

Helmuth Goepfert, M.D.

Interview #23

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Helmuth Goepfert, M.D.

Interview #23

Interview Profile

Interview Information:

Two interview sessions: 27 August 2012, 28 August 2012
Total approximate duration: 4 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:

Helmut Goepfert (b. 13 September 1936 in Santiago, Chile) first came to MD Anderson in 1967 as a research fellow. In 1974 he joined MD Anderson as a part-time associate professor (while serving as the first Chief of the Otolaryngology Section in Dept. of Surgery at University of Texas Health Sciences Center Medical School. Dr. Goepfert is a Professor Emeritus in the Department of Head and Neck Surgery. He has provided clinical support to clinical research addressing chemoprevention w/ derivatives of Vitamin A and combination therapies and to preserve larynx functionality. He served as Chair of the Department of Head and Neck Surgery from 1982 until his retirement from clinical practice in 2003.

Major Topics Covered:

Personal and educational background

Head and Neck oncology: evolution of; patient experiences of; special challenges

History of head and neck surgery; evolution into multi-disciplinary team collaboration

Section of Head and Neck Surgery

Research: combining surgery with chemotherapy and radiation therapy to preserve laryngeal function

Interdisciplinary care for head and neck cancers at MD Anderson

Biomedical publishing; ethics

Biomedical/clinical education, educational publications

The Physicians Network

MD Anderson presidents

MD Anderson culture

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Original Interview Profile: Helmuth Goepfert, M.D.
Submitted by: Tacey A. Rosolowski, Ph.D.
Date revised: 17 June 2014

In this two-session interview of approximately four and one half hours, Dr. Goepfert (b. 13 September 1936 in Santiago, Chile) is interviewed about his long career as a head and neck surgeon. Tacey A. Rosolowski is the interviewer and the sessions take place in August 2012 in a conference room in the Department of Head and Neck Surgery in Pickens Academic Tower on the main campus of MD Anderson.

Dr. Goepfert is a Professor Emeritus in the Department of Head and Neck Surgery. He first came to MD Anderson in 1967 as a research fellow. After a number of years spent in Chile and in Europe, he returned to Houston for additional surgical training and in 1974 joined MD Anderson as a part-time associate professor (while serving as the first Chief of the Otolaryngology Section in Dept. of Surgery at University of Texas Health Sciences Center Medical School). He became full professor in 1979. From '90 to 2003 he held the M.G. and Lillie A. Johnson Chair for Cancer Treatment and Research. He served as Chair of the Department of Head and Neck Surgery from 1982 until his retirement from clinical practice in 2003.

Dr. Goepfert was received his M.D. in 1962 from the Universidad de Chile Medical School in Santiago, Chili. He went to the J.F. Kennedy Hospital in Valdivia Chile for a Residency in general surgery (finished in '64) and went on to a Fellowship in Surgical oncology and Chemotherapy at UCLA (finished in '66). In 1967 he came to MD Anderson as a Research Project Investigator and stayed through 1968 as a Senior Fellow in Surgery. After several years overseas, Dr. Goepfert returned to complete a residency in the Department of Otorhinolaryngology at the Baylor College of Medicine (1974). He joined the MD Anderson faculty in 1974, becoming full time in 1979. He became Chair of the Department of Head and Neck Surgery in 1982. Dr. Goepfert has performed wide ranging services to his field and to MD Anderson. For succeeded R. Lee Clark as Medical Editor of Cancer Bulletin. He chaired a Joint Council of Advanced Training in Head and Neck Oncologic Surgery to accredit institutions nationwide. In 2002 he published and editor of 1st Web based textbook: "Multidisciplinary Care of Head and Neck Cancers." Dr. Goepfert has received numerous awards, including Presidential Citations from the American Academy of Head and Neck Surgeons ('93 and '94), MD Anderson's Faculty Achievement Award in Patient Care ('94), the Charles A. LeMaistre Outstanding Achievement Award in Cancer in 1998 and the Distinguished Surgeon Award from the Association of Operating Room Nurses of Greater Houston in 1999. In 2002 a group of his trainees established the Helmuth Goepfert Society, an organization that has sponsored lectures in the field.

In these interview sessions, Dr. Goepfert describes his particular focus on the larynx and how he has devoted his career to studying how surgery can be combined with chemotherapy and radiation therapy to preserve the larynx's essential functions for a patient. In the process, he

gives a history of the evolution of head and neck cancer. He gives a very clear picture of the range and complexity of cancers the head and neck and their potential impact on human functions (speech, smell, taste, etc.). He tells some touching stories of how difficult it can be for patients to hear the news that they may lose their ability to speak, for example. Dr. Goepfert gives an overview of the history of head and neck surgery in the United States and enables the listener to grasp the basic need for interdisciplinary care in treating head and neck cancers. He has been an advocate for interdisciplinary care in his field, working with Dr. Gilbert Fletcher in the sixties to combine surgical intervention with radiation therapy, and constantly expanding the range of specialists involved in treating head and neck cancers to insure treatment outcomes that preserve the best quality of life possible for patients. He gives a picture of how this has had an impact on the organization of treatment teams at MD Anderson. He also covers his interest in publishing ethics, education and the educational publications MD Anderson has produced, as well as his post-retirement work with the Physicians Network, a subsidiary of MD Anderson that provides guidelines and credentialing to physicians across the nation.

Helmuth Goepfert, M.D.

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Segment Summaries

Interview Session One: 27 August 2012

Segment 00A
Interview Identifier

Segment 01
Head and Neck Oncology and Related Specialties
A: Overview

Story Codes
A: Overview
A: Definitions, Explanations, Translations
D: Understanding Cancer, the History of Science, Cancer Research
D: The History of Health Care, Patient Care

In this segment, Dr. Goepfert explains that Head and Neck Oncologists work in concert with Radiation oncologists and Medical oncology in order to address the challenges of cancers of the head and neck. “Head and neck” specialists address any cancer occurring between the chest and the brain, and Dr. Goepfert lists the organs, tissues, structures, and functions that cancer can attack. Dr. Goepfert notes that Head and Neck is an “abundant field,” that draws on additional specialties, such as pathology, imaging, oncologic dentistry and such rehabilitative specialties as speech pathology.

Segment 02
An Overview of a Surgeon’s Education
A: Educational Path

Story Codes
A: Educational Path
D: Understanding Cancer, the History of Science, Cancer Research
D: The History of Health Care, Patient Care
A: Joining MD Anderson

In this segment, Dr. Goepfert sketches his surgical training in Chile, the U.S. and Germany. He explains that he “fell into” surgery as a result of his training in his native country of Chile in the 1960s, where he started as a general surgeon. His interest in cancer grew just as the American Society of Clinical Oncology was being created (1965), and chemotherapy was generally put in the hands of surgeons. He describes how he received a fellowship in 1964 to go to UCLA to train in the chemotherapeutic management of solid tumors, then extending his visa to come to

MD Anderson to train under Drs. John Stahling and Dr. Richard Jesse. He spent four years in Stuttgart, Germany, setting up a radiation therapy unit at the Katherinenhospital, then was offered a job at MD Anderson by Richard Jess. Dr. Goepfert had to pass his board certification, and so became a Resident at Baylor.

Segment 03

Friction in the Evolving Field of Head and Neck Surgery

A: Overview

Story Codes

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

D: The History of Health Care, Patient Care

C: Controversies

In this segment, Dr. Goepfert explains the debates in the 60s and afterward, over how to divide conditions of the head and neck between general surgeons and those trained in Otorhinolaryngology (Ear, Nose, and Throat). He talks about the friction between the Society of Head and Neck Surgeons (mostly general and plastic surgeons) and the American Society for Head and Neck Surgery, founded by otolaryngologists. He gives an example of the Mayo Clinic, where (in the 1980s) cancer was treated by a Head and Neck surgeon and a general surgeon performed necessary neck dissections. He also discusses the debates over which field should handle surgical reconstruction after procedures to address cancer –plastic surgeons or the head and neck surgeon. He notes that, at MD Anderson all plastic surgeons are trained in that specialty, not in head and neck surgery, then lists various plastic surgeons at the institution, beginning with Margaret Sinclair, the first reconstructive surgeon at MD Anderson.

Segment 04

Farming or Medicine?

A: Personal Background

Story Codes

A: Personal Background

C: Funny Stories

A: Character, Values, Beliefs, Talents

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: Professional Path

In this segment, Dr. Goepfert explains that his father, Pablo Goepfert, was a surgeon and had a strong influence on his choice of career. Nevertheless, Dr. Goepfert recalls how much he enjoyed working on his uncle's farm during the summer, helping with farming, taking apart engines, driving a tractor at age nine and then a truck at twelve. Though he enjoyed biology, geometry, and algebra in school, he thought of farming as an alternative career. He ends this segment with a funny anecdote about taking his medical school admissions test.

Segment 05

Surgery in Transition to Multi-disciplinary Collaboration

B: Building the Institution

Story Codes

A: Overview
A: Definitions, Explanations, Translations
A: The Researcher
A: The Clinician
A: Professional Path
C: Portraits
C: Understanding the Institution
B: Building/Transforming the Institution
B: Multi-disciplinary Approaches

In this segment, Dr. Goepfert observes that he came to MD Anderson during a time when cancer treatment was expanding beyond surgery to include chemotherapy. He gives a brief overview of the treatment practices at the time and notes that specialties debated who would administer chemotherapy. While Dr. Goepfert was a Senior Fellow in Surgery at MD Anderson, he observed that hematologists were actively involved in redefining who administered treatment (not the case at UCLA). (He also notes that he wanted to leave Chile for a fellowship in the US because of the “dismal state” of cancer therapy.) He witnessed the evolution of multi-disciplinary cancer treatment while working with Dr. Gilbert Fletcher. Dr. Goepfert notes that he established the “Thursday Afternoon Planning Conferences in the Department of Head and Neck Surgery in 1982, where multidisciplinary treatment plans were created. These sessions became a model for the entire institution. Dr. Goepfert then shares memories of Dr. Fletcher’s influence on his own thinking about how disease processes respond to radiation, how important give and take is in interdisciplinary care, and how critical it is to establish liaisons with basic scientists. He notes that he took part in the initial efforts at MD Anderson to establish a track for physician-scientists, mentioning the key roles of Dr. Garth Nicholson and Dr. Josh Fidler. He explains how a tone was set for the interdisciplinary management of head and neck cancers. He describes the working relationship between Dr. Fletcher and the gifted surgeon, A.J. Ballantyne. He notes that the process of establishing multidisciplinary care was not as “bumpy” at MD Anderson as in other parts of the country. He credits R. Lee Clark’s vision in setting up the remuneration system at MD Anderson for smoothing this process.

Segment 06

An International Pathway back to MD Anderson

A: Professional Path

Story Codes

A: Professional Path
A: The Researcher
A: The Clinician
B: Building/Transforming the Institution
B: Multi-disciplinary Approaches
A: Joining MD Anderson

Dr. Goepfert begins this segment by describing his activities on returning to Chile in 1968, after finishing his research project in the Section of Head and Neck Surgery at MD Anderson. He practiced general surgical oncology at the Instituto Radium in Santiago and also created a multidisciplinary pediatric tumor clinic at the Hospital Roberto del Rio. He explains that Chile was in political turmoil with coming elections and anticipated the election of a Socialist

government that would not put a high priority on cancer treatment. He took his family to Stuttgart, Germany and went to work at the Katherinenhospital ('70-'71). He did not flourish in the rigid work environment in Germany, and he returned to Houston for a residency in Otorhinolaryngology at Baylor College of Medicine and was a research project investigator in the Section of Head and Neck Surgery⁶ at MD Anderson. In 1974, as he says, he walked out of his residency and became Chief of Surgery in the Otolaryngology under Dr. Stanley Dudrick at the University of Texas Health Science Center Medical School. He describes how he met his main goal: finding a way for a range of specialties (general surgeons, plastic surgeons, dentists, etc.) to collaborate in handling trauma of head and neck surgery. He also talks about the first resident in the Head and Neck section, Pedro Jimenez. He did not "give up" MD Anderson, but was appointed Associate Surgeon and Associate Professor in the Section of Head and Neck Surgery. He then describes the process of becoming Chair of the Head and Neck Section of MD Anderson, the first board-certified otorhinolaryngological surgeon to take on the role.

Segment 07

Laryngeal Preservation Studies

A: The Researcher

Story Codes

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

B: Multi-disciplinary Approaches

C: Discovery and Success

C: Professional Practice

C: The Professional at Work

In this segment Dr. Goepfert describes his long-term work on laryngeal therapy and survivorship (protocol 91-11). He begins by briefly characterizing the perspective that otolaryngeal specialist brings to cancer of the head and neck. He then notes that, at the beginning of his career, most of his research was retrospective (he conducted such studies with Gilbert Fletcher on effects of radiation therapy). Then he describes the context of the Protocol 91-11 study, beginning with a landmark article that demonstrated that the survivorship rates were identical, whether a patient was treated with a laryngectomy versus intravenous chemotherapy plus radiation therapy. With the second course of treatment clearly better for the patient (as it preserved the voicebox and, thus, the ability to speak), Dr. Goepfert explains that Protocol 91-11 looked at whether chemotherapy was essential to preserve the larynx or would radiation alone suffice. He some advances in radiation therapy that presented some stumbling blocks to initiating the study (launched in 1991), and MD Anderson provided the largest percentage of patients (10%) to this nationwide study.

Segment 08

Financing Clinical Research

A: Overview

Story Codes

B: The Business of MD Anderson

D: Business of Research

D: Fiscal Realities in Healthcare
A: Character, Values, Beliefs, Talents

In this segment, Dr. Goepfert describes the difficult finances of clinical research in an environment where academic clinicians compete with private practitioners for patients. He broadens his focus and speaks about the country's need for a "social network" system that covers all individuals, noting that Scandinavia and many European nations have "socialized medicine" systems and the highest rates of satisfaction with their health care systems. He notes that though MD Anderson offers some of the best health care, that level of care is not necessarily available to the general community. He notes that rising health care costs affect cancer care and also the viability of research. He observes that in the journal, *Head and Neck*, fewer and fewer innovative articles are published by American researchers; more authors come from Asia and Europe.

Segment 09
Supporting Physician-Scientists
B: Building the Institution

Story Codes
D: On Research and Researchers
D: The Life and Dedication of Clinicians and Researchers
C: Patients
C: Cancer and Disease
B: Building/Transforming the Institution
B: Multi-disciplinary Approaches

Dr. Goepfert begins this segment by noting any physician-scientist must have passion in order to succeed. The idea that time can be protected for research in the current work environment is a myth, and research simply has to be added to the long list of activities demanded of the academic medical professional. A main question for administrators planning support systems for surgical physician-scientists is When does one begin the training? Absence from clinical practice can compromise a surgeon's skills. In the Head and Neck Department, physician-scientists spend 1-2 years in a lab before their advanced training, and it's key that a department have a team of faculty who believe in the principles of translational research. He mentions Jeffrey Myers and J Freireich as true physician-scientists. He explains that the program for physician-scientists in Head and Neck began in the mid eighties, when the chief of surgery, Charles Balch, arranged for an outside review of the Department and received feedback that they needed a basic scientist on the faculty to encourage translational research. Dr. Goepfert sketches how this idea developed and the involvement of Garth Nicholson and Joshua Fidler. He notes that it has been difficult to fund head and neck research because the cancers are diseases of the working class. He mentions that he approached the president of the institution, John Mendelsohn, to establish the Helmuth Goepfert Society to train physician-scientists. He notes that Dr. Mendelsohn did not offer practical support, and the Society eventually was only able to support a lectureship.

Segment 10
A Summary of Research
A: The Researcher

Story Codes

- A: Contributions
- A: Career and Accomplishments
- A: The Researcher
- A: The Clinician
- A: Overview
- A: Definitions, Explanations, Translations

Dr. Goepfert notes that he has generally served a supportive role in research studies. He participated in a study of a chemoprevention protocol involving derivatives of Vitamin A (Principle Investigator, Waun Ki Hong, MD [Oral History Interview]). His research in the eighties and nineties focused on the preservation of functionality of the larynx. He notes that his main contribution was to determine how to use chemotherapy in combination with surgery to preserve the voicebox, though that procedure was not long in use due to improvements in treatments using concomitant chemo- and radiation therapy. Dr. Goepfert ends this segment with a description of endoscopic surgical techniques and the new robot surgery in use by Dr. Floyd Holsinger.

Interview Session Two: 28 August 2012

Segment 00B

Interview Identifier

Segment 11

Patient Reactions to News of Speech Loss

A: Overview

Story Codes

- A: The Clinician
- C: Patients
- C: Cancer and Disease
- C: Professional Practice
- C: The Professional at Work
- A: Critical Perspectives
- C: Offering Care, Compassion, Help
- C: Controversies

In this segment, Dr. Goepfert explains how devastating it can be for patients to receive the news that they will lose their ability to speak because of a cancer of the head or neck. He the field is still struggling to find better ways to both preserve the larynx and its many functions. He sketches how the stage of the cancer determines the treatment that offers the best hope for preservation, but that existing treatments often fall short of what the patient and surgeon both hope for: full preservation of the power of speech. He gives an example of a member of Houston society who refused a necessary treatment, noting that some patients simply cannot “face reality.” He also describes how surgeons must help patients understand their options and how treatment will proceed, especially when they have gotten “second opinions by Google,” sometimes arriving at MD Anderson with stacks of printouts from the internet. Dr. Goepfert

gives a final example of a banker from Dallas who committed suicide rather than face losing his voice. Dr. Goepfert offers his philosophy about suicide in the face of such news.

Segment 12

A Brief History of the Section of Head and Neck Surgery

B: MD Anderson Past

Story Codes

B: MD Anderson History

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

C: Portraits

C: Controversies

Here Dr. Goepfert sketches the history of the Section of Head and Neck Surgery, officially started in 1952 with Dr. William McComb. He discusses Dr. McComb's commitment to the principle of radical surgery, noting that during this period there were only limited possibilities for reconstructive surgery. He also talks about Dr. McComb's collaboration with Gilbert Fletcher to combine surgical intervention with cobalt-60 radiotherapy, also discussing radiation therapy applied via implants. He notes that Drs. McComb and Fletcher published an excellent book in '65/65, *Cancer of the Head and Neck*. Dr. McComb was succeeded by Dr. Richard Jesse, who advocated for surgery combined with radiation and chemo therapy. He worked to define specific treatments for disease sites, using a single treatment when possible to avoid complications. He also implemented blood saving techniques during surgery and started intra-arterial infusions of chemotherapy. He was also a strong proponent of multidisciplinary care during a time of antagonism between surgeons who believed in radical surgery and those advocating radiation therapy. Dr. Goepfert explains that Dr. Jesse should also be remembered for creating the chaplaincy at MD Anderson, an initiative that was fundamental to creating the Lutheran Pavilion. Dr. Goepfert compares the leadership styles of Drs. Jesse and McComb. (Continues, Segment 13)

Segment 13

Chair of the Section of Head and Neck Surgery"

B: Building the Institution

Story Codes

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Institutional Processes

In this Segment, Dr. Goepfert talks about his leadership of the Head and Neck Surgery from 1982 until 2003. His primary goal on assuming the role was to facilitate multi-disciplinary care practices. He notes that all head and neck patients at MD Anderson came through Head and Neck Surgery, whether they ultimately needed surgery or not, and the Department followed each patient through treatment and aftercare. Dr. Goepfert notes again his role in establishing the Thursday Conferences where thirty or thirty five individuals from different specialties and services would gather to plan multidisciplinary treatment. These sessions served as a model eventually implemented by everyone at MD Anderson. Dr. Goepfert also says that he wanted to train physician-scientists, following the model of Dr. J Freireich in Developmental Therapeutics.

He talks about the qualities needed to succeed as a physician-scientist, the need for proper mentors in both the clinical and laboratory science fields, and other requirements to support translational research. Dr. Goepfert sketches the evolution of the physician-scientist role at MD Anderson, and what he did to support this growth.

Segment 14

MD Anderson Publications and Publication Ethics

A: Overview

Story Codes

A: The Administrator

B: Ethics

D: On Research and Researchers

C: Professional Practice

C: The Professional at Work

A: Professional Values, Ethics, Purpose

B: MD Anderson History

B: Information for Patients and the Public

B: Education

B: Beyond the Institution

Dr. Goepfert has served on a number of editorial boards and is keenly interested in the educational dissemination of information critical to cancer research. In this section he talks about some of MD Anderson's publications and also addresses some controversies with publication. He first raises the ethical issue of how authorship is assigned to a manuscript going out for publication. Today there are guidelines for assigning authorship, but twenty years ago, he explains, some department chairs at MD Anderson reviewed all manuscripts going for publication and insisted on being listed as first author of an article, whether they made any contribution to the research or not. Dr. Goepfert contrasts his own practice of putting his name on a paper only if he has contributed. Dr. Goepfert then shifts subjects and describes several MD Anderson educational publications, beginning with *Cancer Bulletin*, distributed free to all physicians across Texas.

Segment 15

The First Web-Based Textbook

A: The Administrator

Story Codes

A: Contributions

C: Professional Practice

C: The Professional at Work

C: Discovery, Creativity and Innovation

A: Influences from People and Life Experiences

B: Education

A: Personal Background

In this segment, Dr. Goepfert describes a promising, but ultimately failed, attempt to publish what was the first web-based text book. In 1997 he secured some funding to set up a team to plan the book and identified companies that could collaborate on design. His vision was to

create an entirely web-based and interactive publication that kept text to a minimum, relying instead on multi-media and multidisciplinary training in head and neck surgery. The project was completed in 3-4 years and he presented it to the Vice President of Academic Affairs, Margaret Kripke, who was very enthusiastic. The textbook was launched and housed on the MD Anderson server. Dr. Goepfert then explains that a committee decided that MD Anderson could not pursue any web publishing. He then comments on the difficulty of obtaining high level support for projects. The web-book project closed down when an outside publishing company decided that marketing the book would not be profitable. He then talks about what the web can offer researchers and clinicians, e.g. education via visual documentation of surgical techniques; a forum in which physicians can submit cases and receive input from specialists; a storage bank for cases for future reference. He notes that MD Anderson could be producing educational programs and offered for a fee. Dr. Goepfert first talks about the family origins of his interest in education and communication. He then mentions his Hayes Martin Lecture on education in '95, which focused on the fundamentals on what it takes to be a physician scientist.

Segment 16

Accrediting Head and Neck Services

A: Professional Service beyond MD Anderson

Story Codes

B: Institutional Processes

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

A: Activities Outside Institution

A: Contributions

B: Education

In this segment Dr. Goepfert talks about his service on the Joint Council, a combined effort of two societies of Head and Neck surgeons to regularize accrediting of surgical services. He first describes how the two societies came to work together, then notes how rigorous their parameters were for accreditation and the process of making site visits and making reports. (Dr. Goepfert also notes his discovery that some hospitals do not care about accreditation.) He was interested in the training of fellows who assist faculty members and observes that MD Anderson has a very well organized training program: often fellows who come into the program have to be retrained to meet MD Anderson standards.

Segment 17

The Physicians Network

A: Post-Retirement Activities

Story Codes

C: Funny Stories

B: Building/Transforming the Institution

B: Beyond the Institution

A: The Administrator

B: Institutional Processes

B: Critical Perspectives on MD Anderson

A: Post Retirement Activities

In this segment, Dr. Goepfert describes his post-retirement work on the Medical Board of the Physicians Network, a subsidiary of MD Anderson that helps physicians offer better patient care. He explains how a service can be connected to the Physicians Network through evaluation according to MD Anderson guidelines for best practices and standards set by other institutions. (Programs pay Physicians Network a fee.) Right now standards for care in breast, lung, prostate, and colo-rectal cancer are in place and standards are in development to evaluate care for more cancer types. Dr. Goepfert explains that there are nine host programs, and that the Physicians Network link –and the MD Anderson name—helps them with their marketing and funding. In response to a question about the expansion of the MD Anderson name, Dr. Goepfert says that the expansion of MD Anderson standards of care is still not well structured, and not much has been learned from past mistakes. He points out the Orlando, Florida remote site as one that is still very “nebulous” and MD Anderson Espana as a “model of what not to do.” He observes that quality of care relies on the participation of faculty to insure quality in both technical and intellectual components of care, but that faculty are still not clear on how to participate and how they will be rewarded. He explains his concern for the peer review program for Madrid oncology. He says that a strong future for the Physicians Network lies in better cooperation, and notes that while physicians see problems with care in remote sites, administration often does not and does not understand the danger of doing nothing.

