

## **C. Stratton Hill, Jr., M.D**

Interview #9

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## **C. Stratton Hill, Jr., M.D.**

Interview #9

### **Interview Profile**

#### **Interview Information:**

Four interview sessions: 14 February 2012, 17 February 2012, 20 February 2012, 28 February 2012

Total approximate duration: 9 hours and 20 minutes

Interviewer: Tacey A. Rosolowski, Ph.D.

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

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

Dr. C. Stratton Hill, Jr., M.D. (b. 28 July 1928, Humbolt, Tennessee; d. 2015) came to MD Anderson in 1963 as an oncologic endocrinologist with a specialty in thyroid cancer. By the 1980s, his career had expanded to include pain management, the work for which he is perhaps best known. Dr. Hill served as the Associate Director of the Ambulatory Care Clinics from 1974-1979. In 1981 he set up the Pain Clinic (now the Pain Management Center) and served as its director until 1992. In 1996 Dr. Hill received the American Cancer Society Humanitarian Award, given for his dedication to improving cancer control and for his accomplishments in human welfare. Post retirement, Dr. Hill has worked with the Open Door Mission Foundation for Recovery and Rehabilitation in Houston. He is a Professor Emeritus and Internist Emeritus in the Department of Symptom Research. Dr. Hill retired in 1996. He passed away in December 2015.

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

Personal and educational background; faith

Research: thyroid cancer; pain management and policy

MD Anderson history and culture: research innovation

Pain management: development of field; first book on; cultural and social factors influencing use of opioids

Developing the Ambulatory Care Clinic

Hospice and MD Anderson

The Texas Cancer Council; Texas Cancer Pain Initiative

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

**Research Medical Library: Historical Resources Center**

ORIGINAL Interview Profile: Dr. C. Stratton Hill, Jr., M.D.

Submitted by: Tacey A. Rosolowski, Ph.D.

Date Revised: 24 June 2014

Dr. C. Stratton Hill, Jr., M.D. (b. 28 July 1928, Humbolt, Tennessee) is a Professor Emeritus and Internist Emeritus in the Department of Symptom Research at the MD Anderson Cancer Center. This interview is conducted over four sessions for a total of 9 hours and 20 minutes. Dr. Hill came to MD Anderson in 1963 as an oncologic endocrinologist with a specialty in thyroid cancer. By the 1980s, his career had expanded to include pain management, the work for which he is perhaps best known. Dr. Hill retired in 1996. These sessions, conducted by Tacey A. Rosolowski, Ph.D., are conducted at Dr. Hill's home in Houston, Texas during February of 2012.<sup>1</sup>

Dr. Hill was awarded his BA from Rhodes College in Memphis, Tennessee, and went on to the University of Tennessee's College of Medicine, where his M.D. was conferred in 1954. He had a clinical clerkship in Scotland before joining the Air Force, where he was Chief of Professional Services from 1956-'58. At MD Anderson, Dr. Hill served as the Associate Director of the Ambulatory Care Clinics from 1974-'79. In 1981 he set up the Pain Clinic (now the Pain Management Center) and served as its director until 1992. In 1996 Dr. Hill received the American Cancer Society Humanitarian Award, given for his dedication to improving cancer control and for his accomplishments in human welfare. Post retirement, Dr. Hill has worked with the Open Door Mission Foundation for Recovery and Rehabilitation in Houston: in 2010 he was awarded the Mayor's Volunteer Houston Award (by Mayor Annise Parker).

In this interview Dr. Hill covers his three-part career in thyroid cancer research, administration, and pain management. He also traces the broad networks of people he has worked with (and whose help he has leveraged) in these areas. He worked closely with Dr. R. Lee Clark for many years and here offers insight into Dr. Clark's attitudes and leadership style. Dr. Hill is candid, quick to point out political contexts of medical events, and equally quick to share a vivid anecdote to illustrate a personality a patient's condition, or a medical dilemma.

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<sup>1</sup> There is occasional background noise as the phone rings or members of Dr. Hill's household converse.

## **C. Stratton Hill, Jr., M.D.**

Interview #9

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*Publishing the First Book on Pain Management*

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Segment 00B

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*A Southern Baptist Background Inspires a Life of Service*  
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## **C. Stratton Hill, Jr., M.D.**

Interview #9

### **Segment Summaries**

Interview Session One: 14 February 2012

Segment 00A  
*Interview Identifier*

Segment 01  
*Early Experiences with Physicians and Illness*  
A: Personal Background

Story Codes  
A: Character, Values, Beliefs, Talents  
A: Personal Background  
A: Professional Path  
A: Inspirations to Practice Science/Medicine  
A: Influences from People and Life Experiences  
A: The Patient  
D: The History of Health Care, Patient Care;

In this segment, Dr. Hill links his choice of career to his own bout with osteomyelitis as a youngster and the care that his family physician provided. He gives an interesting portrait of disease in the thirties/forties—including being anaesthetized with cocaine—and the role of the small-town doctor.

