, but I want to give you a few more aspects. In Italy I developed a tremendous relationship with doctors. I was invited to be a visiting professor at the oncology institute. I can't remember the exact title that it has. It's the [Rizzoli Institute](#), R-I-Z-Z-O-L-I, Rizzoli Institute, and I was a visiting professor there for six weeks. There I developed a very good relationship with three prominent doctors. In fact, you can sing their names. They rattle off my tongue almost. It's Picci, Bacci, and Campanacci. [Piero] Picci was the pathologist. [G.] Bocci was the chemotherapist, and [Mario] Campanacci, who died of pancreatic cancer, an excellent surgeon. We're close friends. I still have the relationships with Picci and Bacci, and I spent six weeks over there. They provided an apartment for me. I took two of my kids with me. We had a wonderful time in Italy, and I also was able to follow one of my patients there. I'll give you her name, Giulia Ottaviani, who became a doctor and a pathologist, and now she's interested in pediatric oncology and is making arrangements to come to this country to serve as a pediatric oncologist. In fact, I think I may have mentioned, but I have ten patients who became doctors.

*Tacey Ann Rosolowski, PhD*

**0:34:29.0**

Yeah, you mentioned that when we were talking about the ski program.

*Norman Jaffe, MD*

**0:34:30.7**

[redacted]

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***Tacey Ann Rosolowski, PhD***

**0:34:59.8**

Why, when you decided to reach out to other physicians fifteen years ago, did you decide to do it globally?

***Norman Jaffe, MD***

**0:35:08.0**

It was not my real intent, but they began to approach me, and I certainly did not reject them. I think fifteen years is probably a little inaccurate. It should be about twenty years ago, twenty to twenty-five. Whatever the circumstances, from Italy let's drop down now a little bit further to Slovenia. Slovenia is one of the three countries that constitute the original Yugoslavia. Tito brought them all together and established the country of Yugoslavia, which broke up several years ago. In Slovenia there were a number of doctors who decided they wanted to contact me and to get me to help them in developing a pediatric oncology service. They made great efforts to nominate me for a [Fulbright scholarship](#). I was granted the scholarship, and as a result, I spent six weeks as a Fulbright scholar in Slovenia and organized their pediatric oncology program. While I was here at MD Anderson I was given permission to go as a Fulbright scholar. They really appreciated it, and I think they were impressed, because when I left two years later I was again re-nominated by them for a Fulbright scholarship, again accepted, and went there and developed the program further. And I did something in addition to that. I organized for three of their doctors to spend two months at the MD Anderson Cancer Center. They had no money, but I housed them in my own home. Professor [Marija] Auersperg, head and neck surgeon, came, Dr. Derganc, D-E-R-G-A-N-C. Her name is Meta, M-E-T-K-A, Metka Derganc [pediatric intensivist], and a third doctor, Dr. Gabriela [Gabriela Petric-Grabner]—I can't remember her surname—as a radiation therapist. [Added: the group also included Professor Marija Us Krasovec, cytologist, and Marjanca Cucek Plenicar, orthopedic surgeon.] They stayed at my home, came to MD Anderson every day with me. My wife prepared sandwiches because they didn't want me to take them to lunch. They said it was too expensive. It wasn't for me, but for them it was, and I was prepared to even pay for it, but they said, "No, we'll take the sandwiches." They spent six weeks to two months with us at my home, training at MD Anderson.

When they left, there was something interesting. Professor Auersperg, Dr. Auersperg, incidentally, stems from royalty and has many castles named after her family in Slovenia. They were all taken by the government. She owns nothing, but she went to the operating room every day and followed patients and what happened to them, and she came back one evening and said, "You know, you have discarded"—not me but MD Anderson—"had discarded very, very good operating instruments saying they are no longer operable, they are not useful." She says, "I would like to take those instruments back to Yugoslavia. We can fix them and do things with

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them.” When she left, she left with a crate of instruments, taking them back to Yugoslavia, where they have people who are able to repair and reuse them and so on and so forth, and she said that is one of the major dividends that she accumulated through this particular visit to MD Anderson. She was with us for two months, as I say.