Segment 18

MD Anderson Presidents

B: Key MD Anderson Figures

Story Codes

C: Portraits

B: MD Anderson History

C: Funny Stories

B: Critical Perspectives on MD Anderson

B: Controversy

B: Institutional Politics

D: On Leadership

Here Dr. Goepfert gives his views of the leadership styles of MD Anderson’s first three presidents. He describes R. Lee Clark as a “unique leader” with a strong character and decisive leadership style. (He observes that Clark advocated thinking big, but “built small” when it came to the inpatient unit.) Dr. LeMaistre was a very gentlemanly man, a good delegator, who was able to put smoking cessation at the forefront of MD Anderson’s initiatives and also made the first connections with other institutions such as MD Anderson Orlando. Dr. Goepfert next describes the search process (including some internal political strife) that resulted in Dr. John Mendelsohn’s presidency, describing him as the most “eccentric” of all the presidents and a significant physician-scientist who conducted valuable work on epidermal growth factors and antibodies. Dr. Goepfert notes that Dr. Mendelsohn’s name was associated with an insider trading scandal and that Dr. Mendelsohn did not support him in his efforts to develop the Head and Neck physician-scientist program. He observes that Dr. Mendelsohn was able to stimulate significant philanthropy for MD Anderson. Dr. Goepfert also explains that he advised Dr. Mendelsohn to step away from MD Anderson once Dr. DePinho assumed the role of president (though he notes that Dr. Mendelsohn appears to be reestablishing his connection with the institution). Dr. Goepfert emphasizes his own philosophy and practice of stepping away once an administrative role is done: he could have continued in his department after retiring, but

advocates that one should “go before they make you go” and that younger people in “the pipeline” need to have their chance.

Segment 19

A Career Devoted to Interdisciplinary Teams; Earning the name, Dr. Fixit

A: View on Career and Accomplishments

Story Codes

A: Contributions

A: Activities Outside Institution

A: Career and Accomplishments

A: Post Retirement Activities

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Definitions, Explanations, Translations

A: Character, Values, Beliefs, Talents

A: Professional Values, Ethics, Purpose

C: Funny Stories

Here Dr. Goepfert comments on his accomplishments and a significant award and shares some details of his life outside of work. He says that as he looks back on his work at MD Anderson, he says he is very gratified that he got three sons through medical school and a daughter through college with no debt. Taking a more serious tone, he says that he believes he used resources in his Department and Section wisely and made Head and Neck surgery visible enough to be recognized as the number five program nationwide. He is proud of the fellowship program and hopes that his focus on interdisciplinary care will be carried on. He is also proud of the Distinguished Surgeon Award he received from the Association of Operating Room Nurses of Greater Houston in 1999. He notes that he was brought up as a scrub technician in his father’s operating room and knows the value of nurses to a team. Speaking about his hobbies, he immediately talks about his love of riding motorcycles. He only stopped riding about four and a half years ago, when he felt his reflexes were not quick enough to insure safety. Otherwise, he reads and listens to music. He enjoys car trips and looks forward to taking driving trips up both the east and west coasts of the country. He notes that he washes his own cars. He tells an amusing anecdote about fixing bicycles for kids in the neighborhood in Sugarland, Texas, an activity that earned him the nickname, Dr. Fixit.

Helmuth Goepfert, MD

Session One: August 27, 2012

A note on transcription and the transcript:

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

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

In addition, the Archives may have redacted portions of the transcript

Chapter 00A Interview Identifier

Tacey Ann Rosolowski, PhD

0:00:01.8

All right. We are recording. I'm Tacey A. Rosolowski, interviewing Helmuth Goepfert, MD for the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson. This interview is taking place on the tenth floor of the Pickens Academic Tower opposite from the Department of Head and Neck Surgery. Dr. Goepfert is a Professor Emeritus in that department. From 1990-2003 he held the M.G. and Lillie A. Johnson Chair for Cancer Treatment and Research. He also served as chair of the Department of Head and Neck Surgery from 1982 until his retirement from clinical practice in 2003. This is the first of two planned interview sessions. Today is August 27, 2012, and the time is about 2:03 So thank you, Dr. Goepfert, for taking part in the oral history project.

Helmuth Goepfert, MD

0:01:00.3

Thank you.

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Chapter 1

A: Overview

Head and Neck Oncology and Related Specialties

Story Codes

A: Overview

A: Definitions, Explanations, Translations

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

D: The History of Health Care, Patient Care

Tacey Ann Rosolowski, PhD

0:01:01.7

Now, I wanted to start with just a couple general questions to get a sense of your specialty. I wanted to ask, what are the special challenges that an oncologist faces with head and neck cancers?

Helmuth Goepfert, MD

0:01:18.0

Okay. Your group here—the oncology—three specialties basically. You have Radiation Oncology, Medical Oncology, and Head and Neck Surgery. All three specialties, for many years, have worked very closely together in the management of head and neck cancer in this institution and have shared the patient load that has come in through the input of the different specialties and the input of different treatments. So the special challenges, of course, are that you have—number one—you have the complexity of the organs that are involved. As we speak now, we deal with our mouth, with our throat, with our voice box—or larynx. We have the nose through which with we breathe. We have the sinuses. Of course, then we see through our eyes. They are in the field as well. So basically what you're dealing with is anything that is between the chest and lungs, and the brain itself is involved in this specialty, and we have a variety of tissues here to deal with. We have the lining of what is called the upper aerodigestive tract, which basically is the breathing system, the eating system, the swallowing system, and the speak system. You have tissues that deal with digestion, not only the oral cavity itself but the saliva that is produced by the salivary glands. These can present abnormalities. Then you have the thyroid gland that is basically located within the neck and is an organ, again, that is subject to diseases that are treated by Head and Neck in one form or another. You have then, of course, the skin that covers everything, and by skin we mean the scalp skin, the face skin, and the skin of the neck. There are diseases there that you normally see in dermatology or plastic surgery, so there is a group of diseases that are involved that are present in this case. We have so-called squamous epithelium, we have glandular epithelium, we have connective tissue and integuments, we have bones, and

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we have cartilage, so we have a series of tissues that can have abnormalities that would require intervention. You have important structures in this area. You have the blood vessels that go to the brain, of course, without which function we couldn't exist anyhow. You have the veins, the arteries. You have all the nervous system that goes through this area. Particularly, in the neck itself there are nerves that function with the lower gastrointestinal tract to speak to the esophagus and the stomach. You have nerves that deal with breathing and respiration, and then you have all the nerves that go through the innervation of the upper extremities, which is the brachial plexus on both sides, so there are an abundance of tissues that can give us challenges in one form or another.

When I speak about the three specialties that are involved here, these are the clinical specialties, of course. There is always the very important field of pathology of the head and neck. There is the very important field of imaging studies of the head and neck, which is a specialty in itself. You have all the ancillary specialties that participate in the care of head and neck cancer—speech pathology, because we do alterations of deglutition with our treatments or patients have tumors or abnormalities that cause alteration of deglutition, of course, alteration of speech, alteration of breathing. And then you have the other sensory organs that are important here. I already referred to vision, but you have the sense of smell, and you have the sense of hearing. All of these in one form or another we deal with through subspecialization, more or less. So in view of that, as I say, you can always write a whole book on any of these areas. There are volumes written about salivary glands, volumes written about the thyroid. About ophthalmology, certainly there is a subspecialty that we head and neck surgeons basically don't deal with unless it is in the context of cancer of some sort or in the context of the lacrimal glands, for example, which can cause problems. So it is a very abundant field, and you can sort of subspecialize or specialize in any one of the areas. So if anytime you go into treating something here, you have to deal with certain functions that will be altered that can undergo permanent changes or that can present significant challenges for rehabilitation. Another group that is vividly involved in the care of these patients are the oncologic dentists or Dental Oncology, as the department used to be called. Certainly speech pathology I mentioned already before. The other subspecialty that is married to oncologic dentistry is prosthodontics. You take off, for example, a portion of a jaw, a portion of the maxilla, and you can rehabilitate that by prosthesis. They are already very adept at making prostheses in case somebody loses a nose. They make a prosthesis that looks like a nose. All of these are subspecialties that contribute to the care of patients that have diseases in the head and neck area.

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Chapter 2

A: Educational Path

An Overview of a Surgeon's Education

Story Codes

A: Educational Path

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

D: The History of Health Care, Patient Care

A: Joining MD Anderson

Tacey Ann Rosolowski, PhD

0:08:02.4

Now, in your particular focus within this whole world of dealing with the head and neck, how would you describe what your career has been about?

Helmuth Goepfert, MD

0:08:12.6

My career has been basically surgery, and I basically fell into head and neck surgery on the training I had as a fellow back in the '60s. When I originally trained in my home country of Chile, I trained as a general surgeon. That means you take care of everything that you can cut on. In those days the subspecialty was very limited. I obtained a fellowship to come to the United States in the field of cancer chemotherapy, which was sort of the parent organization for medical oncology. This was—I mean—the biggest society of medical oncology today as you know it is the American Society of Clinical Oncology—ASCO. ASCO was born in 1965, so before that it didn't exist, and before that the solid tumors—that excludes leukemia, lymphomas and so forth—the management, as far as chemotherapy was concerned, was in the hand of surgeons. It didn't develop as a medical subspecialty until some of the hematologists that treated solid tumors formed a new society. I obtained a fellowship back in 1964 to come to UCLA, into the Department of Surgery, to train myself in the chemotherapy management of solid tumors. It was relatively simple in those days—relatively simple. There were a few drugs that were available. There certainly wasn't the sophistication that exists nowadays for that. The evaluation of this treatment was done in a mainly clinical basis. There were no CT scans available, no MRIs. The imagining was sort of limited. Pathology certainly was already developed as far as the clinical pathology and anatomical pathology, but certainly there was nothing of molecular pathology—a sort of subcellular level pathology that didn't exist in those days. So then, from UCLA, where I spent two years, I obtained an extension of my visa to come to MD Anderson. Again, I was transferred onto a research program that was under a surgeon.

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Tacey Ann Rosolowski, PhD

0:11:08.7

How did you find out about that program, and how did you end up coming to MD Anderson?

Helmuth Goepfert, MD

0:11:12.5

Because my mentor at UCLA was a good friend of mine that sort of took me under his wings then. He was Dr. John Stehlin, whom you may know as associated with the Stehlin Foundation here in Houston at St. Joe's Hospital. I was his last fellow here. I arrived July 1, 1966, and he left February 1, 1967. Rather than being ousted, Dr. Richard Jesse, who had a program of regional chemotherapy, took me under his wings. That's how I became familiar with head and neck surgery. I stayed an extra year here in order to acquire more knowledge of oncologic surgery under Dr. [Richard] Martin, Dr. [Edgar] White, Richard Jesse, and people like that. So then I was a surgeon. I did give chemotherapy. I returned back home again, and things didn't work out the way I wanted them to, so I applied for an immigrant visa in the United States. The immigrant visa took at least 6 months to a year. I got invited to Stuttgart, to the Katherinenhospital, to be the one that organized, for the radiation chemotherapy department, solid tumor chemotherapy—again, something that today you would consider totally normal, but the knowledge of solid tumor chemotherapy didn't evolve then as rapidly as it evolved after ASCO was created. So I spent six months there, and then I came to the United States. Again, Dr. Jesse helped me in a sense of offering me a job. I was a project research investigator, but I had no residency training towards a board certification. I knew nothing about not having a board certification. So I was lucky enough to obtain a residency position at Baylor College of Medicine under Bobby Alford. I obtained my training in otolaryngology, and I graduated from that program and did my American Board of Otolaryngology in 1974.

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Chapter 3

A: Overview

Friction in the Evolving Field of Head and Neck Surgery

Story Codes

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

D: The History of Health Care, Patient Care

C: Controversies

Helmuth Goepfert, MD

0:14:02.5

So that's how I got into "head and neck surgery." Throughout this time, there still was very much friction between the two big societies of head and neck surgery. There was the Society of Head and Neck Surgeons, which was predominantly general surgeons and plastic surgeons. Then you had on the other side the American Society for Head and Neck Surgery, which had been founded by otolaryngologists about four years after the previous one. Now, even though they attempted to work together, there was animosity in the fields between surgery done by general surgeons, surgery done by otolaryngologists, but over time the pendulum swung towards otolaryngology. Nowadays, ninety-plus percent—almost 100 percent—of head and neck surgery is done by otolaryngology-trained physicians, and the two societies, again, eventually merged into one, which is the American Head and Neck Society—AHNS.

Tacey Ann Rosolowski, PhD

0:15:37.3

What were the points of contention between these two societies after their founding?

Dr. Helmuth Goepfert

0:15:47.0

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Ego. (laughs) Specialties evolve, and otolaryngology, from its beginning, had a certain interest in part of cancer of the head and neck, predominantly the larynx. The general surgeons sort of hung on to the rest of it—the neck dissections, the thyroid, the skin, and all the diseases that are surrounding the paranasal sinuses and the oral cavity and so forth. So it was sort of they got training in it, the departments dealt with it, but gradually the general surgeons got away from that. On the other side, otolaryngology sort of lost due to the advent of antibiotics for all the infectious diseases of the head and neck. The ear infections became less, sinus infections became less. In general, anything that had to do with infectious disease became less prevalent and was treated medically now. That was an important event. And even in the '80s—early '80s—there still was a certain separation in some organizations. I'll give you an example. In the Mayo Clinic, for example, until about that time, if there was a cancer of the larynx being treated, the otolaryngology took care of the treatment of the cancer of the larynx, but then the general surgeon came in to do the neck dissection. So it was sort of a strange split. Now, there has always been friction between specialties. Another friction between specialties that is not quite resolved yet has to do with the surgical reconstruction of the defects we do in our operative procedures. There is a very strong move from otolaryngologists to do that. On the other side, there is an established rote that is done by plastic surgery. In this institution we follow the latter, so all our plastic surgeons here are trained in plastic surgery and come up. I'm partly responsible for that way back then.

Tacey Ann Rosolowski, PhD

0:19:00.1

Why did you support that particular training track for plastic surgeons?

Helmuth Goepfert, MD

0:19:06.2

Because we always felt the necessity to stay in touch with them. This is from the time that the first plastic surgeon at this institution, Dr. Margaret Sinclair—she sort of was a plastic surgeon that had been trained before the war in Germany. She came via Cleveland Clinic, or one of those clinics, to MD Anderson back in 1952 and was the first reconstructive surgeon here who was—Of course, the armamentarium then was very limited. Then, following her, there was another surgeon that was a plastic surgeon that was with us, Dr. Don Gard, and he retired recently from private practice here in Houston. When he left, a man who had been double trained in otolaryngology and plastic surgery, David Larson, took over, and he came as a plastic surgeon and developed certain techniques in plastic surgery that were used for many years. He basically set a tone for that. During his tenure we did the first attempt of getting a microvascular surgeon. That failed, and we sort of abandoned that. When David Larson left it became quite critical. There was one plastic surgeon whose name escapes me right now that in the interim covered the waterfront. I forgot his name. He committed suicide. You must remember that, possibly. And

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then we appointed Dr. Mark Schusterman, and Dr. Mark Schusterman was basically the one who started an independent department of plastic surgery at this institution, and that evolved into what it is today—probably the biggest surgical reconstruction unit in the country.

Tacey Ann Rosolowski, PhD

0:21:26.0

And when did that happen? When was that department established?

Helmuth Goepfert, MD

0:21:29.4

Dr. [Charles M.] Balch was the chairman of surgery. It was in the mid '80s.

Tacey Ann Rosolowski, PhD

0:21:34.8

Mid '80s, wow.

Helmuth Goepfert, MD

0:21:43.4

What was his name?

Tacey Ann Rosolowski, PhD

0:21:45.8

Well, you'll think of it. We can pop back and slide it in later.

Helmuth Goepfert, MD

0:21:55.2

[Steve] Kroll—K-R-O-L-L.

Tacey Ann Rosolowski, PhD

0:21:57.4

K-R-O-L-L, okay.

Helmuth Goepfert, MD

0:21:58.5

The first name comes back soon—Steve.

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Tacey Ann Rosolowski, PhD

0:22:02.1

Steve Kroll. Okay, great. We've really covered a lot of territory. I'd like to go back and pick up some details of the evolution of your career. It's interesting. As I was reading through your CV I thought, "Wow." I was wondering how you maneuvered into this role, because it seems as though you did so many things. I had questions about how you got involved with chemotherapy and why and the ways in which you began to set up programs in that. Just the snapshot that you gave at the beginning of the interview—where you described all these specialties—it gave me a portrait of how very, very complicated this universe of treating this area of the human body really is.

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Chapter 4

A: Personal Background

Farming or Medicine?

Story Codes

A: Personal Background

C: Funny Stories

A: Character, Values, Beliefs, Talents

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: Professional Path

Tacey Ann Rosolowski, PhD

0:22:02.1+

So do you mind if we kind of take a few steps back? First of all, just for the record, where were you born and when?

Helmuth Goepfert, MD

0:23:02.1

Santiago, Chile, September 13, 1936.

Tacey Ann Rosolowski, PhD

0:23:05.6

And you were raised in Chile, right?

Helmuth Goepfert, MD

0:23:07.7

I went to all schooling and medical school in Santiago, Chile. My father was a general surgeon who basically participated in my training. This was during the residency that I did for two years in a city that's called Valdivia, where the big earthquake was in 1960. I basically moved down there after I graduated from medical school. In Chile in those days, we didn't get our diploma until after we had done an internship, so we didn't have college. From high school you went directly into the career sort of schooling.

Tacey Ann Rosolowski, PhD

0:23:55.2

So it was a more European-style system?

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Helmuth Goepfert, MD

0:23:56.5

The European style, which was seven years of medical school followed by a year of internship, which was basically a mixed surgical internship.

Tacey Ann Rosolowski, PhD

0:24:06.6

Now, your father's name?

Helmuth Goepfert, MD

0:24:08.0

Juan Pablo Goepfert.

Tacey Ann Rosolowski, PhD

0:24:10.8

Okay. And did you decide to go into medicine because of his career? How much did that influence you?

Helmuth Goepfert, MD

0:24:17.1

Probably. This was an interesting choice. At home you had to take—yes, you obtained all your records from your high school. That was submitted to the university. But then you had to take an added exam. On this exam that was sort of unspecific as far as any school itself was concerned, you got sort of tiers—the result was given in tiers of scores. And of course for medical school you had to achieve a pretty high score to get in. The positions available, for example, at that particular university that I went to there were 180 and there were about 600 applicants, so it was tough. Then the next tier was sort of all the schools of engineering and thereof. I don't like math, I don't like all of that, but one of the things that I really like because I grew up working summers on the farm was to go into farming and sort of the agriculture side of it. So one of my uncles was a farmer, and from age nine on I used to go and spend the summer working on the farm. It was harvest time. I spent three months there, whatever it was in the south of Chile, and learned a lot.

Tacey Ann Rosolowski, PhD

0:25:47.5

What were the crops that were grown?

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Helmuth Goepfert, MD

0:25:49.7

Corn, predominantly. We had some cows for milk, and that was fundamentally the crops that were grown. So, as I say, that was interesting and was— I learned a lot from my uncle. He was a character.

Tacey Ann Rosolowski, PhD

0:26:06.6

What kinds of things did you learn from him? He obviously made a huge impression.

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Helmuth Goepfert, MD

0:26:10.8

I mean, just common sense things—how to use a gun. I’ve never used a gun since, but I went hunting. I knew how to take apart an engine and put it back together. I worked the tractor. Yes, I was nine years old and was driving a tractor. I was driving a truck at age twelve. I learned those things which were sort of practical and common sense. There was no electricity where we were back in the early days out there, so there was a wind charger that charged the battery, and basically at night you had the petroleum lamps and stuff like that. There was no refrigerator, so it was the cooling—you know—that cooling system in which you put a cloth over something and let the wind sort of cool it down. As I say, I learned how to carry sacks, and I learned how to drive the harvester, all those things I learned on the farm. This was a fun time. Then in school itself, I liked biology. I liked everything that was sort of related to the human body, but I loved geometry, algebra, math, and so forth. I loved that too, and had a very good teacher. There were these three choices. I happened to fall into the category that I could expect to apply, but nevertheless you still have to give an additional exam at the medical school—an admission exam, aside of the one that you got before. So once that was accomplished and I found out— I had already taken the exam and decided, okay, I going south to work with my uncle. I told my dad, “Would you mind looking what qualifications I got, because it won’t be available for another two weeks?” “Sure,” he said, “I’ll take care of it.” So I get a letter about two weeks later. He said, “It was a little difficult for me to find because I kept looking at it every day and I didn’t find you until I looked higher up. You were number three.” (laughs) So that was that story. So I went through medical school in Santiago. The medical school burned down in 1947, so these were several buildings where the basic sciences took place. Your first three years you weren’t a basic science, so once I finished med school and my internship, I decided to go work with my dad and to do my residency at the same time in that town. As it was set, you did your residency, and in the afternoon you could do something else to earn a living, because the residency itself didn’t pay much, so I earned my living as being an assistant to my dad in surgery, which I already had done before. I mean, I was twenty-one years old when I was helping my dad in the operating room as a scrub tech, and I did my first appendectomy when I was twenty-one. So, as I say, I loved surgery, and I loved all that. My dad was a very good teacher. In 1962-63, I applied for a fellowship at UCLA. There was an exchange program between UCLA and one of the universities in Santiago. It so happened that my father-in-law was a professor of medicine at that university and facilitated my application in the sense of moving it forward. The day Kennedy was assassinated I obtained a notification that I would be accepted to this fellowship. So, my then-wife Monica [Goepfert] and I came to the states, and both of our children were born here— Paul [Goepfert] in Los Angeles and Susan [Goepfert Willingham] here at Methodist. Basically in ’68 we returned back to Chile and I started in Santiago trying to open a private practice and working at the cancer institute—Instituto Nacional de Radium—which basically was a barn. That’s what it was.

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Chapter 5

B: Building the Institution

Surgery in Transition to Multi-disciplinary Collaboration

Story Codes

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

A: Professional Path

C: Portraits

C: Understanding the Institution

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

Tacey Ann Rosolowski, PhD

0:31:15.6

Let me ask you a quick question, because in '66, when you were in UCLA—well, let me backtrack a little bit. When I interviewed some people here about the use of chemotherapy here at MD Anderson around that time, they were talking about how there was some tension between people who were interested in using chemotherapy and surgeons, because surgeons kind of felt that tumors needed to be treated surgically. So what was your experience with that?

Helmuth Goepfert, MD

0:31:43.1

No, the experience was that this was a transition. Now, when I came to UCLA I was put in charge of the solid tumor chemotherapy clinic. Look at where this was in those days, okay? When I came here I came with the specific purpose of working on regional chemotherapy and intra-arterial chemotherapy. In those days, it's the isolated perfusions that still were done to some extent and the intra-arterial infusion, which in those days there was not the Seldinger Technique that is done today by interventional radiologists, but you sort of cannulated the arteries by open procedure. You went here with a local anesthetic, found the artery, put the catheter in and tied it in and left it there and gave the drug.

Tacey Ann Rosolowski, PhD

0:32:39.9

And just for the sake of the recorder, you're pointing at your temples, so you literally go through the—?

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Helmuth Goepfert, MD

0:32:44.9

Go through the arteries. You find the artery and do a retrograde catheterization, test if it is in the appropriate place based on a fluorescent test, and we left the catheter there and hopefully it would not dislodge or something. Then it would stay in there for so long, and the drug would be infused. In those days what was infused was fluorouracil, and they usually gave concomitant chemotherapy with that. The other tension of course still was not so much who will treat the patient but who will give the drug, and of course the medical oncology at this institution became quite strong because of the leaders it had. The track record, especially in hematology malignant tumors—leukemias and lymphomas—basically were a very strong point for them to build on that and then take over the management of the so-called adenocarcinomas—breast, colon, lung, and what have you.