Segment 02  
*Developing Interests in Oncology and Pain Management*  
A: Professional Path

Story Codes  
A: Professional Path  
A: Military Experience  
A: Inspirations to Practice Science/Medicine  
A: Influences from People and Life Experiences  
D: The History of Health Care, Patient Care  
B: Personal Background  
A: The Researcher  
C: Mentoring  
C: Evolution of Career  
C: Professional Practice  
C: The Professional at Work

In this segment, Dr. Hill sketches his professional training, including his experiences in the 8<sup>th</sup> Air Force Strategic Air Command base in Plattsburg, New York, where he became Chief of Professional Services and encountered cancer cases that convinced him to apply for a residency at Memorial Sloan-Kettering Cancer Center. He then talks about the New York phase of his early career. He paints an interesting picture of the state of medicine and of different hospitals in New York at the time.

### Segment 03

#### *An Evolving Specialty and Coming to Texas*

A: Joining MD Anderson/Coming to Texas

#### Story Codes

A: Professional Path

A: Influences from People and Life Experiences

D: The History of Health Care, Patient Care

B: Personal Background

A: The Researcher

C: Evolution of Career

Dr. Hill begins this segment by describing how the politics of building a new medical school in Jersey City influenced his career path. He talks about meeting Dr. Ray Houde, who studied analgesics and spurred his early interest in pain medications. He also met Roulon Rawson who had treated thyroid cancer and radioactive iodine and “that rubbed off on everyone who worked with him.” He rotated through the general endocrine service at Bellevue Hospital, which helped convince him to focus on that specialty. He talks about the professional connections that alerted him to a position at MD Anderson.

### Segment 04

#### *Thyrocalcitonin –Confirming the Marker for Thyroid Cancer*

A: The Researcher

#### Story Codes

A: The Researcher

A: Joining MD Anderson

A: Definitions, Explanations, Translations

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

D: The History of Health Care, Patient Care

C: Discovery and Success

In this segment, Dr. Hill talks about his work in the Department of Medicine when he first arrived at MD Anderson in 1963. He describes discovering a “treasure trove” of cases of medullary thyroid cancer. He sketches his epidemiological studies of families and his study of the nature of thyroid cancers, then goes into much greater detail on his study of calcitonin in the thyroid, determined to be a marker for thyroid cancer, as well as gene-related calcitonin.

### Segment 05

#### *MD Anderson in the Sixties –A Culture of Innovation*

B: MD Anderson Past

Story Codes

B: Institutional Mission and Values

B: MD Anderson Culture

C: Portraits

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: MD Anderson History

B: MD Anderson Snapshot

In this segment, Dr. Hill compares MD Anderson to Memorial Sloan-Kettering and the Mayo Clinic (Dr. Clark's model for MD Anderson), noting that, at the time, MD Anderson could not replicate the cultures and traditions of these well-established services. Dr. Hill comments on Dr. Clark's leadership style and vision and the innovative ideas he implemented at MD Anderson.

Segment 06

*Collaborations with Dr. R. Lee Clark and the Climate for Research at MD Anderson*

B: The Researcher

Story Codes

C: Discovery and Success

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

C: Collaborations

B: Institutional Politics

C: Portraits

In this segment, Dr. Hill talks about the research connections he shared with Dr. R. Lee Clark, also a thyroid surgeon. He talks about standard procedures for treating thyroid cancers. Dr. Hill concludes the interview with some comments on how basic and clinical scientists collaborated very informally during his first years at MD Anderson.

Interview Session 2: 17 February 2012

Segment 07

*Publishing the First Book on Pain Management*

A: The Researcher

Story Codes

C: Discovery and Success

B: MD Anderson Impact

A: The Researcher

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

D: The History of Health Care, Patient Care

In this segment (which begins when the Interviewer switches on the recorder during an informal discussion) Dr. Hill talks about his efforts to publish the first book on his work in pain management, *Drug Treatment of Cancer Pain in a Drug-Oriented Society*. He explains that pain management is a complex societal and medical issue that is “like trying to pick up a greased watermelon out of a swimming pool.”