*Tacey Ann Rosolowski, PhD*

**0:38:55.4**

I imagine you observed some pretty amazing situations in visiting these other nations.

*Norman Jaffe, MD*

**0:39:01.8**

Absolutely, absolutely.

*Tacey Ann Rosolowski, PhD*

**0:39:03.3**

The facilities and equipment are not up to what we expect here.

*Norman Jaffe, MD*

**0:39:10.0**

Absolutely. You reminded me of a story of when I first came to this country. My father-in-law came to visit us, and we had a toaster, the usual toaster, given to us by a bank. The toaster was useful. It broke down, and I said, “Well, I’ll buy a new one.” And my father-in-law was shocked, and he said, “I will repair it,” and he repaired it. He came from South Africa. He repaired it. The neighbors heard about this, and the next thing is we were inundated with toasters which he was prepared to repair at no cost. They had an extra life off their toasters for several years, but that’s the sort of thing. In the United States we don’t repair. We discard.

*Tacey Ann Rosolowski, PhD*

**0:39:54.3**

It’s a throw-away culture now.

*Norman Jaffe, MD*

**0:39:55.7**

That’s right, but he repaired toasters.

*Tacey Ann Rosolowski, PhD*

**0:39:59.3**

I’m curious, was there anything that came of that experience of collecting these broken bits of equipment from surgery and sending them?

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*Norman Jaffe, MD*

**0:40:10.0**

They used them.

*Tacey Ann Rosolowski, PhD*

**0:40:11.1**

Right, but did that continue?

*Norman Jaffe, MD*

**0:40:11.4**

No, that was it. She could take them with her in the plane or at the same time, but nothing further developed after that. Anyway, let's go a little further. I think we're getting nearer. Then from Yugoslavia we can go down to Turkey. I was invited to go to Turkey, and in Turkey I had a very—and still have—a very good relationship with several doctors, Dr. Inci Ayan, I-N-C-I, Ayan, A-Y-A-N, and Dr. Rejin Kabudi, R-E-J-I-N,<sup>2</sup> Kabudi, K-A-B-U-D-I, and I'm often consulted about problems and difficulties that they have. Incidentally, it was a two-way stream. I invited them over here, and they also invited me, and I've been to Turkey and Slovenia and so on several times as a consequence of that.

*Tacey Ann Rosolowski, PhD*

**0:41:15.4**

What have you noticed about the facilities and treatment there?

*Norman Jaffe, MD*

**0:41:19.9**

They are not optimum, but they are definitely improving. They improve more and more with each subsequent visit that they come over here and when I go there. And let me tell you something, some of them are equivalent to the United States. They are not fools. They're innovative, they understand things, and their standard of medicine is very good.

*Tacey Ann Rosolowski, PhD*

**0:41:41.8**

Are there different rates of childhood cancer in those countries—in other countries—than in the US?

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<sup>2</sup> The interview subject said "Rejian" but later corrected the spelling to Rejin.

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*Norman Jaffe, MD*

**0:41:47.1**

Some cancers may be a little more prevalent than others, but in general, they are more or less the same. Now, this doesn't apply to the underdeveloped countries like those in Africa and so on and so forth, but in these countries in Europe, in the Americas and so on, they're more or less the same. Mexico has a tremendous amount of [retinoblastoma](#), more than the United States. I don't know why. But the principles, the tactics, and the strategies are identical that they use that we use. Just in passing, that's the end of Turkey. Let's go to Egypt. I've been invited several times to Egypt, and there is a man called Dr. [Sherrif] Abouelnagu. I came to my office one morning at the MD Anderson Cancer Center, and there was a doctor sitting in the office, Dr. Abouelnagu, and he said to me, "I have come to learn how to treat osteosarcoma." I said, "Who arranged this?" He said, "I've come." Well, he came.