Tacey Ann Rosolowski, PhD

0:33:55.9

Now, at UCLA, that wasn't the same situation? Or it was the same situation?

Helmuth Goepfert, MD

0:34:03.7

At UCLA there was basically the perfusions and the infusions—the isolated perfusion and the infusions. The hematologists were doing the first attempts to participate in solid tumor chemotherapy, but were not really interested in it because probably the limited availability of effective drugs. I mean, at UCLA I still was using nitrogen mustard for intravenous chemotherapy in some of the tumors. Cytosan existed, fluorouracil, nitrogen mustard, vincristine, Velban, methotrexate certainly was there and melphalan. That's about it, so there was not the large amount of drugs, and we really didn't know what would work, so the first trials of vincristine were done in those days.

Tacey Ann Rosolowski, PhD

0:35:07.5

What were some big lessons you learned at that fellowship that really helped you in that next move?

Helmuth Goepfert, MD

0:35:13.6

The reason I took one of the fellowships is because I saw the dismal state of cancer therapy in Chile. The horrendously advanced cancers that I saw in the clinic or that my dad took care of, particularly of the breast, I said, "There has to be a different way to treat this." So, as I said, yes,

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in those days the whole issue of prevention and so forth was not there. Then, of course, the radiation therapy that was given then was called orthovoltage therapy, and it was not the best in the city where I was working. I wanted to see something that would be a step forward, and, yes, in my limited experience I considered that a step forward, and, yes, I saw that there was a lot that could be done with the availability of these drugs, but still it was limited.

Tacey Ann Rosolowski, PhD

0:36:19.9

Now, so you went back? Well, in '67 you went to MD Anderson, so you really had—

Helmuth Goepfert, MD

0:36:27.7

No, it was '66-'68 I was here. The first year I was a research project investigator, and the second year Dr. White, who was the chair of surgery, offered me a senior fellowship in surgery, so I was basically in surgery. In those days you rotated through colorectal, breast, soft-tissue sarcomas, and melanoma. As a senior surgeon I did not really participate in the care of lung cancer—senior fellow of surgery—but it was those—and the team leaders in those days were Dr. Richard Martin and Dr. John Stehlin. Now, when Dr. John Stehlin left, Charles McBride came to be one team leader there. I left in 1968 to go back home.

Tacey Ann Rosolowski, PhD

0:37:24.5

You refer to these team leaders, and in using that term are you referring to kind of interdisciplinary care teams?

Helmuth Goepfert, MD

0:37:33.9

No, surgery teams.

Tacey Ann Rosolowski, PhD

0:37:34.9

Okay. Surgical teams.

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Helmuth Goepfert, MD

0:37:35.6

Pure surgery teams. The first interdisciplinary activities really happened in Head and Neck Surgery way back then. It started between Dr. [William] McComb and Dr. Gilbert Fletcher, but it then really became more organized under Dr. Richard Jesse, and when Dr. Jesse died and I became the chairman, I made sure that the so-called interdisciplinary planning process would take place. So ever since then, the Thursday Afternoon Planning Conference exists in this institution, and it was the model after which all the other ones were modeled at MD Anderson.

Tacey Ann Rosolowski, PhD

0:38:25.3

Really? So that—wow.

Helmuth Goepfert, MD

0:38:27.1

Yeah. So that was the beginning of it, and that was in 1982. One of the important teachers I had in the whole issue of oncology was actually the chief of radiation oncology then, Dr. Gilbert Fletcher. He was a great teacher in showing you how cancer sort of evolved in a sense of how it was important to observe what was going on in order to plan the right treatment. Great lessons were learned in that he already had a planning clinic that was exclusively for radiation therapy. You probably have heard that he used to have, every morning at 8:30, one to three patients presented to him, and in front of the whole department they were discussed and what was the treatment recommended.

Tacey Ann Rosolowski, PhD

0:39:28.8

I hadn't heard that.

Helmuth Goepfert, MD

0:39:30.3

Yeah. And he was a hothead, but he knew what he was talking about. He was really a wonderful teacher, and he deserves to be credited with many of the later advances. Nowadays nobody knows anymore who Gilbert Fletcher was. Only the elderly know who he was and worked with him.

Tacey Ann Rosolowski, PhD

0:39:58.5

What were some of the strategies that you learned by observing him work with patients?

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Helmuth Goepfert, MD

0:40:04.7

I learned the fundamental fact that—number one—there are certain disease processes that were better treated by radiation therapy. Number two—that it's not all or none. Number three—that there is a give-and-take in interdisciplinary care. And number four—and this sort of guided me later in my career—that there was need for establishing a liaison with basic sciences in order to further the knowledge, and that's where the concept of the physician-scientist came to bear. These were people—I mean—the physician-scientist track was established at this institution, and I must admit, I participated in the initial intents of that with Dr. [Isaiah J.] Fidler, whom I saw today in the hallway, and there was another one that was—he left for California—Nicolson—Garth Nicolson. Garth Nicolson was the other one. They were, I would say, the first members of this team in which we interact with each other in order to train young minds in being tied to basic science and sort of a bridge between basic science and clinical science—for example, Stimson Schantz in our department. One of the early ones that went through this track is Dr. Raphael Pollock, who is at present time the head of surgery. He was one that went through the early phases of this type of training. Now in the department there are several—in the department of head and neck surgery—there are several that were trained on that track—Dr. [Jeffrey N.] Myers, Dr. [Gary L.] Clayman, Dr. [Michael E.] Kupferman, and I think those are the principles that are left here. As I say, my evolution into that—I could never do that because I was involved in a different training. I didn't get my board certification until I was thirty-eight years old, so it was four or six years later than normally. I had other fights to fight. I was the first chairman of Ears, Nose, and Throat at a new medical school here, where I basically took care of ear, nose, and throat problems over at Hermann Hospital, and at the same time I had a part-time appointment here at MD Anderson in the Department of Head and Neck Surgery. Now, what else did I learn from interaction? As I say, Dick Jesse and Dr. Fletcher sort of—and in those days, Bob Lindberg too, because he was subspecialized in head and neck radiation oncology. He still lives in town here. He retired several years ago. First he moved to Kentucky and then came back and retired here in Houston. They sort of set the tone for the interdisciplinary management of head and neck surgery, and then gradually medical oncology came in. That started basically with some initial attempts to participate in an interdisciplinary management with earlier disease than the advanced disease that medical oncologists usually take care of. When you get hold of what we are writing with Dr. [Randal S.] Weber—the history—you will recognize how that evolution sort of took place.

Tacey Ann Rosolowski, PhD

0:44:22.8

Was it bumpy getting to that point of getting people working together in a smooth way?

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Helmuth Goepfert, MD

0:44:29.4

It always has been bumpy.

Tacey Ann Rosolowski, PhD

0:44:31.4

What were the reasons for the bumps?

Helmuth Goepfert, MD

0:44:35.4

Let me put it this way, most of the time it had to do with characters and strong personalities. In the evolution of this institution it should be recognized that one of the technically more gifted surgeons was Dr. A.J. Ballantyne. A.J. Ballantyne, for example, was the first resident of this institution. He then went to Mayo Clinic for two years, and when he came back he worked as a head and neck surgeon. He had been trained in general surgery, worked as a head and neck surgeon. He was a great collaborator with Dr. Fletcher in many aspects. But interestingly enough, over the years, the two distanced themselves because Dr. Ballantyne himself sort of felt very strongly that some of the side effects of radiation therapy were too much for the patient to bear and felt strongly that surgery was better, none of which was probably totally true, but nevertheless it was enough for them to split and become very antagonistic at the later time of their careers. So this is one thing that you would say, yes, it evolved in that form. Bumpy, yes, but not as bumpy as it was in other parts of the country, because the one thing that needs to be said is interdisciplinary care has to thank Dr. [R.] Lee Clark for creating the remuneration principle at this institution in the sense that whoever brings in the money does not control that money; it's a separate board that controls the disbursement of the these funds. That is the basis of why, at this institution, interdisciplinary care could be given the way it is. That should not be forgotten. You look at Memorial Hospital. They've never been able to do that, and they still are separate private practices up there. It was very easy for a surgeon to say, "In reality, I don't need to operate on this patient. This patient will be better served by radiation therapy." So that prevailed over the years and has been sort of the motive for all of us that are ever trained here or that still work here.

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Chapter 6

A: Professional Path

Building MD Anderson Care and an International Pathway back to MD Anderson

Story Codes

A: Professional Path

A: The Researcher

A: The Clinician

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

A: Joining MD Anderson

Tacey Ann Rosolowski, PhD

0:47:25.1

Now, after you did your research project in regional chemo here and your senior fellow in surgery, you mentioned that you went back to Chile, and you were developing, as I understand from doing my background research, a multidisciplinary pediatric tumor clinic at the Hospital Roberto del Rio. Can you tell me about that, and why did you choose to leave that?

Helmuth Goepfert, MD

0:48:11.1

I left Chile for another reason, but I was at the Instituto Nacional Radium, which I told you was basically a barn; it was very primitive. Radiation therapy—they had a covered unit that was underserved in the sense that God knows when was the last they what the output was. It was very primitive. Pediatrics was done in a separate hospital—Hospital Roberto del Rio, which was across the street. To some fortuitous meeting, I had talked to the then chief of maxillofacial surgery, which was a general surgeon that made his reputation in Latin America for the management of cleft lip and palettes. He invited me to help him in this, which was, again, a way to enhance my income because the income from the Instituto Nacional Radium was miniscule and I had to feed a family of three plus myself. So I helped him, and he said, “Listen, our tumor system at Roberto del Rio is very disorganized. Would you mind looking at it?” I said, “I’d be happy to. Whom do I talk to?” He gave me the contact. I immediately saw that the basic thing was a limited knowledge, a willingness to do something provided that you sort of made clear what the boundaries were. So I figured out, I said, “Okay, I myself, I love surgery, but here I have to tackle this a little bit differently.” So I created a tumor board, but I did not intend to do the surgery because I knew there were surgeons that wanted to do it. I offered myself to assist them in the surgery but not to take over the surgery. So I organized this clinic, and we had

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routine meetings every week in which we discussed cases and we decided on cases, and some of these cases are used for case reports that are in the initial literature of what I published in Chile. So, as I say, this is the way I worked it. Now, at the Instituto Nacional Radium people really didn't work very hard. They had a salary there because it was an assigned salary, and they worked from 9:30 until 12:30 and then did their private practice in the afternoon, so that's all they did. I could not get enough steam among these older folks to really create anything different, so I went out of the system and looked at the university and helped them develop some modern of interdisciplinary care, but it was incomplete. Now, this is 1968-'69, and the country was in some turmoil. It was clear that the next president very likely was going to be a socialist/communist, which was Dr. Salvador Allende. Now, Salvador Allende had been a classmate of my dad, but that certainly wouldn't help me. But what I sort of figured immediately was if a socialist takes over, it would be the first government in the world where a communist had been elected in a democratic fashion. I thought cancer, the way I see it, is at the bottom of the list of what they would like to improve. You cannot gain much in a system that is basically a country in development by improving cancer care. You gain much by improving infant mortality, infectious diseases, transmittable diseases, and all of that has to do with vaccination. That gives you much more product for the buck. So it was that that I saw. Then I saw, too, if they take over they may close the borders just like Cuba or like China. This was a little difficult. So the family council decided we were going to leave, so I applied for a visa to the United States, but the quota was such that it would take at least 6 months to a year. Now, the election was going to take place in November, or somewhere there, so when I saw that this was coming I basically said, "What do I do next?" Now, the history has to be taken back for my initial years in Bolivia, where as a German-speaking physician I was invited to Santiago to host one of the visitors that came from Germany for the Latin American Cancer Conference. I was the host for the director of radiation therapy at the Katherinenhospital in Stuttgart. I showed him around Chile in 1963. Now, in 1970—yeah, the beginning of '70—he said, "Listen, if you are having trouble in Chile, I can give you a job." So of course we took it. We took a boat from Buenos Aires to Genoa. I took all of my family with me, and we left Chile. I was in Katherinenhospital, hired as a physician in charge of organizing the chemotherapy for solid tumors at this hospital. Now, the system in Germany, of course, is a very silo-oriented system. It still is to an extent. The only one that really has to say what is to be done is the professor. The democratic organization that exists within medicine within the United States— Although, yes, there are some silos here but not as visible as there. I couldn't live with that. So I had been in touch with Rick Jesse. I came for the cancer conference that was here in 1970. I visited with him. I visited Germany. I stayed in Germany for as long as I needed, but the minute I transferred all my papers to the embassy in Frankfurt, and as soon as they said, "You have a visa," we were on a plane and back to Houston. So that's how I arrived here in May, 1971.

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Tacey Ann Rosolowski, PhD

0:55:39.4

In '74.

Helmuth Goepfert, MD

0:55:40.7

In '71. Now, I had no training, and by just a stroke of luck Dr. Alford, who ran the department over there, had four residents and one of them unfortunately got a back problem. In those days back problems basically limited your existence, not like today. He was out of the residency, so he had a vacancy, and he offered me the vacancy, but going in there as one that had already been trained in head and neck cancer, I became a threat to his junior faculty. The initial discussion we had he said, "Listen, I'd love to have you work as a resident, but—" I said, "No. I can handle that." So I had to be very careful how I dealt with anything that had to do with tumor management or anything like that because I obviously, based on the two years I had been at MD Anderson, was more capable than the fellows they had there. They were good guys, but obviously they didn't have the ability to deal with it technically as somebody who had been trained at MD Anderson.

Tacey Ann Rosolowski, PhD

0:56:56.3

Can I ask you just a quick question about your experience at the Katherinenhospital? Was there anything—I mean—despite the limitation of what you were able to do there because of the way it was structured—?

Helmuth Goepfert, MD

0:57:09.6

I was basically in charge of the inpatient unit. Patients there, in those days, were admitted for the length of their treatment. So, as I say, I treated advanced patients. We were doing some limited neoadjuvant treatment in the sense of giving chemotherapy before treatment even though there was no evidence for that. But in those days evidence didn't matter much. And I worked very closely in certain areas of gallium scintigraphy with the radiologists and even wrote a paper in German. So, as I say, these are the things that I did then, and I had to dictate letters in German and correspond with these referring physicians and so forth, so it was an interesting time.

Tacey Ann Rosolowski, PhD

0:58:01.8

Was there something that you gleaned from that experience that helped you develop as a surgeon or as an administrator? Because that became important later.

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Helmuth Goepfert, MD

0:58:12.2

Basically I learned how things were not to be done. I learned from the failures of somebody else. As I say, no, I didn't get any training in administration ever except by following the example of somebody else. Formal training in administration only came later in the late '80s when we had the Rice course.

Tacey Ann Rosolowski, PhD

0:58:41.6

Right. In '92 you went through that executive development course.

Helmuth Goepfert, MD

0:58:45.3

Executive development course, but before that it was trial and error—it was trial and error. And why they made me chairman then when there were other candidates, I don't know, but it was a difficult time for me. So I came here and I did my three years of residency. Interestingly enough, they waived the requirement for me to do general surgery. The board waived it; otherwise it would have been five years.

Tacey Ann Rosolowski, PhD

0:59:14.7

Why did they waive it?

Helmuth Goepfert, MD

0:59:15.8

Because of the training I had in the past. They accepted that.

Tacey Ann Rosolowski, PhD

0:59:20.1

That's great.

Helmuth Goepfert, MD

0:59:22.0

And in those days the University of Texas Health Science Center Medical School here in Houston had just hired a chief of surgery, Dr. Stan Dudrick, and Stan Dudrick was developing his sections. One of the sections was otolaryngology, because that was under surgery. The ex-chairman there, Dr. [Herbert] Harris, suggested my name to Stan Dudrick, and I walked out of residency and became chief somewhere. You see? As I say, those were interesting times because Stan Dudrick loved to hear himself. He's a marvelous guy otherwise. He loved to hear himself,

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and some of our monthly staff meetings started at 6:30 in the afternoon and didn't end until midnight. I mean, I was there together with Red Duke. You know who Red Duke is. (laughs)

Tacey Ann Rosolowski, PhD

1:00:28.2

That's pretty astonishing to walk out of being a resident and then to be Chief of Section. So what did you see as your goals when you took on that role?

Helmuth Goepfert, MD

1:00:42.0

Number one, my heart was in head and neck cancer. Number two, I had the necessary training to do all the subspecialties of otolaryngology—stapes surgery, laryngology, all of what was available in those days.

Tacey Ann Rosolowski, PhD

1:01:02.7

I missed that first phrase.

Helmuth Goepfert, MD

1:01:04.6

Stapes—otosclerosis surgery. I did only one stapedectomy once I finished the residency. I said, "No. I'll leave this for somebody else," because I immediately recognized that there are certain things that, unless you have the proficiency of repetitive action, you shouldn't be doing it. That was one of the first things that I learned. The second was I wanted to create the section because this was the job I had—to create a section. But this was in the presence of General Surgery that did not want to give up thyroid surgery, Plastic Surgery that did not want to give up the trauma at Hermann Hospital, and dentists who wanted to participate in the trauma of head and neck surgery. So one of the first, not battles to fight but issues to agree upon, was these three separate sections—how were we going to handle the trauma? We know that the oral surgeons have a mastery of dentition, of occlusion. The plastic surgeons are basically predominantly for the beauty, and the otolaryngology, okay, because it's part of where we work daily—day in and day out. So we came to an agreement—and there was no resident available yet at that time—6 months later we had the first resident—that we would alternate every 3 nights in the emergency room on call. So when trauma came in on the night of Ear, Nose, and Throat, we would take care of it, and the day it came in for Plastic Surgery, they would take care of it. The day it came in for Dental, they would take care of it. We tried to be available for the need between us.

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Tacey Ann Rosolowski, PhD

1:03:05.5

Now, that seems like a kind of arbitrary way to—

Helmuth Goepfert, MD

1:03:08.7

Yeah, but it is the way that it had to be solved in order to satisfy the need of three specialties. Now, shortly after I started the job, a gentleman that had been trained in Cuba and practiced in Cuba came to me. He came over to Miami. His wife already was in the States. She was a pathologist in Miami. He wasn't going to start a practice here without having done a residency. Mind you, he was 57 years old, and he offered himself to be a resident, so I basically had the first pillar to form a residency. I approached the residency review committee and the board and everybody else, and I got a temporary permit to run a residency with one resident. That was Pedro Jimenez. Now, Pedro Jimenez finished the three years of residency with me. The first time, at age sixty, that he sat for the boards in otolaryngology he passed it, which was unusual. Nobody had done it, and nobody had done it at that age. He started practice here in Houston. Pedro Jimenez eventually died a couple of months ago of old age, but he was the first resident in otolaryngology at UT Medical School. Now, I wasn't going to totally give up MD Anderson, and during my residency I kept work in chart review with Richard Jesse. It was a grand supplemented part of my income. I wasn't going to give up what I had learned at MD Anderson nor give up my participation there. When I got my initial appointment, it paid sixty percent by medical school and forty percent by MD Anderson.

Tacey Ann Rosolowski, PhD

1:05:16.6

Because you were a part-time faculty member at that point—associate professor in 1974?

Helmuth Goepfert, MD

1:05:21.7

Yeah. I became associate professor. Why so quick? I don't know. (laughs) I became associate professor here and over there. As I say, in those days there was basically hot, black asphalt between here and Hermann Hospital. You got out of the back of MD Anderson, and you walked across the hot pavement all the way over to the other side a couple times a day. It was quite a bit of sweating. As I say, this was in 1974. Then we had the big flood in 1972, where six feet of water was here on Holcombe. Everything flooded. Then in 1979, when Dick Jesse was already with advanced cirrhosis from hepatitis he had acquired from a patient back in '73, I gave up the Hermann Hospital because it was a little too much. It was getting crazy. Somebody else was selected. Then I came full-time to MD Anderson. Shortly thereafter, Dick Jesse was asked to put me in as a deputy chair—this was sometime around there—Deputy Chair of Head and Neck Surgery, and Dr. Jesse then died in August of 1981. So that is how I got into the role of being a

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chairman here. Now, I basically was the first otolaryngology board-certified member of this department. All the other people had been general surgeons or were general surgeons, which caused a little bit of friction. Most of the time it went without a hitch, and certainly it was not a big deal outside the institution. The institution itself was not bad, but outside of the institution it was said, oh, finally MD Anderson has become an otolaryngology department. But I didn't see it that way. Life has to go on regardless of what it is, but the otolaryngology out in the community, they made it a big deal.

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Chapter 7

A: The Researcher

Laryngeal Preservation Studies

Story Codes

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

B: Multi-disciplinary Approaches

C: Discovery and Success

C: Professional Practice

C: The Professional at Work

Tacey Ann Rosolowski, PhD

1:07:59.5

Let me ask you a question. It may seem kind of obvious to you, but I'm trying to get a sense of what the perspective is that you bring as a person who has been trained in this particular field versus a general surgeon. When you see a cancer of the larynx or of the salivary glands, what is it that you see that a general surgeon would not see?

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Helmuth Goepfert, MD

1:08:27.4

Nowadays it is no different. No. The perspective is basically based on the basic training. Yes, laryngology is more sophisticated among otolaryngology. General surgeons don't do benign laser surgery. General surgeons didn't do repair of septum and plastic surgery in the head and neck area. Otolaryngology was doing it, and they do it now more than ever. So as I say, these things were new instances of a specialty or subspecialty contributing to the global aspect of it. Since then we have had only a few general surgeons that became members of this department. I think the last one was Stim Schantz. All the other ones have been otolaryngology from then on. In addition to that, this department then had the plastic surgeon, Dr. Larson, and the neurosurgeon. And even though before there was Dr. George Ehni, he was sort of a part-time member that came, a member of the Department of Head and Neck Surgery that is the beginner of neurosurgery at this institution was Milam Leavens, who died last year. Milam Leavens was a member of the Department of Head and Neck Surgery until Dr. Charles Balch created the department and brought in Ray Sawaya. Ray Sawaya has been here since the mid '80s too, so that's how it separated off. Now, ophthalmology has been a different story. Way back then there was an ophthalmologist that sort of as an outsider gave consultation. The first staff member as an ophthalmologist in the Department of Head and Neck Surgery was Dr. Sue Ellen Young. Dr. Sue Ellen Young, in the '90s, retired to Austin and took on a private practice. We then didn't have any member on the faculty, so to speak. We dealt mainly with Dr. Richard Ruiz as consultant from Hermann Hospital, and we eventually had Dr. Bitá Esmali. Dr. Bitá Esmali was hired here, and then the other ophthalmologists that exist now in otolaryngology and ophthalmology came back into head and neck surgery again. Will it ever be a separate department? God knows.

Tacey Ann Rosolowski, PhD

1:11:18.8

Let me ask you where you'd like to go next in the interview. I wanted to ask you about the variety of subjects that you've done research on over the course of your career, but we can also talk about your role as the head of the department. So which would make most sense to you right now?

Helmuth Goepfert, MD

1:11:39.5

I don't know. (laughs) Base your experience on that.

Tacey Ann Rosolowski, PhD

1:11:45.9

Well, maybe we can go—

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Helmuth Goepfert, MD

1:11:48.0

Research in itself, I never ran a lab. I did, yes, sort of the clinical description of situations and sort of looked up—in those days you still went to the Index Medicus to look up the literature, not like today. You then would go to medical records and identify the ones from one databank. Hopefully somebody had a listing of that disease entity, and you reviewed it. That's how most of my papers were produced in the early years. Then of course came the participation of radiation oncology, or radiation therapy, with Dr. Lindberg and Dr. Fletcher. We worked together again to review cases and doing reports on that, which was always a retrospective type of research. Prospective research in the sense of randomized trials and so forth, I participated very often. The only trial that I really was significantly involved in was the Laryngeal Preservation trial in '91-'11. It took ten years to accrue not enough patients but enough to satisfy the need.

Tacey Ann Rosolowski, PhD

1:13:11.0

Could you tell me about that? So that's the Laryngeal Preservation Protocol 91-11? You were co-investigator and surgical leader. So what was the aim of this study? You said it was a ten-year study, so how did it evolve and what did you discover?

Helmuth Goepfert, MD

1:13:30.0

Okay. Let's make a note here that this is going to be a full history of that protocol. The clinical interdisciplinary research in head and neck cancer was in those days predominantly in the hands of the RTOG—Radiation Therapy Oncology Group. It had specialties of head and neck surgery/otolaryngology, radiation oncology, and medical oncology among its members. In the early or mid '80s, Dr. Ki Hong and some other members who were affiliated—when Dr. Ki Hong [Waun Ki Hong, MD [Oral History Interview]] was in Boston—affiliated with the VA Hospital had published a landmark article in which they had randomized patients with larynx cancer to the then traditional treatment of laryngectomy, which was basically cut out the voice box, to a treatment that consisted of intravenous chemotherapy for several cycles followed by radiation therapy. The outcome of this study certainly showed the world that the survivorship was the same between the groups. Yes, there was a chance for the patients that went with the chemo/radiation to preserve the voice box—their normal voice—and that was significant enough, but one of the questions that remained unanswered is, was the chemotherapy, the way it was given, really significant in its contribution to the better survival of laryngeal preservation or was radiation therapy alone sufficient to achieve the same thing? That formed then the basis for this 91-11. It already had been proven that laryngectomy itself was not better, so you couldn't offer this as an alternative treatment because every patient said, "Why do you take my voice box out if there's something else?" It had to be defined which treatment was better, so there was an

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arm of chemotherapy pre-radiation and arm of chemotherapy together with radiation—concomitant—and an arm of radiation therapy alone. The formulation of that protocol and the different bodies that had to approve it is a different history because it always takes longer than you want to. But in the formulation of this protocol, one of the stumbling blocks was that the radiation oncologist recommended the standard radiotherapy be used—standard fractionation. For the time being, let's keep it that way—standard fractionation.

Tacey Ann Rosolowski, PhD

1:17:21.4

And that means a standard level of—?

Helmuth Goepfert, MD

1:17:24.5

Yeah, it was a certain amount of gray every day for five days a week. Nevertheless, the water had been muddied a little bit, so to speak, around that time, when a group of radiation oncologists proposed that hyperfractionation, or any other modification of standard fractionation, could be better. And although it had not been proven on a randomized basis yet, the hoof beats were loud enough so that the surgeons—and I exclude myself—but the surgeons in the community felt that by using standard fractionation we were not doing the patient a service and became reluctant to offer patients this protocol, so it took two years to launch it. It was opened in 1991. That is why it's called 91-11. No, wait a minute. In 1991, yeah. And I always joked that the accrual would be finished after my retirement. I made jokes about it because I felt it was ridiculous. The biggest contributor to that protocol was MD Anderson. We contributed ten percent to the total volume of patients. Out in the community it was not a beloved child. Now, the protocol was finished, and the publication was done back in 2002-2003. The last update of that was published last year. So, as I say, there is enough history of that now. That was a joint effort by RTOG and the subspecialties, and I think that they hoped that my presence in the steering committee would facilitate the accrual by patients in the community, but, as it always is, there is not enough esprit de corps among specialties in this country to make sure that something is finished before the next thing starts. That is very prevalent. It's one of the difficulties that society has, in my opinion. We don't use the appropriate tools to identify what works best, and this is in the economy of medicine and everything else. It's more the voice of the one that has the strongest opinion that prevails. And I hate to tell you, that's what's going on in politics too. (laughs) So, as I say, that is the story of 91-11.

Tacey Ann Rosolowski, PhD

1:21:02.3

I think I'm confused or I missed the point.

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Helmuth Goepfert, MD

1:21:07.0

It proved that it was better to add chemotherapy than give radiation therapy alone, and of the two, the concomitant treatment of radiation together with chemotherapy gave the best results as far as the ability to preserve a normal larynx.

Tacey Ann Rosolowski, PhD

1:21:27.7

Okay. Now, did you end up deciding to go with the hyperfractionation or did you keep it at the standard level?

Helmuth Goepfert, MD

1:21:35.6

No, we kept it standard because the radiation oncologists—

Tacey Ann Rosolowski, PhD

1:21:38.3

They were very uncomfortable.

Helmuth Goepfert, MD

1:21:40.0

They were uncomfortable because they said it still has not been—we haven't finished our studies to determine which is best.

Tacey Ann Rosolowski, PhD

1:21:48.0

Now, where did you weigh in on that? You said you didn't include yourself in—

Helmuth Goepfert, MD

1:21:53.8

The radiation oncology—I did not decide on that because I said, “You radiation oncologists tell us what you think is necessary.”

Tacey Ann Rosolowski, PhD

1:22:02.9

So you didn't feel that you could really form an opinion about it. Okay. So the survivorship rates, how did they—?

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Helmuth Goepfert, MD

1:21:11.8

The survivorship was about the same, a little bit—

Tacey Ann Rosolowski, PhD

1:21:14.8

Right. But in terms of the preservation, I guess.

Helmuth Goepfert, MD

1:22:16.7

The preservation of the larynx, definitely the group that had concomitant treatment was better. And that has been the basis for many of the existing protocols in which concomitant treatment is used nowadays.

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Chapter 8

A: Overview

Financing Clinical Research

Story Codes

B: The Business of MD Anderson

D: Business of Research

D: Fiscal Realities in Healthcare

A: Character, Values, Beliefs, Talents

Tacey Ann Rosolowski, PhD

1:22:30.0

So that particular study has kind of been one that people look to as a model.

Helmuth Goepfert, MD

1:22:35.4

Yeah, looked for as a model, but it has been— Clinical research in general has been very difficult in this country, and it has to do predominantly because physicians don't like to lose control of their patients. The otolaryngologists particularly feel quite strongly that they don't want to give up the management of a patient when there is something that they would gain—and it has to be said—financially if they take care of the patient. That's the reality out in the community, and it is the reality in modern financing of departments within the United States of America. Academic medicine—clinical departments are hurting, and they're hurting because they have to compete with the physician outside and at the same time do other things.

Tacey Ann Rosolowski, PhD

1:23:38.1

Does that influence that lack of esprit de corps you were referring to?

Helmuth Goepfert, MD

1:23:42.4

Yeah.

Tacey Ann Rosolowski, PhD

1:23:44.2

Do you see a way out of that? What observations would you have to start chipping away at that problem?

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Helmuth Goepfert, MD

1:23:55.0

I would say that one of the tragic events in the United States is that we do not have a social network—or social net—to capture the people who need it. I mean, I have my Medicare, and I have a supplement of Blue Cross Blue Shield. Basically I'm pretty well off. But there are fifty million people out there that don't have it. Now, everybody screams bloody murder when the word socialized medicine comes about, but socialized medicine, in addition to other social-oriented safety nets, is what is available in Canada, and yes we in the United States tend to poo-poo it as a bad system. It was created in England when they came out of the ruins of World War II and had nothing available. It evolved in Germany as a result of the post-World War II era. It is prevalent in France. It may or may not be very good, but it allows us to treat everybody. It is available in many parts of the world. Now, is it the best system? There is something to be said if countries like Denmark, Norway, Sweden, even Germany and England are relatively happy with their system. And, dammit, we claim to be—and I include myself because I'm an immigrant but I'm a naturalized citizen—we think we have the best system in the world, but it isn't. That is sort of very, very sad. As I say, it is sad because it shouldn't be that way. It should not be that way, and it is going to get worse. God almighty, already seventeen percent of our gross national product is healthcare. Where is that going? Soon we're going to be twenty-five percent. God almighty, I hope I'm dead before then. But it's going that way, and we're not doing anything to improve it. Yes, we think we have the best healthcare. Here at MD Anderson for cancer, at least we hope, but out in the community—now that I work for PN—Physician Network—I get to see a little bit more how people are treated out there—it is not often a happy story.

Tacey Ann Rosolowski, PhD

1:27:11.0

What do you think that—? If the nation were to go more in the direction of a “socialized medicine system” as the Scandinavian countries have or Canada or France, how do you think that would affect academic medicine and the ease of doing studies of the kind that would really advance cancer care?

Helmuth Goepfert, MD

1:27:33.5

It is already affecting it. It is already affecting it because all the cutbacks that have occurred have significantly impaired the ability of departments to cost shift anything for the purpose of doing something else. Right now, physicians who opt to go into academics have to basically compete for the patients out there against the private practitioners that have to make a living, but the private practitioners, especially if they are shrewd enough in business, don't have to deal with education of somebody and certainly don't have to deal with the issue of research, which are two added things. Now, research, there used to be some funding available. It's becoming less and less

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and less, and education is something that is hard to come by if you obey all the new rules that are being implemented as far as the eighty-hour week, the fact that the faculty member has to be always present to sign off on a patient. It's very hard to teach these kids some responsibility in a sense of being able to handle something with the proper background on what they have received. It is difficult. I know that because my youngest son is now a resident in otolaryngology at UCSF, and he has daily this problem that he is on call and the next day at noon he has to leave. If he is on a big case, learning something, he has to leave. He is out—absolutely out. They have to keep track of it very carefully; otherwise the department gets slapped on the hand. I observe, for example—another example along with this—as you know, I was the second editor of *Head and Neck*. When I look at the articles that are published nowadays in *Head and Neck*, the minority, by far, come from the United States. The majority come from other countries with a large influx from Asian countries, particularly China, Taiwan, some from Japan, and some of the more interesting research is done in departments in these countries. You see more articles coming out of Europe as well. But really interesting and groundbreaking sort of ground-shaking research coming out of the United States departments is less and less and less because they have to fight for their living first. Publications are last. So as I say, how that can be corrected is hard to tell, but it sure is hurting all over the place. And it's not getting any better.

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Chapter 9

B: Building the Institution

Supporting Physician-Scientists

Story Codes

D: On Research and Researchers

D: The Life and Dedication of Clinicians and Researchers

C: Patients

C: Cancer and Disease

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

Tacey Ann Rosolowski, PhD

1:31:09.0

When I spoke with Margaret Kripke [Oral History Interview] she was saying that the one thing she regretted after she left service as Executive Vice President of Academic Affairs was that she had not been able to make more headway in solving problems and supporting the career path of a physician-scientist, because there's probably no individual who is under more pressure, with the clinical demands plus the research demands.

Helmuth Goepfert, MD

1:31:39.9

And MD Anderson had the funds to do that. MD Anderson has enough endowment to do that.

Tacey Ann Rosolowski, PhD

1:31:46.6

What would it take? Aside from the question of why it hadn't been done, what would be needed?

Helmuth Goepfert, MD

1:31:53.3

The difficulty is that you have to see— For one, it is necessary to have a certain passion for it. That's fundamental. People have to have a passion for pursuing that. Protected time is a myth. You just work on top of the time that you do something else, and most of the physician-scientists have done it that way. The training is crucial, and when do you begin it? If you start too early in the career, like, for example, going through an MD/PhD in medical school. By the time you have finished your residency or want to start research of the residency, you have to retool because it's at least 8 years.

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Tacey Ann Rosolowski, PhD

1:32:48.6

Things change so fast.

Helmuth Goepfert, MD

1:32:49.7

They change so fast. Technology changes so fast. So when do you start this? Now at MD Anderson, we in Head and Neck Surgery have played around with this idea and established basically that a fellow that wanted to do advanced training should spend a year or two in the lab before they did their advanced training so that it doesn't become too late and so that they don't lose what they have learned clinically to apply. So that was the principle we established. Yes, it is easier, though not totally easy, to do this in an organization where we don't keep control of our monies but where there is money to support the time that these people need to be in the lab or need to work on their masters or work on their PhD or whatever they want to pursue in doing so, and you have to have a team of scientists—basic scientists—that believe in this principle. There is where Garth Nicolson came, and certainly the one that has done the most for this has been Josh Fidler [Isaiah Joshua Filder, DVM, PhD [Oral History Interview]] over and over again. So these are issues that MD Anderson, to some extent, has funded and supported. They even have a vice president for that. I forget his name. He used to be the chief of medicine. He is the one that is in charge of translational research. How efficient is it, and have these people been able to get grants? Some of them did. Some of them really did very well. Clayman did very well until he decided to step down from there and devote himself exclusively now to head and neck surgery. He is their national expert in advanced thyroid cancer. The one that still does it very efficiently is Jeffrey Myers. So these are people that really had the passion for it, had the dedication, and went to do it. There are others in other departments. The one that in this institution is to be credited with being the leader in this is J Freireich [Oral History Interview]. J Freireich really was the one that recognized this as a fundamental way to improve the care of leukemia and lymphoma. He really is the one that has put physician-scientists on the map in oncology. Others in history have been important outside of the institution, but within the institution is certainly was J Freireich.

Tacey Ann Rosolowski, PhD

1:35:46.8

Well, while we're on the subject, could you tell me about the system that you set up in Head and Neck to support the physician-scientist? Talk about that in more detail. When did that initiative begin?

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Helmuth Goepfert, MD

1:36:04.4

It was somewhere in the mid '80s, and it actually came about around the time that the head of surgery, Dr. Charlie Balch, wanted to do an outside review of the department. Now it needs to be said that he basically wanted to do this to oust me. That didn't work, but in doing so the committee that came recommended that the department in this hospital would deserve to have a basic scientist on its faculty in order to create translational research. Now, I had been playing around with that idea already with Garth Nicolson, but this gave it the impetus. Now, the funny thing is that I basically went out and got the most visible candidate out there, brought him in, asked him what could be done, said, "What would you require to do this? Give me your list." I agreed with the list. When I moved forward in the institution they said, "No, we're not going to do that." So that was the beginning.

Tacey Ann Rosolowski, PhD

1:37:43.9

Who was the candidate you approached?

Helmuth Goepfert, MD

1:37:46.5

Thomas Carey.

Tacey Ann Rosolowski, PhD

1:37:51.7

And what was on his list that you agreed with?

Helmuth Goepfert, MD

1:37:54.6

Oh, all that was necessary for the lab that he would run. Basically a basic science lab was a necessary space and so forth.

Tacey Ann Rosolowski, PhD

1:38:04.1

What was—?

Helmuth Goepfert, MD

1:38:04.5

The details escape me, but he was already a well-known entity in Michigan.

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Tacey Ann Rosolowski, PhD

1:38:10.5

And what was his area of research at the time?

Helmuth Goepfert, MD

1:38:16.8

You know, I forgot what it was. Later, when we reinitiated this, the natural killer cells were there. Dr. Jack Roth's wife in basic science—her name was [Dr.] Elizabeth [Grimm] something—she was the one that ran that, and it developed in that direction. But he basically—I don't know—because what we started with Garth Nicolson was metastasis—was dealing with the study of metastasis. It became much more focused and much more diverse in its approach under Dr. Josh Fidler. He and his seed and soil theories and his macrophages and all of that played a role in that. So it was along those lines that it was done then. Yes, we dealt for a while with perineural invasion, which is one way of head and neck cancer to progress, and we had a program there. We even had a researcher that was with us for quite a while here and worked on it, but it was not that formalized, and it was always a difficulty.

Tacey Ann Rosolowski, PhD

1:39:44.4

So did the institution ever get behind Head and Neck establishing this?

Helmuth Goepfert, MD

1:39:49.4

Yes, but on chips here and there. I've never been very good at asking for money from potential donors out there. I've never been very good at that. Besides, head and neck patients—by and large, it's not the upper class. Prostate and breast cancer are much more upper class people that have money left, but head and neck is becoming more now where the human papilloma virus is bringing some of the young executives in with cancer of the tonsil. Yeah. The HPV has changed the demographics of head and neck cancer.

Tacey Ann Rosolowski, PhD

1:40:28.4

I had no idea that there was a class differentiation with head and neck cancers.

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Helmuth Goepfert, MD

1:40:32.7

Head and neck cancers were usually the drunks and the smokers—the majority of them. Yes, when thyroid came about it was shifted more in that direction, but the history of modern head and neck cancer in the sense of cancer of the upper digestive tract is right now basically focused on the advent of the HPV virus infection and HPV virus cause of certain cancers of the head and neck. That has changed in the last 10 years. But, yes, I repeatedly went to John Mendelsohn and said couldn't we establish—I mean—we wrote up a proposal for—and the other thing to be mentioned is that when I retired—and that was my first retirement in nineteen—what was it?

Tacey Ann Rosolowski, PhD

1:41:36.0

In 2003?

Helmuth Goepfert, MD

1:41:37.0

In 2002, my first retirement, because I said I'm going to retire and they did the party and they created the Helmuth Goepfert Society. The proceeds of that society were for the purpose of training physician-scientists. It was started, but then history changed. They had not elected a chair member when 2002 came around, and they asked me to stay on for a year. This year produced—at the end Dr. Weber was elected chairman, and all the efforts that had been put into gathering the funds for the Helmuth Goepfert Society of Head and Neck went by the wayside. Now the funds that exist there basically support a lectureship a year, which is considerably less than what I intended to do, and I must admit that Dr. Mendelsohn was never up front with me on this issue, because I went to him several times including a couple years later. I said, "Listen, you can change the name, but I think that the Head and Neck Department deserves to have an independent major endowment for the training of physician-scientists." He said, "Yes, I will do it if you agree to talk to Dr. Hong and to Dr.—then it was Lester Peters? No. It was after Lester Peters. It was Kian Ang. Everybody agreed, yes, let's do it. So I sent them the result of my recommendation and all of them said yes, but he said, "Okay, we'll do it," and never did it. So as a result of what—that's one of the things done that I feel sorry that it never happened. But I've still been able to get, here and there, some support from the institution in order to get somebody through on the career for physician-scientist.

Tacey Ann Rosolowski, PhD

1:44:05.5

It seems like a very thorny problem.

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Helmuth Goepfert, MD

1:44:08.1

Oh yeah. It is a thorny problem, but it's life. Now, the other thing that—and we have tomorrow still to discuss the issue of the electronic publishing in the institution, because that's something else that I want to address is the publications and the electronic publishing.

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Chapter 10

A: The Researcher

A Summary of Research

Story Codes

A: Contributions

A: Career and Accomplishments

A: The Researcher

A: The Clinician

A: Overview

A: Definitions, Explanations, Translations

Tacey Ann Rosolowski, PhD

1:44:27.9

We have about ten minutes left. Would you like to just return briefly to the issue of research? I know that you've had a number of other types of grants that talk about adjuvant therapy and also preventative therapy. Is there one of those you'd like to address?

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Helmuth Goepfert, MD

1:44:49.1

I was not principal investigator on any of those, but I basically participated in development of those grants and had irresponsibility on a certain facet. For example, let's take the chemo prevention protocol of Dr. Hong. That was in the time of the vitamin A derivatives used for "chemo prevention of head and neck cancer." Yes, it was a randomized study that was done nationwide. My intervention basically was to define, when patients got a new cancer or recurrent cancer, was this patient a recurrence or was it a second primary? So I was the chair of the committee to determine the nature of the treatment failure. That was my intervention. Interestingly enough, that study was randomized, and the patients either got the vitamin carotene derivative or not the carotene derivative. The interesting thing, after the study was closed, nobody knew which arm had received what. People were sort of it's funny to know what happened. What is it? We need to know who got what. I said, "You don't need to know who got what because, both arms, the results are exactly the same. So no matter what the intervention arm it is—" Everybody said, "Oh, you are right." (laughs) So before they sort of broke the code, you already could tell what had happened. Both had the same amount of recurrences, and both had the same amount of second primary, so that sort of put a lid on all of that chemo prevention stuff that Ki Hong had done with the vitamin A. Of course, there have been other chemo prevention studies, but this was the big thing because his pilot study that he had done prior to coming to MD Anderson was in Boston and had, according to him, shown that the use of beta carotenes or whatever carotene it was reduced the incidence of second primaries. Now, when you went to a national study that was sponsored by RTOG and of these organizations and had very rigorous parameters in it, including what I said—a rigorous committee that would determine is this a second primary or was it a recurrence—it didn't show to be of any benefit. So that was a big flop for him, but to his credit it was published. Then you have another one that you mentioned?

Tacey Ann Rosolowski, PhD

1:47:57.6

Yeah, there was one on the adjuvant therapy—the randomized adjuvant therapy of head and neck cancer. That was from '98-2002. You were using biomarkers for patients with stage III and IV head and neck cancer.

Helmuth Goepfert, MD

1:48:12.8

That was run by medical oncologists, and I was at the tail of it. I basically was the one that assigned patients to go into the study, but it was run by medical oncologists.

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Tacey Ann Rosolowski, PhD

1:48:24.7

What are some of the most significant studies that you feel you've done? You have lots and lots of publications, and it's hard for me to kind of pick out—

Helmuth Goepfert, MD

1:48:32.1

The research, I basically made sure it got done, but I, myself, spent little time in developing protocols. I was basically a clinician. I looked for the clinical part of it and for the vocational part of it, but research itself, more than anything, during the late '80s and '90s, became more complicated. I worked by the principle that if you're not doing it all the time, don't do it.

Tacey Ann Rosolowski, PhD

1:49:03.8

And the complications that arose, were these the guidelines about use of human subjects? Or I should ask you what the complications in doing studies at that time were.

Helmuth Goepfert, MD

1:49:14.7

No, the complexities, not complications—the complexities of research, not the complications. The complexities of doing research increased. They are more stringent and rigid now. In those days, it really didn't matter because we didn't know, but it became more stringent how research had to be done. But, no, it has nothing to do with complications.

Tacey Ann Rosolowski, PhD

1:49:43.5

So were there any other studies about preservation of functionality?

Helmuth Goepfert, MD

1:49:52.2

Yeah, but the preservation of functionality—when I came to this department there was no expertise in what's called conservation laryngeal surgery, in which you do take out the cancer and keep the voice box. My contribution was to combine the best of both worlds—take care of the big cancer by doing a partial laryngeal surgery followed by radiation therapy. Now, this demanded a very stringent protocol. It was not randomized, but it proved it could be done and it was very effective. The series that we developed was significant. Of course, nobody believed that it had no complications, and we had somebody else review it. It was interesting. We had some failures in a sense of people not being able to get rid of their tracheostomy tube. We had some failures in a sense of people not being able to swallow because the voice—the larynx is a

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complex organ. It has to do with speech, it has to do with deglutition, so both of them you have to preserve. Basically that is the issue of that protocol, and we are able to preserve the normal voice in many patients, but the protocol did not survive very long because parallel to it evolved the improvement of concomitant radiation and chemotherapy, so that other one went by the wayside. Now, the other part that needs to be said is that a traditional open laryngeal surgery, in the sense that you cut through the neck to do it, has disappeared. More and more now it's done through the endoscopic approach—going through the mouth with a scope and with the laser and so forth. These tools cut out the cancer. Now, there is a place for that still, but other treatments have made it less important. Yeah, there may be a renaissance now with this so-called robot surgery. The robot surgery, the one that is involved in that here, Dr. [Floyd C.] Holsinger, is trying to prove that this is a way to proceed with the treatment of primary tumors in those areas, so the advances certainly have been parallel on different disciplines so that some of these treatments that we created and were successful in those days became obsolete.

Tacey Ann Rosolowski, PhD

1:52:52.1

Why would the robotic surgery create a renaissance?

Helmuth Goepfert, MD

1:52:58.4

Because it has less morbidity, it can work around corners, and the fine tuning of the robot is that you basically can do a magnification of something without having to rig your fingers in there. It is an interesting surgery, but the learning curve is very steep, so you have to leave it for people who do it all the time. That's why I'm glad that Dr. Weber decided to assign one surgeon to do it and established the principles of credentialing and re-credentialing so that it would not impair safety. So it's now done pretty safely by a group of surgeons here, but even Dr. Weber, who has become certified, he says, "I'm not doing it because it has to be done all the time." Now he's certified, yes, but you immediately, after you haven't done it for several months, you lose your certification. You have to be honest about that.