*Tacey Ann Rosolowski, PhD*

**0:43:00.0**

And you welcomed him.

*Norman Jaffe, MD*

**0:43:01.5**

Absolutely, and he was with me for three months and then invited me to go to Egypt, where I established a program. We published a paper about the program. They treat them very, very well.

*Tacey Ann Rosolowski, PhD*

**0:43:14.0**

What did you do with him when he was here?

*Norman Jaffe, MD*

**0:43:16.2**

I took him around the wards with me. Wherever I went, he went, and so on and so forth. I mean, he became my close, personal aide, so to speak, and I told him what I was doing and why I was doing it. I questioned him. I didn't let him get away with things, and he really appreciated it, so much so that, as I say, he invited me two or three times to come to Egypt at different times to inspect what he was doing, to advise and guide him and so on.

*Tacey Ann Rosolowski, PhD*

**0:43:44.8**

And he set up a solid tumor service?

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*Norman Jaffe, MD*

**0:43:47.0**

Well, it was in existence before, but he developed it. As a consequence of this, incidentally, when I returned from Egypt the first time—it was in 1960—I got a call from the—I wouldn't call him ambassador, but he was really someone under the ambassador of Egypt, and he said, "Listen, I need to talk to you." I said, "Sure," and he said, "You've just come from Egypt. I want you to write a report about your findings in Egypt." I said, "Mr. Ambassador, if I write a report of Egypt, they will never let me get into Egypt again. There's so much conniving. There's so much graft, so much difficulty, that you are not giving the patients the proper attention." He said, "Do me a favor. Write that report." And I wrote the report, and three or four weeks later I got a call from a woman, Susan Worth, W-O-R-T-H, and she said, "I'm establishing an organization called the [Friends of Egyptian Children with Cancer](#). I want you to be a founding member of this, and we want to send information, drugs, whatever they need in Egypt in order to improve the treatment of childhood cancer." I became a founding member. I, at one stage, was a president of this organization, and I'm still a member. We meet every three or four months and discuss things. We hold an annual gala, and next year the gala will be held at the Junior Club. We have sufficient funds that we can send about twenty dollars' to thirty dollars' worth of drugs and money and so on to Egypt every year to special hospitals where we believe this is a vital need for them to treat childhood cancer.

*Tacey Ann Rosolowski, PhD*

**0:45:48.6**

What is the amount that you spend for the drugs each year?

*Norman Jaffe, MD*

**0:45:55.3**

It varies. About \$20,000 to \$30,000 a year.

*Tacey Ann Rosolowski, PhD*

**0:45:59.6**

Wow, that's amazing. Have there been other initiatives like that either local or in the states that have come out of some of these connections?

*Norman Jaffe, MD*

**0:46:08.3**

Not to my knowledge.

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***Tacey Ann Rosolowski, PhD***

**0:46:08.7**

That's really striking and great that there was someone as farseeing as this individual to say, "Go ahead and write that report."

***Norman Jaffe, MD***

**0:46:17.2**

[redacted]

Then you have another place where the American fleet is. I don't remember the name of that country, but they invited me in the Middle East to give some talks over there, and finally, I think, what I call the piece de resistance. When I was in Egypt and I was giving a talk in Egypt, I got a call from a doctor in Saudi Arabia, and he said, "We have just heard your talk through the mechanism of Internet, and we want you to come to Saudi Arabia." I said, "Listen, my friend, you will never let me go into your country. I am a Jew. I have been in Israel. I have a stamp on my passport, and you do not let me come into the country." He said, "Hold on a moment." There was a discussion, and they said, "We will let you come in. Just send us your consent." I did that, and after a lot of sending information to the Saudi embassy in Washington and so on I was given two visas to go to Saudi Arabia. One was a visa for myself, which was given to me gratis. A second was a visa for my wife, for which I paid \$150. Mine was gratis, and they admitted me to Saudi Arabia. I want to tell you they treated me with the utmost respect. It was a pleasure to go there, and recognizing my religion and so on was of no barrier, no consequence, so much so that at the end of my visit I was approached by the chief of the hospital. He said to me, "Listen, we are impressed with what you have done for us. We are impressed with how you've handled things, and I'm authorized to offer you a senior position in this hospital." I didn't want to insult them, and I said, "Listen, I have grandchildren. I need to go and see the grandchildren." He said—he was very clever—he said, "Listen, with the amount of money that we will pay you, you can fly and see your grandchildren every month." But it was nice of him to offer that, and I would have a divorce at that stage. My wife had to wear an abaya. We were advised by the United States government, the consulate and so on, travel almost incognito. Blend in with the country, so my dear wife had on an abaya. She looked like an Arab, and I hope I looked like an Arab, but they treated me with the utmost respect. It was an interesting experience, and I was there for ten days as a visiting professor. I was invited to go back, but I said, "Listen, I think that I have other things that I have to attend to."