Tacey Ann Rosolowski, PhD

1:54:02.5

Wow. That's amazing. So I gather that the instruments that are used in the robotic surgery must be very tiny and very flexible. So it's kind of like a complement to endoscopic, but—

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Helmuth Goepfert, MD

1:54:15.7

It is endoscopic. It is through the mouth. It is endoscopic, but the availability of special optics, special illumination, allows you to almost work around the corner. With the rigid scope you couldn't, so it is quite an accomplishment what can be done with it, but again you have to select the patient properly, and you have to have a surgeon who is well-trained and able to manage it.

Tacey Ann Rosolowski, PhD

1:54:43.3

What kinds of patients would be candidates for that kind of surgery?

Helmuth Goepfert, MD

1:54:46.6

Certainly larynx cancer patients, tonsil cancer patients, base-of-tongue cancer patients, limited patients of the pharyngeal wall cancer—those are the principal patients for that. I mean, the ones that have made the biggest headway with robotic surgeons are the urologists, with the prostatectomy. Other surgeons are attempting to use that tool for the purpose of doing certain things in the abdomen and so forth.

Tacey Ann Rosolowski, PhD

1:55:21.3

Well, we're almost at 4:00. Would you like to stop for today and then we'll resume tomorrow?

Helmuth Goepfert, MD

1:55:26.8

Let's resume tomorrow.

Tacey Ann Rosolowski, PhD

1:55:27.9

All right. Thank you very much.

Helmuth Goepfert, MD

1:55:29.4

I appreciate you doing this. Thank you, Tacey.

Tacey Ann Rosolowski, PhD

1:55:32.3

Sure. Thank you.

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Helmuth Goepfert, MD

1:55:33.2

So tomorrow we look at the issue of education to see what else you find in the summary that can be related to what I do or not do.

Tacey Ann Rosolowski, PhD

1:55:41.8

Sure. Let me just say it's about 4:02. I'm turning off the unit.

1:55:45.7 (End of Audio 1)

Helmuth Goepfert. MD

Interview Session Two: August 28, 2012

Chapter 00B

Interview Identifier

Tacey Ann Rosolowski, PhD

0:00:02.7 I'm Tacey A. Rosolowski. Today is August 28. The time is 1:58, and I am sitting down with Helmuth Goepfert, MD for our second interview session together. Dr. Goepfert, I mentioned before we began that I was hoping that you could take me through a particularly interesting or challenging case that you recall from your career so that I, and also the listener, can have a clear idea of what you do as a clinician who is intervening in head and neck cancers.

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Chapter 11

A: Overview

“Patient Reactions to News of Speech Loss”

Story Codes

A: The Clinician

C: Patients

C: Cancer and Disease

C: Professional Practice

C: The Professional at Work

A: Critical Perspectives

C: Offering Care, Compassion, Help

C: Controversies

Tacey Ann Rosolowski, PhD

0:00:02.7+

Dr. Goepfert, I mentioned before we began that I was hoping that you could take me through a particularly interesting or challenging case that you recall from your career so that I, and also the listener, can have a clear idea of what you do as a clinician who is intervening in head and neck cancers.

Helmuth Goepfert, MD

0:00:40.9

One of the important issues in head and neck cancer is the preservation of an organ and, at the same time, the function of such an organ. If I take you out of the area of head and neck itself, you have a similar situation, more emotional than physical, with cancer of the breast. The woman that loses a breast, it is a very severe and emotional and heart-breaking situation that is hard to carry. Even though there are means to reconstruct, it usually falls somewhat short of the ideal. Now, similar situations exist in all areas of the body. If a person has a cancer of the rectum, they would like, after the operation, to be able to function as normal and not to have a colostomy. So in the head and neck area you have cancers that affect the mouth, especially the tongue nowadays, cancers that affect the throat, and cancers that affect the larynx. In this circumstance, at each one of these sites, two functions predominantly are going to be affected. One is the ability to speak, and one is the ability to eat. Now, yes, don't forget breathing, but the breathing, to some extent—if you want to say—has to take place regardless of what treatment you use. Over the years, the organ that is more dramatically influenced by our treatment—if you want to use that terminology; although it's probably not correct—is the larynx—the voice box. For many, many, many years, there has always been a need to find better means to treat laryngeal cancer,

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preserving the larynx itself and its function. There is no use to preserve a larynx if it isn't going to fulfill the functions of speech and deglutition and breathing.

So when you meet with a patient with a laryngeal cancer, the stage of the tumor will dictate what are the treatment modalities available to preserve the larynx. The more advanced the disease, the less is the availability of treatments that will allow us to preserve a functioning larynx, so if you have a patient with an early-stage cancer, it is very well established nowadays that either by radiation therapy or by surgery—and this is usually endoscopic surgery, nowadays, produced through an endoscope, and then with a laser beam you can resect the tumor or you can radiate the tumor with a high possibility of eliminating the cancer. If the tumor is more advanced, yes, there are surgical procedures nowadays predominantly going through the mouth with different scopes and different techniques—I mentioned yesterday the use of the robot for something like this—where you can basically, from the inside, core out this cancer and leave the essence of the larynx there, and if there are certain structures of the larynx that are preserved, the patient will function relatively well, though they may have a change in their voice. They may not be able to sing the way they used to before, and certain things they give up for preserving the larynx. It becomes really critical when a cancer is of such magnitude that, number one, it already interferes with breathing, so the patient may have to have an emergency tracheostomy—hole in the windpipe in order to breathe—and comes to you now with this relatively advanced cancer where the existing treatment modalities—be it surgery, be it radiation therapy with or without chemotherapy—fall short of what the patient's desires are and what you wish could be accomplished. You are then faced with explaining to the patient that the only solution is to let us take out the voice box. Yes, we suture up the pharynx, which is the gullet, and you can swallow immediately. Yes, we leave the trachea windpipe out here, out on the skin, so you can breathe, but forget about immediate speech. Yes, speech can be rehabilitated, but it takes a significant effort, and the speech that comes out by any means has a certain mechanic, monotone pitch to it. You cannot change the pitch very well.

Then there are other things that are sort of forgotten in this but to some degree are important to the patient because one of them is, for example, the sense of smell. How do we smell? Yes, we smell with the back of the nose basically, but we can do that only if we can bring air through. Now, if you're not breathing through, you won't be able to smell unless you do certain maneuvers with your throat that you bring air up and bring air in. But patients complain of the lack of smell. If you lose the voice box, yes, you do as much as possible to explain that the voice can be rehabilitated by some means, and these are better than they used to be, but still, to the patient, this is a very severe blow. It's probably one of the most severe blows in this. To explain it to the patient, it does not usually sink in the first time, and even if there is a relative there—usually the next of kin or the significant other or a son or a daughter or somebody that will be present—the emotional impact of this is on all of them. You have to be cognizant of that because

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it takes quite a bit of convincing, and, yes, patients at that time, at that moment, very often become somewhat obstinate and often leave unhappy about what you have told them and may end up in the wrong hands because they go out shopping for treatment.

Tacey Ann Rosolowski, PhD

0:09:04.2

So, in other words, they're looking for somebody that will give them an alternative?

Helmuth Goepfert, MD

0:09:08.6

Yeah, and that can happen. Now, other times the patients are totally negative to whatever you want to offer them because it does not fit their lifestyle.

Tacey Ann Rosolowski, PhD

0:09:28.4

What do you mean?

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Helmuth Goepfert, MD

0:09:31.0

Okay. I'll give you a typical example, and I'm going to leave the names out. It is an important issue. There was a very prominent member of society who happened to be a Count or something like that from Italy. He was married to a very wealthy Houstonian woman. He was a significant party man, drinker, smoker, in his late '50s or early '60s who developed a cancer of what's called the pharyngeal wall, and, yes, the radical treatment for this would have been to do laryngopharyngectomy—take out the larynx—because you have to take out the voice box, otherwise it doesn't function. But of course he wanted to have none of this. He liked to control his environment and people that "served" him. So for his initial appointment, which came through—and you know how things are here at the institution; all the way down from the president down, somebody comes to greet the patient—the appointment was given for 9 o'clock in the morning, and the patient didn't show up until noon. So I dealt with a patient that would not look me in the eye when I was talking, a wife that was a little bit of a princess, much younger than him—well, not much younger, but at least she was a little bit of a princess—that sort of tried to talk for him. He would not look me in the eye. He was sullen, he was sort of introverted in his thinking ability and totally negative. So I said, "We need to get a few things done before we can decide what's the best treatment for you." There will be a few x-rays and tests and this and that that has to be done so that we can meet together tomorrow or the day after tomorrow in order to discuss what the treatment options are. But I knew already that this man was not going to show up. I knew already that for some reason we did not connect, and you immediately get that feeling as a physician that I'm not connecting with this patient. Now, for him to be late because he doesn't get up before noontime, and for him not to participate at all in the discussion, was for me a significant hurdle, so I set out to take the bull by the horns. I may lose a patient, but I'm going to tell the wife when she comes what I think the problem is. The woman, of course, came. He didn't come. I said, "We have a very difficult problem here, because your husband needs a treatment. We basically know what it will entail. We have decided that he probably would do okay with radiation therapy." He had been seen by the radiation oncologist. Everybody had seen the patient. I said, "But he has not shown up here for the discussion. In my opinion—and I'm telling you this because of my experience—your husband, for the first time in his life, is facing a situation that he cannot buy himself out of." That was a bomb. She flew off the chair, ran up to the tenth floor, complained bitterly to the president about what I had said. I stood by it. I said, "Somebody else can take care of the patient, but this has to be established." Yes, somebody else took care of the patient. Eventually the patient died of the disease. I mean, there were all sorts of things that went wrong with this because of his heavy involvement with [Michael E.] DeBakey. DeBakey had sent the patient here, but DeBakey was going to be in the surgery. They finally consented to have one of my staff members do the surgery over at Methodist. The Chairman of Head and Neck Surgery at Methodist was the assistant in the operation, and DeBakey was hovering over both of them. I wouldn't have tolerated that for a

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minute. I would say my personality would not have gone along with that, but that is the type of thing that you can find in these situations where patients do not want to abide by reality. Many variations thereof can occur, but I would say that is sort of the most classic one of somebody who totally rejected this. I then had to make a statement that was my own interpretation of things, and obviously it must have been that way because it caused a tremendous upheaval. So, as I say, those are the things that you can face when you deal with these patients. The fact of the matter is that life is a little complicated, and cancer complicates life even more in the sense of what functions are altered. For the human being, we have a voice that no other animal has on earth, and we have a sense of community that involves speech. We have, on the other side, a behavior that allows us to interact in one form or another, and it is always wise—that's why we have the patient advocates here, because, yes, most of what they do is move patients around so they get all the parts where they need to go, but the patient advocacy is a good guide for the blind. Patients get hit with the reality of major magnitude. Like if it is likely that you're going to lose your voice box, this poorly blocks anything else that you will tell them, so they need a wayfinder and a guide. That's where the patient advocates are very good. In that sense, they are almost like navigators for these patients. So that's the positive part of patient advocacy. Some of the other stuff, over the years, has become sort of murky. It is probably very different right now from what it used to be, but there is a need for these other people in the team that help the patient to go through decision making, when it comes to a very radical assault on their physical person.

Tacey Ann Rosolowski, PhD

0:17:35.0

Let me ask you—I mean—the example you gave of this particular man was so extremely negative, and I can't imagine—I mean—obviously the news would be just devastating, but what is a more positive, if no less difficult, process by which a person gets such news and then works through it in order to have some kind of rehabilitative outcome?

Helmuth Goepfert, MD

0:18:03.8

You can sometimes find a good answer by just walking in and asking, "What do you want to know?" Particularly nowadays, where people have the access of second opinion by Google, they bring you a stack of material, and you have to have time in order to go through it. You have to identify what is the positive side of what they have read here, and what is their perception of what has been printed on the Xerox machine or however it comes? An approach to try to make it positive for them is to have them voice their impression of what is to happen, and through that process get them to easily find out, oh, this is how it has to happen. Rather than being a little bit paternalistic, walking in I say, "You need to have your voice box out." That's the way it was. We

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had Dr. Ballantyne, who I mentioned before; he would sometimes just walk in and say, “Listen, the only solution for you is you have to have the voice box out. I have time next Monday to do it.” (laughs) So that is sort of the extreme, which today is totally unacceptable. But that is sort of what goes in. I forgot to mention something else here. When you talk about bad news, it is often interesting to see how patients are going to react to that. I refer here specifically to a patient that was a very prominent banker in Dallas. The gentleman had been treated by the available treatment then for a cancer of his back part of the tongue, which is called the base of tongue. You have the oral tongue, which is the part you see in the mouth, and you have the one behind—the base of tongue. This cancer had recurred. That happens. So the gentleman was sitting there in the chair. I explained to him, “Listen, the only solution there is for you is an operation where we need to take out the tongue, and because you won’t be able to swallow, we have to take out the voice box too.” Now this man was in his early ‘60s. I said, “You may not like that because your livelihood is communication and you communicate as a banker. You communicate with people.” So he said, “I think there’s another way out.” I said, “Okay. Do you need help with that?” “No,” he says, “I know what I’m going to do.” It was less than two months later that he had killed himself. That rarely happens, but it does happen. He basically shot himself.

Now, you can say anything you want to about people committing suicide and being cowards and doing this and that, but that is the way that somebody solved his problem. When it became sort of difficult to swallow and he couldn’t communicate well and he had this big lump in the back of his throat, he took his gun and took his life. I knew that he was going to do it, and yes, somebody may have criticized me for not having advice that he was going to do it. I sort of read in him that he didn’t want to have any help with this. He was not a depressed patient, and the alternative for it was not really good. The alternative for him to live out his life and die of his cancer, that was miserable. I did not have any problem with that, but I can see many people that would have raised a flag and said, “This patient is going to commit suicide. Do something about it. Send him to a psychiatrist.” In my opinion, there is a time when you have to sort of go by the principles of self-determination. So, now, you want to talk about these two men there?

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Chapter 12

B: MD Anderson Past

A Brief History of the Section of Head and Neck Surgery

Story Codes

B: MD Anderson History

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

C: Portraits

C: Controversies

Tacey Ann Rosolowski, PhD

0:23:21.9

Yeah. Let's shift gears. Before we talk about your role as head of the Department of Head and Neck Surgery, I did want to get a little bit of a sense of the history and the two gentlemen that preceded you.

Helmuth Goepfert, MD

0:23:36.6

The program in the head and neck section basically officially started when Dr. McComb, back in 1952 or thereabouts—I think it was '52—was hired by Dr. Clark. Now, mind you, from what you know already from the history of MD Anderson, you know how limited it was in those days. They operated in one place, patients were hospitalized somewhere else. So I'm not going to go into that. But Dr. Clark [R. Lee Clark, MD], before that—as he was a general surgeon—he would operate thyroids. That was his favorite disease to treat, and he published extensively in that. There are some landmark articles that still exist, that still are quoted, from Dr. Lee Clark. Of course, McComb came, and McComb was a product of Memorial Hospital in New York.

Tacey Ann Rosolowski, PhD

0:24:42.7

Do you know why Dr. Clark selected him?

Helmuth Goepfert, MD

0:24:46.4

That's a good question. McComb basically was one of the favorite students of Dr. Hayes Martin, who was the chairman of Head and Neck Surgery at Memorial, a very unique person that sort of has endured through generations his name. Now nobody knows him anymore, but he was really

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an icon. He set forth some principles of head and neck surgery that McComb espoused and brought with him.

Tacey Ann Rosolowski, PhD

0:25:29.8

What were those principles?

Helmuth Goepfert, MD

0:25:31.8

Radical surgery in the sense that you could not enter a larynx if you were not going to do a total laryngectomy. So any cancer that was not amenable to radiation therapy, the only option surgically was a total laryngectomy, which in those days is what existed. They were very much, for example, against modified or less than radical neck dissections. The neck dissection itself evolved over the years as part of the treatment of head and neck cancer.

Tacey Ann Rosolowski, PhD

0:26:08.8

I guess I'm not sure what you mean by neck dissection. Could you define it?

Helmuth Goepfert, MD

0:26:12.8

Yeah, neck dissection is the surgical procedure utilized to remove cancer in the lymph nodes of the neck and adjacent structures that may be involved.

Tacey Ann Rosolowski, PhD

0:26:24.3

Kind of like when they would remove the—(speaking at same time)

Helmuth Goepfert, MD

0:26:26.4

The axilla—the lymph nodes in the axilla that they remove from the axilla itself all the way up to the level of the clavicle. Here the radical operation was basically to remove lymph nodes all the way from here down to the clavicle.

Tacey Ann Rosolowski, PhD

0:26:43.4

So the level of the ear down to the clavicle.

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Helmuth Goepfert, MD

0:26:45.9

Yeah, and, yes, there was no departure from that principle.

Tacey Ann Rosolowski, PhD

0:26:51.4

That's pretty devastating for the patient.

Helmuth Goepfert, MD

0:26:53.1

But, yes, primarily because you lose the function of one of the important nerves, which is the spinal accessory nerve. The spinal accessory nerve, which goes through the latter part of the neck and what's called the posterior triangle—and radical neck dissection is just eliminated. That function sort of drops the shoulder. They have shoulder drop. They cannot comb their hair anymore. You cannot raise your arm, and it becomes a very painful shoulder and a very painful neck. So he had that principle. He was a strong proponent of radical surgery, yes, but radical surgery in those days was limited by the fact that you did not have any good surgical reconstruction. So the surgical reconstruction in those days was relatively limited, I would say. There were a few techniques that were utilized, but most of patients that had a very radical operation and required reconstruction stayed a long time in the hospital. Hospitalization for these things took over and over and over again, and sometimes it was six months before a patient would finish the reconstruction. Of course, this often was head and neck cancer, and in six months they already had a recurrent disease or metastasis and tired of it, so they have spent the last six months of their life in the hospital. So that was the scenario. The next scenario was that Dr. McComb was radical in surgery and basically did not use techniques to spare blood loss.

Tacey Ann Rosolowski, PhD

0:28:51.5

Why was that?

Helmuth Goepfert, MD

0:28:52.3

Because it was not—they used scissors, they used knives, they used hemostats, but they didn't use any of the electrosurgical knives that we are used to and that allow you to coagulate at the same time that you cut. You sort of followed certain principles that diminished the blood loss. That basically evolved under Dick Jesse, under Ballantyne and so forth. Today it's the way that we operate, but in those days, a patient would have head and neck surgery and they'd immediately hang a unit of blood when they started. Three or four units of blood, okay, that was what I needed. He was radical in his surgery. In those days radiation therapy was still in the old

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mode of orthovoltage therapy. The cobalt unit was developed here by Dr. Fletcher. You know that history from other sources. Eventually the two sort of came together and started looking at the possibilities of, number one, better defining the treatment parameters for disease that could be treated by radiation—be this by external radiation therapy or be this by implants. In those days it was the radium needle implant. It was not the afterloading technique or anything like that. It was the radium needle implant. They started the first attempts to combine treatment—surgery and postoperative radiation therapy. Dr. McComb himself was not a great publisher, but he and Dr. Fletcher in radiation oncology—or radiation therapy—produced what then was probably the best book in head and neck cancer—*Cancer of the Head and Neck* by McComb and Fletcher. That was published in 1964 or '65. I was here when they first published it. I have one that is still signed by the then Vice President for Education. So, this joint interaction between two specialties started then in a primitive way. When Dr. Jesse came, and Jesse had been trained first as a general surgeon in Nebraska, he came to this department as a fellow first, and then Dr. White was the chairman of surgery. He hired him as a surgeon. He was the second surgeon hired in this department in Head and Neck Surgery after Dr. Ballantyne. Dr. Jesse certainly set the foundations for several principles. Number one was the interaction between surgery and radiation therapy and the combined management of head and neck cancer. Number two, the specific definition of what disease sites would be better treated by one or by the other—the principle that for any disease, if it could be treated by just one modality, it would be better than joining two modalities.

Tacey Ann Rosolowski, PhD

0:32:48.9

Why was that?

Helmuth Goepfert, MD

0:32:50.1

Because two modalities add to morbidity, and if they're not going to add on to the outcome, it's not really necessary. Dick Jesse, too, implemented some—he was a very fast surgeon—started to implement some blood-saving techniques. He was using the electrosurgical units and so forth. Chemotherapy, Dick Jesse began the program of intra-arterial infusion, as I explained to you yesterday. Some of these papers were published in the late '60s, early '70s.

Tacey Ann Rosolowski, PhD

0:33:36.3

Were there collaborations with developmental therapeutics? You mentioned J Freireich yesterday.

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Helmuth Goepfert, MD

0:33:40.6

No. Not yet. That came later. Definitely Dick Jesse sort of was a strong proponent of multidisciplinary care and respect for what the other specialty could do. This was a time in which there was still a great deal of antagonism out in the rest of the world, if you want to say so, in the area of radiation—between radiation therapy and surgery. There's a famous quote by Dr. Jesse in the early '60s or mid '60s at one of the international conferences. He had been on a panel of early laryngeal cancer, and there still were proponents of doing total laryngectomy for this. This was predominantly among the otolaryngologists. He got up at the lectern and started his talk by stating that if there are still people that do a total laryngectomy for early laryngeal cancer, they should be—no—to treat early laryngeal cancer by total laryngectomy is malpractice. He stated that in this meeting. It caused a tremendous upheaval, but he was right. He was right. So Dick Jesse is further to be remembered at this institution because he basically created the chaplaincy. Dick Jesse was fundamental in getting the funds for the so-called Lutheran Pavilion, and he was the one that sort of—the first chapel was built under his leadership. Dick Jesse was an educator, a surgical educator, and his death was very untimely because in the early '70s he caught hepatitis B from a patient. In his case, it evolved into liver cirrhosis, and he died of liver cirrhosis and esophageal variceal bleed. Dick Jesse trained most of the ones that were around then and most of the ones that we formed the department. After he left this was Dr. [Lauren A.] Byers, Dr. [Oscar M.] Guillamondegui, Dr. Gard, and Dr. [Robert "Bob" M.] Byers. No, he already had left. [Dr.] John Bardwil had left already before that. But, as I say, this is the history of these two masters that sort of—by 1971 there was a landmark publication between Dr. Fletcher and Dr. Jesse on the interaction of surgery and radiation therapy and the management of head and neck cancer.

Tacey Ann Rosolowski, PhD

0:37:13.7

When you look back at these two men, how would you compare their styles of leading the department?

Helmuth Goepfert, MD

0:37:21.7

Dr. McComb was a man of not many words, but what he said was the way it had to be done. So it was a little bit in the school of Hayes Martin that he—now, mind you, I only knew McComb when I was a fellow, because when I came back as an advanced fellow, back in 1971, he was stepping down already, and he was not that visible anymore. But more of a communicator was Dr. Jesse. That certainly is true. He was much more of a communicator, and he was much more of an interdisciplinary person. He sort of participated actively with Dr. [Joe B.] Drane and some of the people in oncological dentistry to do sort of a program for the dentists in Texas thinking that by doing that and teaching the dentist how to recognize oral cavity cancer they could

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improve the care of cancer. Come to find out that the people that could get oral cancer in those days, which was smokers and drinkers, never go to the dentist. (laughs) So that was the end of it. But, as I say, if the dog doesn't like the dog food, he ain't going to eat it. So these were the basic issues with Dr. Jesse and Dr. McComb.

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Chapter 13

B: Building the Institution

Chair of the Section of Head and Neck Surgery

Story Codes

A: The Administrator

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: Institutional Processes

D: On Research and Researchers

Tacey Ann Rosolowski, PhD

0:39:15.2

Now, you became the full-time Deputy Head of the Department of Head and Neck Surgery in '79 and then became chair of the department in '82.

Helmuth Goepfert, MD

0:39:26.1

Yeah, Dr. Jesse died in '81. And they asked him in '79 to name a deputy chairman.

Tacey Ann Rosolowski, PhD

0:39:35.2

So what were your goals and first steps when you assumed that position?

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Helmuth Goepfert, MD

0:39:42.3

Number one was to create a forum that allowed for the discussion of new patients with other specialties, and it has mushroomed into a very significant endeavor nowadays. It needs to be said that traditionally, at this institution—and it still is like that—the head and neck surgeon sees all head and neck cancer patients, so it's very few of them that come in just straight to radiation therapy. The patient that is referred to head and neck surgery comes through head and neck cancer, comes to head and neck surgery, we do the initial evaluation, we do the local history and physical and make sure that the patient is discussed once we have some basic elements of the history and physical and possibly some of the radiologic studies and other studies that are necessary. Often the medical oncologists see the patient for the purpose of making a joint decision of how this is going to be handled. Is there protocol that the patient can fit in, in the sense of a research protocol? Is this a patient that would predominantly be treated by one modality of treatment? The Head and Neck Department has assumed that responsibility and has always done it that way. In addition to that, we follow the patient through their treatment, in addition to whoever is treating the patient, and we have assumed the role of the followup, which became a little bit of a burden as the number of patients increased, so we had to create a survivor clinic. The Survivor Clinic exists now for patients who have been, the past five years, post treatment and still want to come here. There is a survivor clinic that is basically run by a physician assistant. Most of us have a physician assistant. In Head and Neck, we don't have any advanced practitioner nurses.

Tacey Ann Rosolowski, PhD

0:42:00.5

How did it happen that Head and Neck took on such a broad role with patients even who would not require surgery?

Helmuth Goepfert, MD

0:42:07.2

Because we had the means of examining the patient, and we comprehend the function of the different sites better than somebody else. It was established because we would not control the management of the patient, as we discussed yesterday, at this institution. We wouldn't gain by operating on a patient. Yes, there was a time in which physicians sort of leaned a little bit in one or the other direction that caused some turmoil between some members of the department and radiation oncology. I wanted to preempt that by establishing an interdisciplinary forum where patients could be discussed and these issues brought out into the open in order to make the right decision—what we felt was the right decision.

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Tacey Ann Rosolowski, PhD

0:42:57.4

What were some of the other initiatives you took up? Before I ask you that, was there any kind of discussion or argument about setting up this kind of responsibility?

Helmuth Goepfert, MD

0:43:11.7

No.

Tacey Ann Rosolowski, PhD

0:43:12.4

So people really—it was really the MD Anderson practice?

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Helmuth Goepfert, MD

0:43:15.7

Yes, it was supported by everybody. We made it in such a way that it was—at the end of the day it became Thursday because usually new patients were seen Monday, Tuesday, Wednesday. So we created it to be done on Thursdays so the patients were still untreated. Over time, Diagnostic Imaging participates in it now, and they bring the studies and communicate everything over a cable. They don't need to lug around the x-rays. That, over time, has become better. The oncologic dentists, they give their opinion if a patient needs dental extractions or whatever. The prosthodontics are there in case a major resection is necessary and they'll need rehabilitation. Speech Pathology is there, the nutritionists are usually there, and of course all the trainees are there. What used to be a limited group of maybe fifteen people now is at least thirty to thirty-five sometimes filling the ranks. It has become a very—I would say it has served as an example that later was implemented by everybody else in the hospital, and now it's sort of the hallmark of MD Anderson multidisciplinary care. So that is how that started. The other thing I wanted to do as soon as possible was to create or duplicate the efforts that Dr. Freireich had done in training physicians to become physician-scientists. That is a very hard-to-follow project because these people really have to have a passion for doing it. You cannot do it away from the clinical level. You need to still participate in the clinical care of patients. You need to have a mentor that understands what you're doing on the clinical side, and certainly a training mentorship on the basic science side, so that whatever project they want to study or evaluate or participate in has the proper mentors on both ends. I mean, there was the effort—one of the early efforts was in the study of natural killer cells.

Tacey Ann Rosolowski, PhD

0:46:13.0

That was in Head and Neck?

Helmuth Goepfert, MD

0:46:14.8

In Head and Neck and the man that was in charge of that then was Dr. Stim Schantz. Elizabeth Grimm was the scientist. You may have heard from her. Elizabeth Grimm was the scientist who was sort of doing this on the basic science side, and Dr. Schantz sort of got into this and he created his program of physician scientists on this subject and followed through with it for a long time. Dr. Clayman, for example, who came later—Dr. Clayman came in the '90s, and he did his main work on p53. He did the initial studies of p53 and did even a national protocol to develop p53 by local injections, so there's a long history on that. So you always had to have a sponsorship, and you had to have a mentorship, and you had to let the team of scientists help this person to become the translator from the clinical side to the basic science side. In order to train fellows in that, that's the difficult part, because it demands that a fellow give up, for a year, his

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clinical training and spend time in the lab studying the language of the basic scientists, because you use a different language. I mean, all of this is—pure science is basically a language that most of it I don't understand. That is something that they have to do in order to become really adept in what they want to do in the basic science.

Tacey Ann Rosolowski, PhD

0:48:18.5

Can you give me kind of a sense of how those languages differ? You said you don't understand it yourself, but I'm sure you understand it much better than I do.

Helmuth Goepfert, MD

0:48:26.3

They talk at the submicroscopic level—the ultrastructure of something, the proteins, the genes, and the DNA and then the p53 and all the different elements that—what do you call it?—the targeted therapy is totally Chinese for me, because all of these new elements that are brought about that you have to understand—the pictures of how the epidermal growth factor interacts with antigens and antibodies and what the cascade is and what the down effect is and so forth. All of these things are unknown at the level of the clinical medicine.

Tacey Ann Rosolowski, PhD

0:49:21.1

So it's immersion in the special language of that science?

Helmuth Goepfert, MD

0:49:25.5

Yeah. And people at this institution have the availability of these scientists next door, which really is there. And then you have to credit Dr. Freireich because he started this in leukemia, and leukemia has remained—the progress in leukemia has been fundamentally guided by physician-scientists. Yes, they can have access to their specimens very easily; they draw blood or take a bone marrow, which is usually much easier than what the solid tumors give for the purpose of studying the ultra-microscopy or the structure of any of these cells that they want to target with any of the therapies. So it is something that requires dedication.

Tacey Ann Rosolowski, PhD

0:50:20.4

And it impresses me that it requires not only dedication but a really special kind of mind.

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Helmuth Goepfert, MD

0:50:27.4

Oh, yeah.

Tacey Ann Rosolowski, PhD

0:50:28.2

And very different skill sets—on one hand, having all of those interactive skills and diagnostic skills, but then a whole other kind of intellectual apparatus.

Helmuth Goepfert, MD

0:50:39.4

The intellectual apparatus is very different.

Tacey Ann Rosolowski, PhD

0:50:41.2

Yep. Interesting—very interesting.

Helmuth Goepfert, MD

0:50:43.8

That came about, as I said, in this time after Dr. Jesse. Dr. Jesse already thought that it was necessary to create an individual that would help advance the science by knowing both sides of the street, so to speak. It has become much more important now and much more complex, and it is something that the institution is trying to get more focused by doing all the things that [Ronald A.] DePinho wants to do now, which may or may not pan out. But, as I say, that is what it is.

Tacey Ann Rosolowski, PhD

0:51:20.6

Now, before we turned on the recorder you said that you wanted to give more about your perspective on the physician-scientist. What else did you want to share about the evolution of that role at this institution?

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Helmuth Goepfert, MD

0:51:36.5

The evolution at the institution has been very favorable, and many people have sort of retooled that were still young in their mind—you have a flexible mind. After you are sixty you don't have enough flexibility in your mind anymore to learn these things. That needs to be said. The people who have the flexibility in their minds that can capture this and can formulate it and use it for the purpose of creating something new is what is so remarkable and what can be done in an environment like this institution that has sort of, hopefully, for most of them, an open door. So that is the important part of physician-scientists. They sort of form a very important bridge in bringing the knowledge from the bench to the bedside.

Tacey Ann Rosolowski, PhD

0:52:36.0

What do you feel you were able to do administratively to support the—?

Helmuth Goepfert, MD

0:52:44.6

I selected people to come on the faculty that had an interest in doing that and had shown, at least in the fellowship or by some other means, an ability to work along that line.

Tacey Ann Rosolowski, PhD

0:53:05.9

Who did you bring on board that you felt was particularly successful or exemplary?

Helmuth Goepfert, MD

0:53:12.1

Dr. Clayman, Dr. Myers—those are the two primarily that I have. I had Dr. Schantz way back when, but Schantz then left for New York, and he's still a physician-scientist at the present time. Those are basically the ones I remember right now offhand. Then I trained Dr. Weber, but Dr. Weber followed more the trend of being an expert clinician, an outstanding surgeon, a very great communicator and educator, and, at the same time, focused on the issue of quality of care. That has been the hallmark of his tenure as chairman at the present time. He expanded more on the clinical side. He did not venture into translational. Now, there are others that left the institution then, but they left after their fellowship or after a year in addition to their fellowship. I forgot the name; there is one. [Dr. Douglas] Frank—Frank is his last name. He is in New York, and he still pursues that. But people come in different shapes and with different interests. The fellowship is there, and not only the way we set it up. We brought this through the society that credits our fellowship. The fellowship was not only to teach them how to handle head and neck cancer but to get exposed to an environment of physician-scientists and get exposed to the language of the

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basic scientist. And that goes along with that and it goes along, too, with so-called clinical research or protocol research, where it again is becoming much more complicated. And again, it requires a specific mind and a set of skills that have to be acquired beyond what medical school or medical books can offer.

Tacey Ann Rosolowski, PhD

0:55:16.8

Now, I read that you established both basic science and clinical research sections in the department. Am I understanding that correctly?

Helmuth Goepfert, MD

0:55:26.8

No. I didn't, really. Yes, we had some basic— There was a basic science, and we have a basic science laboratory, but it never was really totally separated from clinical care. Yes, there was a basic science laboratory. I forget the name of the people that were in there. It is over fifteen years ago now, because it later became much more affiliated to a physician-scientist.

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Chapter 14

A: Overview

MD Anderson Publications and Publication Ethics

Story Codes

A: The Administrator

B: Ethics

D: On Research and Researchers

C: Professional Practice

C: The Professional at Work

A: Professional Values, Ethics, Purpose

B: MD Anderson History

B: Information for Patients and the Public

B: Education

B: Beyond the Institution

Tacey Ann Rosolowski, PhD

0:55:53.7

Okay. What are some other initiatives that you undertook during your time as chair?

Helmuth Goepfert, MD

0:56:05.2

I wanted to talk a little bit about the issue of publication ethics. One thing that is a very delicate issue is assigning authorship to manuscripts that go out for publication. There are organizations where the chairman of the department puts down the rule that any paper that goes out of here, I have to review and my name goes first. There are; they exist. In reality, they exist. Or my name has to be on this paper, regardless. My principle was, and always has been—and still was until I finished—that my name would only go on a paper if I particularly was involved in it, did some part of it, gave substantial input into it, or was the one that basically had created that program, but it was not a must. But on the other side, the principles of authorship, as they have been now—better defined in medical publishing—did not exist twenty years ago. It was twenty years ago the existing structure then was the *Cancer Bulletin*, and I don't know if you have gone through the history of the *Cancer Bulletin*.

Tacey Ann Rosolowski, PhD

0:57:45.3

I haven't, no, but we will get to that.

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Helmuth Goepfert, MD

0:57:48.8

I'm the last one to talk about that. But in the *Cancer Bulletin* I remember there was a year that we talked about medical ethics and ethics of publication and authorship principle that never was really addressed before the '70s. It was sort of never brought up to the forefront in order to define it and set the tone for what was the responsible authorship.

Tacey Ann Rosolowski, PhD

0:58:15.8

Why do you think that issue was murky for so long?

Helmuth Goepfert, MD

0:58:24.1

Well, many things in medicine are always murky for a while. I don't know—I don't know. But as I say, it was there. I wrote an editorial in the '90s in the journal *Head and Neck*—I was editor then—on the issue of ethics of publication, responsible authorship. I think that's something that evolved during my time as head and neck surgeon here. It created a little bit of a—not friction but uncertainty when it came about. How are we going to deal with this? Who is going to decide on that? But if you set certain principles as to— Nowadays any article at the end has the lines "Principal Author," who set the concept, who did the work, who did the final analysis, who authorized the publication. That didn't exist then, so this is something that evolved over the last few years. Now, as far as educational publication of the institution, it is an interesting history.

Tacey Ann Rosolowski, PhD

0:59:41.6

Could I ask you, just before we get to that, who set the guidelines that are currently in use?

Helmuth Goepfert, MD

0:59:48.7

I don't know.

Tacey Ann Rosolowski, PhD

0:59:49.7

Okay. I was just curious.

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Helmuth Goepfert, MD

0:59:51.1

But it was sort of a movement across the country because there was an editorial in JAMA and there was certainly an editorial in the *New England Journal of Medicine*. The *New England Journal of Medicine* established some strict guidelines eventually, but I cannot tell you that because I didn't look into that. But as far as educational publications, the history in this organization is very interesting because the first president, Dr. Lee Clark, was the founder of the *Cancer Bulletin*. The *Cancer Bulletin* was a bimonthly publication. Subject varied from here to eternity. You would do well one day to invite Colleen Hubona for a cup of coffee and let her give you the whole history because she was very involved in that. Lee Clark—I mean—the historical aspect of some of these publications is wonderful. I would say the literary content of it, or the way that it was diagramed—the diagrams that he put on the front of the issue were sort of sometimes a little bit, I would say, not vulgar but questionable. For example, there was the whole issue back then of the hormonal responsiveness of breast cancer. That came about in the '60s. And certainly in the '50s came about the hormonal responsiveness of prostate cancer. So the issue was addressed in the form of orchiectomy. And Dr. Clark, on the cover of that issue, put an orchit. (laughs) And the title of the publication was *Orchiectomy and the Treatment of Cancer*. So it's a little bit on the vulgar side, but you must admit there was some humor in this man.

Tacey Ann Rosolowski, PhD

1:02:20.1

Now, how would you describe the subject matter of *Cancer Bulletin*, just for the sake of the recorder?

Helmuth Goepfert, MD

1:02:25.6

It was a publication that was multi-authored by people on the faculty that would write articles for the *Cancer Bulletin*. If you were the editor you had to sort of beat on these people in order for them to abide by the guidelines. Dr. Clark certainly was very good at that, and the subject varied—update on breast cancer, the natural killer cells, head and neck cancer. As I say, the publication was maybe this thick. It was soft-bound.

Tacey Ann Rosolowski, PhD

1:03:02.8

Like a half inch or something. And the audience was—?

Helmuth Goepfert, MD

1:03:04.6

The audience was all—every physician in Texas got it free.

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Tacey Ann Rosolowski, PhD

1:03:10.0

Oh, I didn't realize that.

Helmuth Goepfert, MD

1:03:11.2

And PRS paid for it. So this was at the time of largesse, when there was still a lot of money available, so Dr. Clark basically controlled this, and even after he lost his voice he still was the editor of it, and basically the one that helped much in doing this was Dr. Hickey—Robert Hickey. And certainly the person that carried the load for as long as I can remember—and I don't know when Colleen Hubona came to the institution—was Colleen Hubona. Now, attached to this came other publications that members of the faculty had taken on as editors of other important journals—the *Red Journal*, the radiation oncology journal. There was another one that Dr. [Thomas] Haney had—Tom Haney. He had an endocrine journal. I brought in the *Head and Neck* journal—the one that is now being edited under Dr. [Ehab Y.] Hanna in this department here. The executive editor is Mariann Crapanzano. She works on that here.

Tacey Ann Rosolowski, PhD

1:04:38.9

How long did you edit that?

Helmuth Goepfert, MD

1:04:41.4

Head and Neck? For nine years.

Tacey Ann Rosolowski, PhD

1:04:43.6

For nine years. And you edited—let's see—'89 to '93 you were editor of the *Cancer Bulletin*.

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Helmuth Goepfert, MD

1:04:48.7

The *Cancer Bulletin*, yeah. And I took it on because Dr. Clark couldn't do it anymore. Dr. Hickey didn't want to do it anymore. I took it on for a while and made sure that there was somebody that could follow, because that plus *Head and Neck* was getting a little bit too much. I still had my clinical duties and department chairman duties. But, as I say, publications in the organization, there have been multiple. Now you have the conquest that is guided predominantly to get in money, then you have *Oncology*, and you have all of these other publications that sort of, to some extent, duplicate at a lower scale and was much less expense than the *Cancer Bulletin* was.

Tacey Ann Rosolowski, PhD

1:05:35.6

Now, what did you see as the significance of publications like the *Cancer Bulletin*?

Helmuth Goepfert, MD

1:05:39.8

It would educate people out there, and people got it free. All the physicians in the state of Texas got it, and basically they "loved it."

(break in audio)

Helmuth Goepfert, MD

1:06:06.7

The need for that publication as an organ of education diminished over the years because there were other sources. The stress on the faculty to write increased, and then, of course, PRS made the decision that they were not going to fund it anymore. So that's—

Tacey Ann Rosolowski, PhD

1:06:29.0

And PRS?

Helmuth Goepfert, MD

1:06:30.1

Physician Referral Service, which is the organization that manages the money that comes in through physician practice. So, that's why it ended then.

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Tacey Ann Rosolowski, PhD

1:06:43.9

During the time that those journals were active—

Helmuth Goepfert, MD

1:06:48.6

Now, the reason that it's said about those journals is that the institution created a parallel to the office of—they created an office for scientific publications, and this Office of Scientific Publications would manage all these journals including the *Cancer Bulletin*. They would manage it for us, and Colleen set up a set of people that would be sort of work horses of this. And it was a very efficient office. It had a part-time office. This was in the Prudential Building, before it came down. It was up there on the tenth floor or something like that. Basically that's how we ran those journals, but it was set up on top of the *Cancer Bulletin* publication. So this was the Office of Scientific Publications—or Special Publications, because Scientific Publications was the other one that helped people to edit their journals. That was Scientific Publication. This was the Office of Special Publications.

Tacey Ann Rosolowski, PhD

1:08:03.3

Now, I wanted to ask you what you felt the significance of these publications were for MD Anderson. You talked about the educational side for the public, but what did they do for the institution?

Helmuth Goepfert, MD

1:08:18.3

Not really anything. No. And we sort of— During my tenure at the *Cancer Bulletin*, I remember us sending out a questionnaire to sort of feel the pulse of how people felt out there, that they would gain anything from this, something of value that they would like to still receive. We got—I would say, maybe a third of them said, yes, it's valuable, a third didn't answer, and a third was sort of mixed bag. They said, no, it's really not—I don't read it anymore. So it was very often, if you are in a position of leadership at an institution, if you are not careful you tend to create something that is not going to be of benefit to anybody. I see that now, for example. I'm working right now in the Physician Network to create a program. If it doesn't satisfy the need of the customer, it's not going to be of any benefit.

Tacey Ann Rosolowski, PhD

1:09:32.6

At what time about did you send out this questionnaire about *Cancer Bulletin*?

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Helmuth Goepfert, MD

1:09:38.3

That was during my tenure as an editor, so it was during those years.

Tacey Ann Rosolowski, PhD

1:09:45.2

Yeah, late—

Helmuth Goepfert, MD

1:09:46.3

Late '80s.

Tacey Ann Rosolowski, PhD

1:09:47.5

Late '80s, so the Internet maybe was starting to—?

Helmuth Goepfert, MD

1:09:51.0

The Internet was starting to come about, but Internet education was still an unknown word. Now it's very known, but nobody knows how to handle it. But it was, as I say, around that time. And you can really, if you ever need to get information on *Cancer Bulletin*—which is a very important aspect of the past, of the history of the institution—Colleen Hubona has a wealth of information before she retires.

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Chapter 15

A: The Administrator

The First Web-Based Textbook

Story Codes

A: Contributions

C: Professional Practice

C: The Professional at Work

C: Discovery, Creativity and Innovation

A: Influences from People and Life Experiences

B: Education

A: Personal Background

Tacey Ann Rosolowski, PhD

1:10:23.9

Okay. That's good to know. Now, you mentioned also that you wanted to say something about publishing and its failure at MD Anderson. Does that come under this heading or is that a separate topic?

Helmuth Goepfert, MD

1:10:37.0

No. What failed at this institution is the web publishing.

Tacey Ann Rosolowski, PhD

1:10:43.3

Web publishing. Okay. Well, maybe you could talk about that.

Helmuth Goepfert, MD

1:10:46.6

The example is when I left the division—you know I was head of the division ad interim for two three years or whatever it was—I obtained a fund from the institution that was in the amount of four hundred thousand to five hundred thousand dollars to develop something. So I got all my faculty together and asked the question, “Is there anything of significance that you scientists—?” And I particularly addressed the scientists because the clinicians were happy with what they were doing. I asked the scientists, “Is there anything you need?” “No,” they said, “we are okay right now.” I said, “Okay, because I want to launch a web-based book.” Mind you, this was 1997 or something like that. So I can't remember exactly when it was, but it was when I finished my division head duties. So I set up a team, and we went through multiple architectural changes

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because the companies then appeared and disappeared rapidly on the scene. This was at a time when the dot-coms sort of went up and down and sideways. So the creation of this was based—My vision was to create an entirely web-based publication on head and neck cancer. In order to keep it simple, I was going to use faculty of MD Anderson only, and I abided by that with one exception, I think. And it was not just a textbook put on a disk, but a program that could evolve into something interactive. Now, mind you, at that time it was very labor-intensive. We had to find a person that would be able to translate the content of what was given onto the website; pictures, segments of video and so forth to show how things were done, programs on radiation oncology, and the book was basically called *Head and Neck Cancer According to the MD Anderson Cancer Center*. And we finished this in a matter of about three or four years. Nobody ever had done this. As I say, the principle was that text would be at a minimum because reading text on the screen is getting better, but it's different. It's tiresome. It's not like reading a book. So even though Kindle says it's different—I like Kindle too—you lose the ability to check what's coming.

Tacey Ann Rosolowski, PhD

1:14:10.9

That's true. Or go back and remind yourself.

Helmuth Goepfert, MD

1:14:16.2

Go back and remind yourself of what you read that was difficult to find. But anyhow, we were able to finish this project, faculty only, and present it to the then Vice President of Academic Affairs Margaret Kripke [Oral History Interview]. Margaret loved it. She said, "This is wonderful." I said, "We're going to launch it next month." It will be housed in an MD Anderson server, but it would be web bound and text at a minimum. The highlights of anything would be on bullet points only. Evaluation done by this and this and these principles, staging done according to—and you could click and up came a separate view of the staging available, treatment modality and such and such based on this and this and the evidence is based on this and this publication.

Tacey Ann Rosolowski, PhD

1:15:20.4

When you say staging, do you mean—? What do you mean by that?

Helmuth Goepfert, MD

1:15:23.5

Staging of cancer.

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Tacey Ann Rosolowski, PhD

1:15:24.7

Oh, okay. Stage I, stage II, okay.

Helmuth Goepfert, MD

1:15:29.6

So this you could always pull up the reference in the system. So it was complex. It was not very user-friendly because the system still was in its initial phase. Yes, there were things that today would be totally different, but in those days you sort of had to go two steps back in order to go a step forward and stuff like that. And it required more savviness than it would now. The concept of user-friendliness was just being sort of brought about in order to make these things better. Be that as it may, we set it on the server—on MD Anderson’s server—and months later a committee that existed then at the Institution for Scientific Publication or whatever it was decided, no, MD Anderson is not going to pursue anymore web publishing period. No reason given. It was basically their statement. So here I was; I had what I thought was a great publication to start something rolling in not only the institution but beyond that for people to start doing this. It still hasn’t been done, but the institution lost its momentum in doing web publishing, something that is sorely needed now.

Tacey Ann Rosolowski, PhD

1:17:10.5

Why do you feel it’s so needed?

Helmuth Goepfert, MD

1:17:12.9

Because it’s the way that we can connect with the outside in an efficient patient-management way. I think the decision-making support is not that easy to get out there in the sense of having it. Yes, there are some programs that facilitate it, but they are not really that flexible so that physicians could, for example, put in all the information. It would be guided here to an expert, that expert would sift through it and within two or three days give an answer.

Tacey Ann Rosolowski, PhD

1:17:54.5

So you saw the web-based book as a communication tool between physicians outside and specialists within the institution?