***Tacey Ann Rosolowski, PhD***

**0:51:12.4**

Was it medically interesting as well as culturally?

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*Norman Jaffe, MD*

**0:51:16.5**

Yes, whatever you want medically they have the money to buy it. The trouble is, you see, they have the money to buy it. They have instruments and so on, but there's no one to use it, no one to do it properly. They give contracts to people, and listen, the individual, his wife cannot stay there. A woman is not allowed to drive. She has to put on an abaya. There are no theaters. There are no museums. There's no entertainment for them. They're isolated and things like that. The only place where you can get some taste of American culture is the [Aramco](#) compound, but it is very small, and after a while you can only say hello to about ten, fifteen, twenty people, and what happens after that? You can't move. It's not a life for the European as we know, but I do want to say I give them credit, they treated me with respect. I had no problems.

*Tacey Ann Rosolowski, PhD*

**0:52:23.7**

It's 11:30, Dr. Jaffe, and I want to make sure you're not late for your rounds.

*Norman Jaffe, MD*

**0:52:28.1**

No, because they've canceled the rounds, so I can stay another fifteen, twenty minutes, and then we can tie it all up.

*Tacey Ann Rosolowski, PhD*

**0:52:33.8**

That would be great. Is there anything else you would like to say about your international collaborations?

*Norman Jaffe, MD*

**0:52:42.4**

Let me see. Of course, in Israel I've had a tremendous amount of collaboration, and I try to go there more or less once a year. Let me see, from Saudi Arabia and that area, Bahrain is the other area that I was thinking about where the American fleet is located. I was invited to Bahrain as well. I think we dealt with most of the countries that I have collaboration with. I think just a few points here just to tie it up.

Let me say that I've been in medicine now— I practiced medicine for fifty years. I have been in medicine for fifty-six years since I've been retired for six years, and it's been very satisfying, a very, very enjoyable experience. It's also been a very devastating one. I will not deny that. But I think that you can achieve a great deal of personal satisfaction because life is not always 100 percent. I mean, there are highlights and the lowest ebbs of life in life, and one must recognize

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that. If one is prepared to accept and understand that, then I think you can find medicine is a very satisfying occupation.

My idea was to have the opportunity to train individuals to accept that as a way of life. I asked for each one of the individuals whom I trained that I required no touch of genius from them. I only wished them to be honest, conscientious, and hardworking. Every fellow who rotated through my service—three months, which was the system employed at this institution—they would rotate through my service for three months—was expected to write a paper and have it published in a journal, and that was done in at least eighty to ninety percent of my fellows. Happily, I was sought after as one of the individuals who they would like to have in terms of a rotation, in terms of a mentor, a teacher, and an administrator. I had people from all over the world, as I indicated, people from Turkey, Egypt and so on, as I've indicated. We have kept a close collaboration and relationship with them. It's been a very, very happy association. I think that one must not expect what the world can give you but what you can give to the world, and I've tried to do that in terms of my philosophy and understanding. I think that ties up whatever we need to say about my view, my understanding, my approach to medicine and my journey through this particular field of life. It's not the end that it is important. It is the journey that is important. The journey has been satisfying, invigorating, thrilling, and depressing, and that's the only way I can summarize my life on this earth. I have nothing further I think that I can add. I'm happy to answer any other questions you might have.