Helmuth Goepfert, MD

1:18:03.7

No, as a first step. It was mainly to disseminate our information on the web base, not in a book

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that sits on a shelf collecting dust. I mean, I had already identified that you can take out a chapter and say we need to update this chapter. You would take out the chapter, update the chapter, and put it back in again. That's the way I saw it, and I saw it predominantly at that time as a way to communicate our knowledge to the outside—what you usually do for that purpose. Now, publishers outside that I approached after that really were not able to use it or gather momentum with it. The one that was most interested was certainly Brian Decker, from Toronto—the Decker Publishing Company. He put a tremendous effort into this. He tried to work with Eleanor to do it, but he could not get a business plan that would say this is going to make money for us. Whereas books in hard print make money, web publishing does not. So it is one of those conundrums that will have to be solved somehow or another. It sort of underlines my belief that web education is underutilized. I think it's very much underutilized in complex disease processes like cancer.

Tacey Ann Rosolowski, PhD

1:19:48.8

In the ideal world, what would you visualize?

Helmuth Goepfert, MD

1:19:55.5

I would visualize several products. One of them would be the identification of certain advanced surgical procedures that would create, through the visual documentation of these procedures with video, a library that could be utilized by experts all day if they needed to do this operation. It would create a forum by which physicians out there could submit their difficult cases onto a platform that the only thing we would have to do is make sure that they submit the appropriate information in the shell that we allow them to utilize, and then we would have some kind of a board in front of us with faculty that would be ideal to answer the questions specific to this case. So we do not have only the so-called Tuesday morning MPC—multidisciplinary planning conference—that we have now, where faculty of our organization answers the questions from the people in our network, which is the host programs, and that only can be done once a week. This would be a continuum that could be accessed by anybody out there that wanted to know something about a specific situation. There would be a storage bank where these cases could be sort of loaded and kept for future references. It could be used then for educational efforts, for annual meetings or something of that nature, and basically once the physician expert at Anderson would render an opinion plus supply a list of references that supported his/her decision, it would then go back to the physician who asked the question. And I see that as the best way. And you can use this for nursing training. Nurses out there need oncology training. This can be used as that. It can be used for physical therapists, for their duties. It can be used by nutritionists. It can be used for medical oncologists in order to train the nurses in the safe administration of chemotherapy. It can be used by radiation oncologists to give the necessary parameters of appropriate treatment for—be it breast cancer, rectal cancer or what have you. It would allow for

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multiple medical and paramedical specialties to create educational programs that could be sold by MD Anderson or offered by MD Anderson for a certain fee. Now, it's a major undertaking, and the short—I would say the short answer is, yes, we need to do it. The long answer involves—stumbles on the fact that the MD Anderson faculty is already overtaken. They are torn between research and patient care. They have been told they need to increase nine percent the productivity—God knows how they're going to do it—and they have their own responsibilities vis-à-vis societies that they participate in—scientific societies. Or they have educational programs that they have to run out there and are sent to Pakistan or wherever it is so they give their talks. So all of that is basically in the mesh of where the faculty finds itself now. But, as I say, in some form it will have to be a way to make things easier, because I think we are still using outdated technology to teach out there.

Tacey Ann Rosolowski, PhD

1:24:22.5

I'm really struck at how often the issue of education has come up, as you're talking about your own career. Where did your interest in and commitment to education come from?

Helmuth Goepfert, MD

1:24:35.7

From my father.

Tacey Ann Rosolowski, PhD

1:24:37.0

How did that happen?

Helmuth Goepfert, MD

1:24:38.5

Because he was basically a general surgeon and a great man to educate people. He was not a chairman of a department, but he was a very practical educator in the sense of bringing things down to diagram. He would use this for patients, and he would use this for his students and so forth. So it comes from that time. It comes from that time, and it comes from seeing how Dick Jesse would educate us, how Ballantyne would educate us. Some of them would sort of know that they were doing education. Ballantyne never knew really that he was educating us, because we saw what he was doing and that was education enough. Yes, I had an interest in educating, and it was part of why I stayed here; because you could do it here at MD Anderson with fellows.

Tacey Ann Rosolowski, PhD

1:25:42.8

Okay, so you felt you were making a real impact.

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Helmuth Goepfert, MD

1:25:44.7

Yeah. When I got to the United States I said I didn't want to go into private practice. The majority of physicians, in those days, that came to the states from Latin America and from wherever it was in the world ended up doing private practice. It is only in the last few years that many of them have sort of come as immigrants and sort of settled in institutions like MD Anderson.

Tacey Ann Rosolowski, PhD

1:26:13.3

Now, why didn't you want to go into private practice?

Helmuth Goepfert, MD

1:26:15.9

I didn't like the business part. I'm not a number person. My basic knowledge of economics is that you can only spend what's in the bank. (laughs) So that's all. I don't know more than that. As I say, I had no interest in doing that. I know that some of my colleagues were making money hand over fist, but I didn't care for that.

Tacey Ann Rosolowski, PhD

1:26:44.5

Now, I noticed from your CV that you chaired the Joint Council of Head and Neck Training Oncologic Surgery and also you delivered the 1995 Hayes Martin lecture, *Training the Head and Neck Surgeon Scientist*—both real big evidence of your interest. So tell me about those two opportunities for—

Helmuth Goepfert, MD

1:27:10.1

The Hayes Martin lecture—Hayes Martin was the man I mentioned to you in relation to McComb. The Head and Neck Society had an annual lectureship in which one of the leaders in the field would be asked to give a lecture. When I was offered that opportunity I took it and I made it on the training of the head and neck surgeon scientist. So that was—it's a paper that is published. I even did a questionnaire sent out to the 16 existing programs finding out how much research their fellows were trained in. It was a gamut from left to right—nothing very much.

Tacey Ann Rosolowski, PhD

1:28:00.8

Now, can you summarize the main points of that lecture on education?

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Helmuth Goepfert, MD

1:28:08.1

It was basically what we have discussed, and I would say what made—the fundamentals of what does it take to be a surgeon scientist. I don't have a copy of that with me, but it is published. In my CV you can get the reference and you can find it. It's in the library. But, as I say, the other part is the Joint Council of—

Tacey Ann Rosolowski, PhD

1:28:38.6

Advanced Training in Head and Neck Oncologic Surgery.

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Chapter 16

A: Service

Accrediting Head and Neck Services

Story Codes

B: Institutional Processes

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

A: Activities Outside Institution

A: Contributions

B: Education

Helmuth Goepfert, MD

1:28:42.3

As I mentioned to you, there were two head and neck societies. On two things they sort of worked together rather than against each other. One of them was education and training of head and neck surgeons, and the other one was in their annual meetings. So those were the two things that sort of got them together first. Both of them were interested in accrediting programs for the training of advanced head and neck surgery. So this committee, or this council, so to speak, would supervise that activity and keep up the credentialing of these programs. In addition to that, it eventually ventured into offering the selection of candidates. It was basically through this activity that I remained in touch with the two societies and sort of helped organize the accreditation process.

Tacey Ann Rosolowski, PhD

1:29:57.7

And how did that work? What kinds of parameters did you decide to look at for accreditation?

Helmuth Goepfert, MD

1:30:05.1

We looked at the— Basically what we looked at is what is the composition of the program as far as faculty is concerned, and it gave us an idea of what has been your patient caseload in the last year or two. What is the educational program that you have for your fellows? Are they lecturers? Is there laboratory experience? Is there requirement for publishing a paper at the end of their training? Issues of that nature. It was a pretty rigorous— There were assigned members of the two societies that would go and visit the programs and fill out a report. And according to that, we would grant them accreditation to train one, two, or even as high as three fellows per year.

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Tacey Ann Rosolowski, PhD

1:31:09.4

What is the effect of all of that? What effect did you see after creating that program?

Helmuth Goepfert, MD

1:31:16.9

That there were hospitals that didn't care about accreditation and sort of ran their own training program and still had people on board, but what I wanted to emphasize through this was that the fellow, which is one that comes out of a residency, needed additional training, and that this training be given by a structured program in a department, not by the fellow being the junior faculty. In many of the programs, the fellow was the junior faculty, which ended up the blind guiding the one or the one eye guiding the blind, because they really, as fellows, did not acquire any additional management skills except through practicing themselves. They didn't have a mentor that would tell them this is the way it's done. Our fellowship was very much geared towards training the surgeon how to examine the patient, evaluate the patient, the principles of multidisciplinary care, and how to operate in the operating room. Many fellows, we basically had to train them to operate from scratch. So, yes, that is a reality.

Tacey Ann Rosolowski, PhD

1:32:36.8

Why was that?

Helmuth Goepfert, MD

1:32:39.2

Because many a program in otolaryngology, from where these fellows came, really didn't practice much head and neck surgery itself.

Tacey Ann Rosolowski, PhD

1:32:48.7

And you were emphasizing yesterday the need for repetition in all of these.

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Helmuth Goepfert, MD

1:32:53.8

In some of these, yes. So the group is more homogeneous today, where they get a little bit more exposure to surgery, but in those days it was very heterogeneous. You often had people that, had they seen a laryngectomy? Yes, maybe one or two. Have they done one? No, they hadn't. How many neck dissections had they been exposed to or had they done or participated in? Maybe five to eight. What all of them had a lot of were tracheostomies, but tracheostomies were basically based on the need for an airway in patients that were in the intensive care unit. So, as I say, it was the heterogeneity of treatment—of training in the different programs—is what we wanted to diminish—make it more homogenous, more structured. So we created documents that had to be filled and certain principles that had to be abided by.

Tacey Ann Rosolowski, PhD

1:34:03.8

As you are kind of finishing up this section on your work as head of the department, is there anything that I'm missing? Are there other places where you felt you left your mark that we have not covered so far?

Helmuth Goepfert, MD

1:34:23.6

(laughs) No. (laughs)

Tacey Ann Rosolowski, PhD

1:34:26.4

You know, I never know how to ask that question because if I say, "What were your contributions?" people will say, "Oh, well, I was just part of a team." Everybody is very—

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Chapter 17

A: Post-Retirement Activities

The Physicians Network

Story Codes

C: Funny Stories

B: Building/Transforming the Institution

B: Beyond the Institution

A: The Administrator

B: Institutional Processes

B: Critical Perspectives on MD Anderson

A: Post Retirement Activities

Helmuth Goepfert, MD

1:34:36.0

What everybody remembers me for is my answers to their e-mails. You were not here ten years ago?

Tacey Ann Rosolowski, PhD

1:34:44.0

No. I just arrived in Texas just a year ago, so I'm all new. You're telling me news here.

Helmuth Goepfert, MD

1:34:50.9

Oh, yeah. There would be some notification come through the Internet from one of the leaders of the institution. I'm a little bit, I would say, big mouthed sometimes. I get a little arrogant, that's for sure. And I would put down an answer and just send it to everybody. "This is hogwash."

There was the eternal fight over the reallocation of research space. You can imagine that this is a hot potato. It was always a hot potato. So out came communication from one of the offices of vice presidents and it said, "We're going to reinitiate a program of evaluation of research space allocations. These are going to be the principles." I was sort of at the thought of making a very short comment to it, like, for example, "This has been tried umpteen times before. What is going to be new this time?" and send it to everybody. (laughs). So when I retired I went totally away from the institution for about three years, and then PN approached me.

Tacey Ann Rosolowski, PhD

1:36:22.8

And that's Physicians Network?

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Helmuth Goepfert, MD

1:36:24.4

Physicians Network and the executive vice president of PN, Mr. [William A.] Hyslop, and Dr. Bill Murphy, who is the chairman of the Physicians Network supervising board, met with me for lunch in order to discuss my possibility of being hired. The first thing they said, “You will have to promise us that you are not going to answer more e-mails.” (laughs)

Tacey Ann Rosolowski, PhD

1:36:56.1

Well, since we’re on the topic, would you like to tell me about our involvement with Physicians Network without your e-mails?

Helmuth Goepfert, MD

1:37:06.8

The reason for Physicians Network involvement is that, as I told you several times, I was always a believer that we needed to help the physicians away from their pink palaces and marble towers—ivory towers—to do better care. The institutional efforts in this regard have been multiple over the years. They started way back then under Dr. [Charles A.] LeMaistre [Oral History Interview]. They were pursued certainly under Dr. Mendelsohn [Oral History Interview]. Right now this administration is wanting to launch a big program of national strategy. I think they’re a little bit too full of themselves, but okay. But the Physicians Network sort of offered an opportunity to evaluate programs that would qualify as host programs to become part of a network in which we would send in our team to evaluate certain practices, like radiation oncology practices.

Tacey Ann Rosolowski, PhD

1:38:33.4

And you say “we” meaning—?

Helmuth Goepfert, MD

1:38:35.5

The Physicians Network.

Tacey Ann Rosolowski, PhD

1:38:37.5

Okay, so they would have their evaluators go out?

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Helmuth Goepfert, MD

1:38:40.2

PN is a subsidiary organization from MD Anderson Cancer Center. It exists as a 503c1 or something like that. So Physician's Network in itself has created programs of best practices. These are concordant studies in which we evaluate how patients are treated based on the principles dictated by guidelines at MD Anderson, concordant studies to see how they proceed with certain fundamental guidelines that come from organizations like ASCO, like NCCN, like the Institute of Medicine and so forth—so to set certain things that— Breast cancer—after hormonal-positive breast cancer needs to be treated with adequate anti-hormonal therapy, was it done or was it not done? So these types of things that you look into, and we have created certain very targeted protocols by radiation oncology to evaluate these radiation therapy centers of these host programs that want to improve their care. Now, it costs them money. They pay the Physicians Network for doing this. So I was interested in that, and they sort of felt I could contribute by participating in this effort, and I certainly do participate in the effort as a part-time activity at this time.

Tacey Ann Rosolowski, PhD

1:40:29.3

You are on the board as medical director?

Helmuth Goepfert, MD

1:40:31.9

I am a medical director. I'm not on the board. I'm just a medical director. There are five medical directors now. There is one chief medical director, Dr. [Richard J.] Babaian, and there are four of us outside of that—or three more—four more. So we are the physicians that—and all of these physicians are retired. We're all retired physicians, so we sort of function as the addendum to this activity. Now, mind you, we have programs of evaluation of care for the four big disease sites. This is breast, colorectal, lung, and prostate. These are the four big killers in this country. But we have tools to evaluate the care of head and neck, lymphoma, leukemia, GYN, ovary and so forth, so there are more in development. Now, this movement has gathered nine host programs that are in the southeast of the United States that are basically located—one in the south part of Massachusetts—south coast. There is one in Pensacola, there is one in Spartanburg, there is one in Mobile, there is one here in East Jefferson, which is in Louisiana, there is one in Chicago, and there is one in Missouri. These are programs that basically use our tools for quality improvement. They do a pretty good job, and they sign a contract for three years. They pay a good lump of money for that, but it helps them in their marketing. If they perform satisfactorily according to our principles, they can market that and they can market it with a slogan that says MD Anderson Cancer Network affiliated or whatever.

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Tacey Ann Rosolowski, PhD

1:42:50.1

Okay. Now, on the other side, how is Physicians Network funded, and what happens to the funds that these programs pay Physicians Network?

Helmuth Goepfert, MD

1:43:03.9

They pay Physicians Network. Our budget is based on that, and MD Anderson Cancer Center gets the proceeds. And we exist, too, because MD Anderson Cancer Center cannot hire anybody on the outside, so MD Anderson Physicians Network can hire the physicians that run the regional cancer care centers. All the satellites that exist around there, they are run by physicians that are hired by MD Anderson Physicians Network.

Tacey Ann Rosolowski, PhD

1:43:40.5

This goes to an interesting question of the expansion of the institution into remote locations and how MD Anderson is kind of disseminating a particular standard of care into other institutions. What's your view of that?

Helmuth Goepfert, MD

1:44:00.7

That it is still not well structured. That the definition of levels of participation is haphazard. That not much has been learned from the past, including the existence of the Orlando MD Anderson Cancer Center.

Tacey Ann Rosolowski, PhD

1:44:30.0

What's the situation with that?

Helmuth Goepfert, MD

1:44:32.1

That has existed for twenty years and is still sort of nebulous, some of the aspects of it. That the whole process of going in there and trying to create an institution that has the MD Anderson name and logo on it, like, for example, Banner, in Phoenix, is fraught with some problems. That there are organizations that I think should not have proceeded the way they did, like MD Anderson Espana.

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Tacey Ann Rosolowski, PhD

1:45:07.5

What was the lesson to be learned from MD Anderson Espana?

Helmuth Goepfert, MD

1:45:15.1

That they have no resemblance of any quality—involvement of quality care—and we have no participation in what they do. They carry our name, they pay us money, but we have no input in the quality of what they do. That's a shame. Now, they have other arrangements that are sort of business arrangements only. For example, they have now—with Albert Einstein Hospital in Sao Paulo—they have some kind of consultative arrangement, but what is it? And I say that for the quality of what has to be delivered out there at any of these programs that will be in the network—the Cancer Network that MD Anderson wants to create—Dr. DePinho wants to launch—the participation of faculty for the technical and intellectual component is vital, and the faculty itself still is not clear as to how this is going to happen and how it's going to be rewarded. That is one of the difficult issues to answer. How are they going to be rewarded? If you want to climb the academic ladder, yes, there is the three-legged stool, but now the stool has more legs. How do you evaluate those legs and how you put it in? I mean, it was—

Tacey Ann Rosolowski, PhD

1:46:53.1

Well, and what hours of the day do you put it into?

Helmuth Goepfert, MD

1:46:56.3

Yeah. When do you find time for that?

Tacey Ann Rosolowski, PhD

1:46:59.5

I interrupted you. I'm sorry.

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Helmuth Goepfert, MD

1:47:00.5

No, that's correct. You're absolutely correct. So I see that that whole effort is not well thought through. And based on the experience I have had in the twenty-five years since Dr. LeMaistre launched it, I have seen multiple versions of the same, and I'm very concerned right now. Particularly I'm very concerned with the particular aspect of one peer review program—or I would say it's peer review/on-time review of the care that is given out there that we created for medical oncology. It so happens that the parameters were so stringent that we don't really capture the patients that need to be evaluated.

Tacey Ann Rosolowski, PhD

1:48:02.3

I guess I'm not understanding how that works.

Helmuth Goepfert, MD

1:48:05.2

It's hard to understand, but in creating this program for peer review or on-time evaluation of medical oncologists out there, we placed it at the level of initial treatment with chemotherapy. And initial treatment with chemotherapy, although it is important, it's a relatively simple thing to fill out. What the physicians out there need is a program that allows them to be evaluated in the management of complex cases—patients with recurrent cancer, patients who have failed previous treatment, that type of thing—not what we have. As I say, we barely get one or two patients to be evaluated per week. People out there treat—what?—fifty to sixty patients, and we don't get it.

Tacey Ann Rosolowski, PhD

1:48:59.8

And so the problem is—?

Helmuth Goepfert, MD

1:49:03.0

Is to create a program that will allow us to capture the patients that need to be evaluated and give the physician out there a resemblance of the quality that needs to be delivered.

Tacey Ann Rosolowski, PhD

1:49:16.7

Now, is Physicians Network addressing that in some way?

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Helmuth Goepfert, MD

1:49:20.3

Yeah, but we cannot do it because we need the appropriate faculty to help us with that. We may have the IT people and an IT program to launch an educational program, but the intellectual capacity is not there, and we are having difficulty getting the faculty to help us because the faculty is torn. They have not been given the orders from their leaders that this is part of what you have to do and we'll remunerate you for that. That has not been given to them. So there is a disconnect here, and I think it is a very important disconnect because the business part of the house says, oh, we go out there and just charge them money for a program, but what is the content of the program? I'm worried about that. That is something that will have to be addressed. So there is more to be done, and Physicians Network is basically the tail of the dog, wagging the dog.

Tacey Ann Rosolowski, PhD

1:50:22.0

Right. So there's stuff that needs to happen on the front end before it can be fully functional.

Helmuth Goepfert, MD

1:50:27.4

And the way I see it, they have not really addressed it, and they have not presented this properly to the faculty for their response, input, and participation.

Tacey Ann Rosolowski, PhD

1:50:40.5

If I can ask you, I'd like to just pause the recorder for a second.

[The recorder is paused.]

Is there anything else that you wanted to say about Physicians Network and the future of it is?

Helmuth Goepfert, MD

1:50:55.7

The future definitely will have to be forged in a better, cooperative way. At the present time it's still not a smooth, multiple-input organization where everybody sees us the same way. And we physicians at Physicians Network are very concerned about the quality of what is being offered, and that is not the view that the business side of the house has.

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Tacey Ann Rosolowski, PhD

1:51:30.1

Interesting.

Helmuth Goepfert, MD

1:51:31.2

So that is something that will have to be remedied if we're going to—because the market right now is full of questions and people are desperate trying to find the best way to solve the problems that sort of come down on everybody not only from the point of view of the best care but the best care, and at the same time, most cost-efficient care, and everybody is trying to do it in a different form. What is going to be the outcome? God knows. Things may change radically if the election produces something else at the end of the year.

Tacey Ann Rosolowski, PhD

1:52:18.6

Right. The context is always—

Helmuth Goepfert, MD

1:52:22.1

No, the context is— Unfortunately people don't understand what's at stake because folks, by and large, only listen to the television and the loudest voice will prevail. (laughs)

Tacey Ann Rosolowski, PhD

1:52:35.8

Absolutely.

Helmuth Goepfert, MD

1:52:38.3

So it's very difficult. One of the difficulties in improving our healthcare is the fact that it is murky, it is complex, and people are not really well educated to comprehend the consequences of not doing anything. And I'm not an expert in healthcare, but I can tell you the fact of the matter that we have already almost eighteen percent of national—the NPG—the national whatever it is—used up in healthcare is prohibitive, and people are not happy with their healthcare here, that's for sure. But that's not my thing.

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Chapter 18

B: Key MD Anderson Figures

MD Anderson Presidents

Story Codes

C: Portraits

B: MD Anderson History

C: Funny Stories

B: Critical Perspectives on MD Anderson

B: Controversy

B: Institutional Politics

D: On Leadership

Tacey Ann Rosolowski, PhD

1:53:36.2

I wanted to ask you for some observations about the different MD Anderson presidents that you've worked with—sort of a compare and contrast of what you think they offered the institution and their leadership styles.