***Tacey Ann Rosolowski, PhD***

**0:56:11.6**

That does sum up your philosophy.

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## **Chapter 14**

### **A: View on Career and Accomplishments**

#### ***Healing Children: An Emotionally Complicated Task***

#### Story Codes

A: Character, Values, Beliefs, Talents  
A: Faith  
A: The Clinician  
C: Human Stories  
C: Offering Care, Compassion, Help  
C: Patients

***Tacey Ann Rosolowski, PhD***

**0:56:11.6+**

I guess I did have one question, which is how have you found yourself able to personally manage the devastating and depressing parts, dealing with children and confronting that? How do you as a clinician help yourself through that?

***Norman Jaffe, MD***

**0:56:33.9**

I've found it with great difficulty, and I'm not sure if I've even found it yet. Each one is different. Each one is separate. You develop a different relationship with each one, and as the parents have difficulty, so do I, but you have to show them strength and courage so that they at least can develop the same attitude in life. I've told them, "Do not be afraid to cry. Do not be afraid to show your feelings because it does help." But I'm not sure if one ever develops equanimity. I think it remains with you for the rest of your life.

***Tacey Ann Rosolowski, PhD***

**0:57:16.6**

It would almost be rather inhuman to develop that equanimity in the face of that.

***Norman Jaffe, MD***

**0:57:22.0**

Absolutely.

***Tacey Ann Rosolowski, PhD***

**0:57:23.4**

Do you find—I mean—you mentioned your religion in the context of Saudi Arabia and in a cultural sense. Is your religious life important to you in your medical world?

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*Norman Jaffe, MD*

**0:57:36.3**

Very much so.

*Tacey Ann Rosolowski, PhD*

**0:57:36.6**

How so?

*Norman Jaffe, MD*

**0:57:39.1**

As far as the Jewish religion is concerned, there is sanctity of life. One is not permitted, obviously, to kill in any religion I presume, but life is our most precious possession. There is a particular Talmudic expression—I think it's from the Talmud—which says that you should not remove mercy from any individual, and it's stated in the following way. I'd quote to you in Hebrew, but you would not understand it. "Even if a sharp sword rests on the neck of an individual and he's about to be executed, do not remove the concept of mercy from him that he may still be a survivor." I think it is important that you have feeling for your fellow man and you show the fellow man dignity and understanding, and you can impress the individual with your mercy and your kindness. I think that the world could be a better world whatever the religion is, because I'm sure all the religions do advocate that sort of thing in one way or another. I cannot believe that a religion is there that says that you should kill an individual for absolutely no reason. There are indications, I admit, that even in the Jewish religion one has to consider the possibility of an execution, but it's an interesting concept. The highest court in the terms of the Bible was constituted of seventy-one individuals. Not seventy, seventy-one. The idea was that if there was one individual who was opposed to it, then that individual had to go free or whatever it was. You had to have 100 percent unanimity. You had to have seventy-one. If you had seventy plus one and one was opposed to it, then there would be no execution. That's the way we hold the value of life, and it is our most treasured possession. These things impressed me from my youth, and as I went through life I think they became more and more embolden in my own philosophy of life.

*Tacey Ann Rosolowski, PhD*

**1:00:13.8**

I want to thank you for spending the time this morning.

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*Norman Jaffe, MD*

**1:00:16.0**

I thank you. I just want to have a look at these. It's been a pleasure to meet you, Tacey. I hope that you'll be successful in what you do, and I look forward to seeing it.

*Tacey Ann Rosolowski, PhD*

**1:00:24.8**

Thank you very much. I'm turning off the recorder at twenty minutes of 12:00.

**(1:00:30.4** End of Audio Session 3)