Helmuth Goepfert, MD

1:53:56.0

At the risk of putting my foot in my mouth, Dr. Clark was certainly a very unique leader. He saw the need for a cancer hospital, but interestingly enough, even though some of his motto was “Don’t dream small dreams. Think big,”—you may have heard that—when it came to building the inpatient unit he said, “We are not going to build for too many beds because we just saw the example of what happened to the tuberculosis hospitals.” You know there were all the sanitariums back in the ‘30s? Streptomycin came on board and they disappeared. So he was worried about that, which was interesting. So there was a dichotomy in his thinking, although he was a big communicator and a very strong character. At the same time that he was a good communicator. He had a very efficient style in the sense that when he thought something was right he would just order it to be done, so there was little hesitation in it. **[Redacted]** It was interesting that he was respected so widely that even though the legislature had some trepidation in creating this MD Anderson institute, the private practitioners out there were so worried about the influence of this big elephant suddenly that they requested an amendment to the law that created MD Anderson that the physicians had to be referred by physicians. And you know that lasted until the ‘90s. As I say, that was an issue, but on the other side, the legislature loved this man because he was basically honest and was doing something new. He would go up in front of the legislature and say, “I need this many dollars,” and there was more than one legislator that

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would get up and say, “Dr. Clark, do you really have enough?” That was the type of relationship that existed then. Dr. LeMaistre had a different style. He came from a different background. He was a very gentleman-like person. He was a good delegator in the sense of delegating responsibilities and letting people run with it even though some of these folks became unpopular. He basically stuck with what he had decided. He put at the forefront the issue of cigarettes and sort of made it his main theme during his administration—smoking cessation. Dr. LeMasitre created the first attempts to have affiliations with other organizations. That is why MD Anderson Orlando was formed and developed. Even though he was sort of a mellow man, the presence of Dr. Clark still, to some extent, caused certain friction within, in that, though not visible, people that were around long enough sort of remarked on it that when Ben Love gave money and you had now the three buildings—the Clark Building, the Love Building, and the LeMaistre Building. If you look at it from Holcombe, you see that—the Clark Building, the Love Building, and the LeMaistre Building. So there was a department chairman, his name escapes me right now, he said, “Finally we have Love between LeMaistre and Clark. (laughs)

So then Dr. LeMaistre finished his tenure, and basically, as an administrator of a major institution, they cannot remove you for age purposes, but at age seventy the University of Texas required an annual reappointment. I think he went through two of them but decided this was enough. When his successor came about, of course they created, among other things, a national search committee with the board of regents heavily involved. There was a faculty committee too. One of the members of the faculty committee was Dr. Andrew von Eschenbach. He was the chairman of urology then. He then went on to have other functions in national government. But he decided to throw his hat into the ring of president of the institution, so he was one of the faculty representatives in this committee of the institution. Now, the call to take the job fell on me, and I said, “Okay. I’m going to take this seriously, and I’m going to use it for the best purpose of the institution.” One of the candidates then was Dr. Charles Balch. Charles Balch was the chairman of surgery, and for a while he was the director of the hospital and so forth. He was not a very much beloved surgeon because he could not operate himself out of a wet paper bag. That’s an expression among surgeons for somebody that’s not a very good surgeon, but basically that was the joke. He wanted to become president of the organization, and I made sure that all the problems that he had caused during his tenure would be discussed with the members of the board of visitors. The Board of Visitors was very much influenced by Red McComb. Red McComb is a man from San Antonio who owns several car dealerships. **[Redacted]**

Now, I took it upon myself to do a little bit of education and stuck my neck out at the risk of being fired later that Dr. Balch was not the better candidate, that they should look at other candidates as well. That is how eventually Dr. Mendelsohn was chosen. Now, Dr. Mendelsohn certainly has an interesting tenure in this institution. Among all the presidents, he is the most egocentric of all of them, so far. I think DePinho may overcome that too—or pass him too. A

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significant physician-scientist—he really was a physician-scientist—that after he had been in San Diego where he developed his initial studies with the epidermal growth factor and the antibodies for epidermal growth factor, he created sort of a new paradigm for cancer treatment. His laboratory continued functioning up in New York, and when he came to the institution he brought it all with him. He did not divest himself of any of the companies that he had ownership of, ImClone specifically. I'm still surprised, in the whole Enron/ImClone debacle that occurred in which he definitely had inside information and inside trading knowledge that sent Martha Stewart into prison, he was able to survive that. I mean, it was common knowledge that he made \$6 million on selling his investment in Enron a couple days before the whole palace collapsed, and ImClone was in a similar situation, so I think that it's still unclear how that all unfolded and how it fell in favor of Dr. Mendelsohn. Mendelsohn and I could not see eye-to-eye, that's for sure. I repeatedly showed him what had been accomplished by the physician-scientist program in Head and Neck, and I asked him if he would be favorable to get some of the donors to fund this program. I didn't want him to continue my name on it. I said, "Take my name out of it if you don't want to," but that never happened. Yes, by judging the size of the shrine, you can sort of judge the personalities of the three people that were presidents of this institution. If you would find a bigger wall, a bigger wall would have been plastered with everything. That's my view. That is my view, but, as I say, he did a great deal for the institution. He was a wonderful salesman. He certainly was able to get water out of a turnip and got a lot of philanthropy into the organization—significant philanthropy—more than anybody else before, but during his tenure certain things happened that the institution may regret later. I'm not going to dwell on that. But, as I say, I think that having him as a chairman of a major program under Dr. DePinho, be it called what they may—it's right now called the Institute of Personalized Medicine—something like that—will cause some friction certainly with Dr. [Linda] Chin eventually. It will cause friction with Dr. DePinho because they both are strong personalities.

At the present time, Mendelsohn is sort of feeling his footway again into the organization. Nothing has happened, but I can see that sooner or later something will happen. I wrote a letter to Mendelsohn when he announced his retirement and what he was going to do. I said, "I appreciate that you are open about your retirement, but I strongly advise you to stay away from the institution as such and don't take a department chairmanship for a major development. That may cause the new president some headaches." Of course, he said, "I don't care what you say." He never told me that, but I know that's what he felt because, as I say, I wrote him a letter about that specifically. I myself feel very strongly—I've always felt strongly—that once you leave a position of leadership, the best thing is to not have anything to do anymore with them because people come to you for serious reasons or for not-so-serious reasons and think that you can influence the chair. That undoubtedly, in one form or another, may happen. I remember when Randy [Randal Weber] got here as the new chairman of Head and Neck Surgery, and any occasion that I would come around, faculty would come to me and say, "I'm having a terrible

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time with Randy's way of management." I'd say, "Listen, guys, work through it. I'm not going to interfere with this. It's not my place, not my position." But I can see that if I would have been in the department that would have been hard to live with.

So, as I say, I'm always of the principle that you have to leave things before they ask you to leave. I never have set goals. I've always been a victim and the beneficiary of being there at the right time for the right occasion, yes, but there were certain goals I set myself. One of them was that if I took on something extra like the *Head and Neck Journal*, there were certain principles I wanted to abide by. *Head and Neck*, before that, was sort of a solicited publication type of journal that had plastic surgery in it and all sorts of other subspecialties. I thought this was the opportunity to give impetus to a journal that would be devoted to head and neck cancer, number one. Number two, I said I wanted to make it such a journal that it can survive on peer review, because before that it was just solicited publication. And number three, I wanted to accomplish this within ten years, and I was able to do that. The journal now is really only head and neck cancer, and this is two editors beyond me—Dr. Weber first and now Dr. Hanna. So, that was one. Then, with the issue of retirement too, I could have continued, but I decided, no. I had to deal with the retirement of my father from 5000 miles distance. He didn't want to retire. I had to sort of say, "Dad, it's time that you quit surgery because people are telling me that you are getting not as sharp as you were before." I had to deal with asking Dr. Ballantyne to retire, which can you imagine the clan of the Mitchells—George Mitchell? They were ready to get my guts, because how could I do that? But the man was not anymore—and the nurses were starting to complain. So, as I say, yes, he had been a great man, but to let somebody get into the latter part of their life and still be there and you have to ask them to leave is horrible.

Tacey Ann Rosolowski, PhD

2:10:22.9

Now, did you step away from clinical practice because you felt you were at the point where—?

Helmuth Goepfert, MD

2:10:27.4

No, I said it's time for somebody else to take care of this. And I told the guys, "Listen, when do you want me to stop seeing patients?" They said, "For us who have to take on the load, it's best if you do such-and-such," and I did such-and-such. So, as I say, since I've retired, I haven't touched a patient. I participate in some of the educational venues, but less and less because I am away from the clinical practice and things have changed. But one principle is you have to go before they make you go. And on the other side, there are so many people that are in what I call the pipeline that need to ascend and become chairman and do something different. I mean, what Randy has developed is totally different from what I was doing and has been very successful.

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Tacey Ann Rosolowski, PhD

2:11:23.0

What is it that he's doing that's a different direction?

Helmuth Goepfert, MD

2:11:26.6

He certainly has increased the number of subspecialties in the department, has created some additional clinical, I would say, teams that work in base-of-skull and ear surgery and so forth, and he definitely has put on the national billboard the issue of quality of care. He has made it his presidential address when he became president of the Head and Neck Society and has created multiple programs here at this department, plus, for example, the head and neck program down in Orlando that was super biased by this department and sort of made sure that the same principles would be applied over there that were applied here. So, in that sense, he has done quite a bit. There is one new staff member now, Carol Lewis, who is predominantly devoted to quality of care and measurement thereof.

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Chapter 19

A: View on Career and Accomplishments

A Career of Building Respect for Interdisciplinary Teams and Earning the name, Dr. Fixit

Story Codes

A: Contributions

A: Activities Outside Institution

A: Career and Accomplishments

A: Post Retirement Activities

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Definitions, Explanations, Translations

C: Professional Practice

C: The Professional at Work

A: Professional Values, Ethics, Purpose

C: Funny Stories

Tacey Ann Rosolowski, PhD

2:12:43.0

As you look back over what you accomplished during your time prior to your retirement from MD Anderson, what is it that you're particularly gratified to have accomplished?

Helmuth Goepfert, MD

2:13:00.4

That I got three sons through medical school without them having any financial debt—(laughs)—and a daughter through college without financial debt that never had to pay a penny. So that was the most gratifying thing. But, as I say, I think I sort of built upon what other people before me had done. I tried to use the resources of the institution wisely in order to make sure that it became visible. Head and Neck, ever since then, has been on the national scene as the number-five program in the country—otolaryngology program in the country—although we treat cancer only. We don't treat any benign disease. But—what is it?—the news report?

Tacey Ann Rosolowski, PhD

2:14:06.4

Something News and World Report.

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Helmuth Goepfert, MD

2:14:08.2

News and World Report—the *News and World Report*. The Head and Neck Department is number one in the institution, and it's number three or four in the nation, which is astonishing because we treat only cancer. But that has been always there ever since they started that. I don't know how they measure that—I don't care—but, as I say, it is a visible hallmark. And, as I say, the fact that we have a very well-run fellowship training is something that has been built upon ever since Dr. Jesse was the first one who took fellows in training specifically for head and neck only. Before that—before the '60s—they would become surgical oncologists, but they would do abdomen, they would do breast, they would do colon, they would do sarcoma, melanoma, everything. Dr. Jesse focused this on head and neck only, and we continued that tradition.

Tacey Ann Rosolowski, PhD

2:15:20.9

Is there something that you wish you had accomplished but for some reason were not able to bring to completion?

Helmuth Goepfert, MD

2:15:29.7

No, I don't bemoan anything. The fact the electronic book went by the wayside and everybody has forgotten it, but that's an issue of the times—that's an issue of the time. The one thing that bothers me now is that—Fortunately SCOPUS has come about, and SCOPUS allows us to review literature prior to 1985.

Tacey Ann Rosolowski, PhD

2:15:52.3

I'm missing the name of that.

Helmuth Goepfert, MD

2:15:54.1

SCOPUS. S-C-O-P-U-S. SCOPUS is a program that exists here in the organization that is run by Elsevier. It basically has reviewed the literature all the way back to the 1940s so that finally, on the electronic version, you can get articles from way back then. For almost two decades, ever since the electronic system came to bear and the Index Medicus has disappeared—you remember the Index Medicus? Index Medicus, before the advent of the computer, was a publication of articles in the literature, and it was basically hardbound. It sat in a library. You would pull it down, look up whatever disease it was you wanted to look up, and there were the references. Then, that all translated into the electronics. Index Medicus sort of disappeared. It was changed, yes, and then it eventually became for publications prior to. So SCOPUS is the place to find that.

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Tacey Ann Rosolowski, PhD

2:17:09.3

That's neat.

Helmuth Goepfert, MD

2:17:12.1

Remember that for if you ever need to look up somebody; go into SCOPUS. They know it up in the library. They taught me that.

Tacey Ann Rosolowski, PhD

2:17:21.0

Great. And you passed it on. Thank you. What do you hope—? Is there something in your philosophy or a program that you've created that you hope has been carried on and will be carried on in this department?

Helmuth Goepfert, MD

2:17:39.1

The respect for interdisciplinary care. The only thing that I'm sort of ambivalent about is I have a youngest son who is doing his residency in Ear, Nose, and Throat right now. He wants to do a fellowship in head and neck cancer. But with all the advents of additional and new treatments that eliminate surgery from the management of cancer, I wonder should he really do this? But it is his life and his decision. (laughs) But, as I say, the big operations that we used to do are not necessary anymore, to some extent. There are other treatments available. There are certain modifications of it. Will head and neck cancer surgery disappear? Probably not for a while, but how soon? It's hard to tell.

Tacey Ann Rosolowski, PhD

2:18:34.3

What are some statistics on that? I mean, how have numbers risen or fallen?

Helmuth Goepfert, MD

2:18:40.3

In general, head and neck cancer has fallen in all aspects of the squamous carcinomas of the upper aerodigestive tract, except tonsil and base-of-tongue that are increasing. The reason that that is increasing is with the advent of the human papilloma virus as a causative agent. But as smoking has decreased, much of the cancer of the oral cavity has sort of diminished significantly in incidents. We used to see a lot of floor-of-mouth cancer. Not anymore. We used to see a lot of cancer in the oral cavity, the side of the tongue. It's much less than it used to be because there's

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less smoking. I'll never forget the picture in the '60s of a painter that, in order not to get his cigarettes wet with paint, would push it out of the cigarette box, put it in his mouth, turn it on, and let it hang there while he was painting. Then, so he would have to light another cigarette, before the cigarette was over, he would get out another cigarette, put it in his mouth, light it with that cigarette, and keep smoking. So this was the real chain smoker.

Tacey Ann Rosolowski, PhD

2:19:59.2

I think Jackson Pollack used to do that.

Helmuth Goepfert, MD

2:20:01.7

Yeah, and he used to do it for eight hours a day. So that is how— Now that has disappeared, basically. So there is a change in the epidemiology of certain cancers. Thyroid cancer may or may not be on the increase. It seems to be, or is it that we are treating more because we're finding more the thyroid cancer with all the imaging that we do? God knows. But, as I say, there are the salivary glands still treated by surgery, but as new molecular identifiers evolve, there may be a molecular target that will eliminate that type of cancer as well. It will be treated by that plus radiotherapy or something like that. So, I don't know, but I really don't— The basic philosophy that I always espouse—I lived, during my professional career, in Sugar Land. So I traveled in twenty miles and drove back twenty miles, and it was during the time that Highway 59 was sort of being rebuilt and 288 didn't exist yet, so it was a long trek back and forth, but I sort of developed the philosophy that you have to be happy to come to work in the morning, and you have to be happy leaving work at night to go home again. So those two things were important. And driving for twenty miles allowed me to calm down enough so I wouldn't kick the door when I got home. (laughs)

Tacey Ann Rosolowski, PhD

2:21:39.2

Let me ask you one more kind of institution question. When you were going through the various presidents, you mentioned Dr. DePinho, but you didn't give me your impression.

Helmuth Goepfert, MD

2:21:51.6

I don't know him.

Tacey Ann Rosolowski, PhD

2:21:52.4

And you have had no contact with him?

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Helmuth Goepfert, MD

2:21:54.6

No. I haven't even seen him.

Tacey Ann Rosolowski, PhD

2:21:55.8

Okay.

Helmuth Goepfert, MD

2:21:56.9

Pictures only.

Tacey Ann Rosolowski, PhD

2:21:57.8

Pictures only? All right. I wanted to ask you about the various awards that you've received over the years. There have been a lot of them. You mentioned the Helmuth Goepfert Society that was created in 2002 yesterday when we spoke. I'm just wondering, are there any of those awards that have meant something special to you?

Helmuth Goepfert, MD

2:22:24.1

The one that was interesting was the award I was given by the Nurses Association of Houston.

Tacey Ann Rosolowski, PhD

2:22:31.9

That was in 1999?

Helmuth Goepfert, MD

2:22:33.3

In '99, and it was together with Denton Cooley.

Tacey Ann Rosolowski, PhD

2:22:35.8

Oh, Distinguished Surgeon Award from the Association of Operating Room Nurses of Greater Houston.

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Helmuth Goepfert, MD

2:22:41.9

Yeah, that sort of fell on me. I'd never heard of it. (laughs)

Tacey Ann Rosolowski, PhD

2:22:46.3

So what did that mean to you? Why was that a good award?

Helmuth Goepfert, MD

2:22:50.6

Because you work a lot with nurses in the operating room, and you interact with them. Yes, you work with them, and it's sort of interesting that they see you as somebody that deserves an award like that, because it's them who decide it. It's not anybody else. So here you have an organization that is non-physician giving you an award. That was sort of the unique thing about it.

Tacey Ann Rosolowski, PhD

2:23:17.3

What's your—I mean—when there's sort of a—how would you say it?—sort of a cultural view of the surgeon as the tough—?

Helmuth Goepfert, MD

2:23:26.8

Yeah, the macho—

Tacey Ann Rosolowski, PhD

2:23:28.0

The macho person, yeah, who yells and screams and gets the job done. So what's your style in the operating room when you work with the team? I'm wondering why the nurses felt this is the man to give the award to.

Helmuth Goepfert, MD

2:23:43.3

Because I tended not to, by and large, vent my frustrations at them, and they can be easy targets for that. When things get haywire or get sort of abnormal and intense, usually the ones that feel the brunt of it is the nurses. When DeBakey threw instruments and stuff like that, that's what it was. But, as I say, it is the perception that—I mean—from the very beginning, because I was brought up as a scrub technician—helping my dad way back then—I knew what these people meant to the whole teamwork in the operating room. That's what it was all about. So that when I

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got an award from them—because the nurses from the different hospitals that are in whatever society this was, they had to decide on certain people. So how they selected me I don't know, but it was a recognition probably of my influence I had in the operating room. So that's an interesting award. The other ones are sort of, yeah, you get them. They're there. You don't know what to do with them after you retire because there is no space in the house anymore. (laughs) I can give you the key for the place that I pay fifty dollars a month to keep everything in there. (laughs) And I don't know what my kids are going to do with them. I said, "Kids, if it has any wood on it, use it for the pyre where you're going to burn me."

Tacey Ann Rosolowski, PhD

2:25:29.8

Oh, that's funny. Is there anything that you would like to share from how you spend your time away from all your activities that kind of—?

Helmuth Goepfert, MD

2:25:46.1

I used to ride a motorcycle.

Tacey Ann Rosolowski, PhD

2:25:48.2

What kind?

Helmuth Goepfert, MD

2:25:49.9

I started off when I was in medical school. It was my only means of transportation. My dad gave me a motorcycle. That was in 1954. It was a one-cylinder BMW. I don't know if you have any knowledge of motorcycles. You don't seem to be the character for that.

Tacey Ann Rosolowski, PhD

2:26:06.5

You'd be surprised.

Helmuth Goepfert, MD

2:26:08.2

Then I bought a 500 when I was in medical school—in the last year of medical school. I was getting too much sinusitis, so I decided to trade the motorcycle for—I don't know if you've ever had a concept of the BMW Isetta. It was this little vehicle for two people, smaller than the Smart actually, which had a motorcycle engine in it. You opened it from the front, like this. That was the Isetta. I had one of those. And then I didn't ride a motorcycle until the late '70s, so there was

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a hiatus of at least twenty years. I got into motorcycling again and was basically helped along by Joann's [Goepfert] oldest brother who is a big motorcyclist, so I joined the group. I rode motorcycles basically and often rode to work, yes, but basically it was tours through the country. We went to California, we went here. It was basically the Honda Sport Touring Association, which is what it was called then. But I had a BMW. And, of course, the motorcycles increased tremendously in power and weight over the years. The BMWs were light—very light—compared to what is available now. So I basically started off by attending the courses that were given and was on the safe side and lucky side. I never had an accident.

But four and a half years ago I said, "This is enough," because I was—my reflexes were not fast anymore and I didn't have the strength to manage that beast if it was in a situation where you had to have strength. So I said, no, I haven't had an accident. Let's leave like that. I have an ability to set things aside, and once they are out of sight, they are out of mind, and I don't dwell on it anymore. It's gone; it's past. Goodbye. Fortunately, I have that from my mother. My mother always had that, so she is still capable of doing that and dealing with adult-onset macular degeneration. She is totally blind. She is ninety-nine, almost 100, and totally blind. She is, of course, desperate because she can't die. For her, life is totally miserable. She used to listen to music. She isn't doing that anymore. She cannot see anything. She used to listen to books that would come from Germany. There is a program in Germany for the blind that sends books on tape, and she would listen to that. Not anymore. But she always had an ability to accept what was coming and determine if she could handle it. If not, if it was something that was either unimportant or something that she couldn't handle, she put it aside and didn't think about it anymore, so I learned that from her. From my dad I have different qualities that have sort of carried me through life. As I say, it is interesting, when you think back at your life, why things happen. I don't have any big hobbies. That's one of the problems. I'm not a fisherman. I'm not a hunter. I don't play tennis. I don't play golf. I keep my fitness because, yes, I need it in order to survive. But it's not an issue that I miss anything of that. I read a lot. I like to listen to music. I'm going to make a decision now to probably quit Physicians Network and decide before it's too damn late to take a car and drive all up the west coast all the way to Vancouver. Joann may join me somewhere along the way. She doesn't want to go the whole way. I want to do the same thing around Boston. Our two sons, one is here and the other one is there, so I want to do the coastlines. Another thing we enjoy is— We enjoy car trips, basically, and hopefully the storm is not too bad. We want to go for the holiday to Alabama, where my oldest kids are. So that may happen or may not happen, but now I'm in the process of— I have a BMW, a 3-Series convertible, but that's not really a good road car for longer trips, so I will very likely buy another SUV and add that to the load of cars around the house, which my wife is going to bemoan, but so be it.

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Tacey Ann Rosolowski, PhD

2:31:12.8

Well, you kind of reminded me about when you were talking about how at the age of nine you drove a tractor, and at the age of twelve you drove a truck, and you still have your love of vehicles.

Helmuth Goepfert, MD

2:31:24.0

Yeah. But I'm not a fanatic about it. Once it has served its purpose, it's gone bye-bye. So, I like it, yes, I wash my own cars and polish my own cars. I do all of that stuff. I used to change the oil in my own cars, but that's now very much sophisticated with all the other stuff that has to be done—reset the timer of the car and all of that stuff. Forget about it. I'm not that flexible anymore to get under a car. So those things had their time. I remember we used to fix cars around my house, not that we had them on blocks in the front yard, but, as I say, that was sort of an entertainment. I remember when we lived out in Sugar Land we lived in Sweetwater. It was sort of a cul-de-sac. The kids in the neighborhood called me Dr. Fixit because I would fix their bicycles. (laughs) Dr. Fixit fixed the bike. So I would fix their bicycles and get them in working order. The last time I hunted really was with my dad. Back in 1959, we went deer hunting in Argentina, and the trophy of that hunt I have hanging on our patio, because it was a nice twelve-ender. So that was the last time I really went hunting. Fishing, I don't really like fishing in the hot, murky water, so I don't fish around here. My wife says, "You need to take up fishing." I said, "Not here." The climate in Houston I can't tolerate. Summer climate for me is out, but I have to live with it, so fine.

Tacey Ann Rosolowski, PhD

2:33:14.7

So do we all.

Helmuth Goepfert, MD

2:33:17.9

I have to live with it. It is because basically I am more or less a loner, but Joann likes friendship. She likes conversation. She has her friends. I said, "Okay. We'll stay here." Our kids were here, sure, but now our kids are—one is there and is not going to come back, and Ryan [Goepfert] is in California, and God knows what he's going to do after residency.

Tacey Ann Rosolowski, PhD

2:33:41.3

It's a good time to make the trip to see them.

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Helmuth Goepfert, MD

2:33:44.3

Yeah. That's right.

Tacey Ann Rosolowski, PhD

2:33:46.3

Is there anything that you'd like to add?

Helmuth Goepfert, MD

2:33:49.5

No.

Tacey Ann Rosolowski, PhD

2:33:50.5

Well, thank you very much for talking to me.

Helmuth Goepfert, MD

2:33:53.1

And I will make sure that you get the— Did Mary Jane [Schier] give you that? If you are going to be a historian, check out the *Cancer Bulletin* history before it's forgotten.

Tacey Ann Rosolowski, PhD

2:34:07.3

And SCOPUS.

Helmuth Goepfert, MD

2:34:08.6

Yes. SCOPUS is going to be helpful for you. And you look it up by author. Where was this author? MD Anderson, you put in, and it shows the list of the author and it even gives an index.

Tacey Ann Rosolowski, PhD

2:34:22.4

That's great.

Helmuth Goepfert, MD

2:34:23.9

So, he has published this much. How many times was it cited? Then you get the citations for all the articles, which is a very interesting way to measure publication because you see how useful that publication has been out there. That didn't exist either before. All right.

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Tacey Ann Rosolowski, PhD

2:34:45.0

All right. Well, thank you very much.

Helmuth Goepfert, MD

2:34:46.3

If I need to do anything for you, let me know.

Tacey Ann Rosolowski, PhD

2:34:48.4

I will. And I'm turning off the recorder at 4:32.

2:34:52.4 (End of Audio 2)