Segment 00B  
*Interview Identifier*

Segment 08  
*Understanding the Problem of Pain Management in the 70s and 80s –at MD Anderson and Beyond*  
B: Building the Institution

Story Codes  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
A: The Researcher  
A: The Clinician  
A: Overview  
A: Definitions, Explanations, Translations  
C: Human Stories  
C: Offering Care, Compassion, Help  
C: Patients  
C: Cancer and Disease  
B: MD Anderson Impact  
B: Critical Perspectives on MD Anderson

In this segment, Dr. Hill talks about pain management issues at MD Anderson. He begins by talking about the Pain Clinic, an ad hoc clinic that undertreated pain, a typical approach at the time, since chronic pain is a problem for patients who *live*, and cancer patients were just starting to live longer. He explains the three major causes of pain for the cancer patient and talks about his philosophy of addressing “pain in the cancer patient,” rather than cancer pain. He talks about the knowledge base about pain that needed to be created, including information about dosages, drug mechanisms and administration protocols, the individuality of patients, etc.

Segment 09  
*A Pain Clinic for MD Anderson*  
B: Building the Institution

Story Codes  
A: The Researcher  
A: The Clinician  
A: The Administrator  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
B: MD Anderson History

D: Understanding Cancer, the History of Science, Cancer Research  
D: The History of Health Care, Patient Care

Dr. Hill begins this segment by explaining why he left the Directorship of the Ambulatory Care Clinics (Mays Clinic) specifically to start a true Pain Clinic with a multidisciplinary team of practitioners, including a therapist who worked with relaxation (inspired by the model of Dr. John Bonica). Throughout this discussion he mixes observations about administration, clinical practice and research to give a portrait of how he began to explore effective use of opioids, culminating in his realization that cultural/societal beliefs prevented other physicians from aggressively treating pain with opioid drugs.

#### Segment 10

*Pain Management and Opioids: Today and in Historical Perspective*

A: Overview

#### Story Codes

D: Cultural/Social Influences

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

D: The History of Health Care, Patient Care

A: Critical Perspectives

A: Overview

A: Definitions, Explanations, Translations

In this segment, Dr. Hill explains that American culture does not easily distinguish between the abuse and legitimate use of opioid drugs. He summarizes points he made in an interview he gave for the television program, *60 Minutes* related to a controversial colleague in pain management, Dr. William Hurwitz. Dr. Hill explains that misunderstandings about the nature of what addiction effect physicians, pharmacists, law enforcement agents, media and, of course, patients. To set context for this discussion, Dr. Hill sketches the history of drug regulations and the study of pain, going back to the Civil War (and the understanding of phantom pain), describing pain and pain control mechanisms (e.g. the 'gate theory') in vivid terms. He tells several stories about patients grappling with pain (at times to the point of suicide attempts), and the treatments he explored to ease their suffering.

#### Segment 11

*Pain, Opioids and the Challenge of Working with Patients –and with Government Regulations*

A: Overview

#### Story Codes

A: Overview

B: MD Anderson and Government

A: Activities Outside Institution

A: The Clinician

A: The Administrator

A: The Leader

C: Discovery and Success

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients

Dr. Hill begins this segment by explaining the problem that triplicate prescription forms present to pain management. Since one copy of a prescription for an opioid goes to the police, physicians can be reluctant to prescribe (adequate) pain medication for fear of legal prosecution. Dr. Hill then talks about his related work with Texas Lt. Governor Bill Hobby to write the "Intractable Pain Treatment Act" (1989), adding many observations about how politics can influence medicine. He also talks about lawsuits against physicians who prescribe opioids and the lengths patients will go through to acquire adequate medication. He discusses "*My Word Against Theirs*"...*Narcotics for Cancer Pain Control* (1990-'91), an award winning video ("Heart of Wisdom Award" SMF "Gold Award" [First Place] for the Eighth Biennial John Muir Medical Film Festival in the category of "Patient Care") he produced with the MD Anderson Media services and a 1996 episode of *60 Minutes*, during which he discussed a lawsuit against physician William Hurwitz for prescribing narcotics. Dr. Hill then talks about obstacles that still prevent the medical profession from adequately treating chronic pain. He also discusses the need to teach pharmaceutical companies how to tailor medications to maximize pain relief and avoid toxicity.

### Interview Session Three: 20 February 2012

Segment 00B  
*Interview Identifier*

Segment 12  
*A Brookhaven Laboratory Study in the Marshall Islands*  
A: The Researcher

Story Codes  
A: The Researcher  
A: Activities Outside Institution  
D: Understanding Cancer, the History of Science, Cancer Research  
D: The History of Health Care, Patient Care

In this segment Dr. Hill speaks about his involvement (and that of other MD Anderson personnel) with the Brookhaven National Laboratory studies of the effects of nuclear fallout in the Marshall Islands. He describes his work with patients in the Islands. He then talks about how MD Anderson became an important treatment center for thyroid cancer because of the use of the "avant garde therapy" of radioactive iodine, noting that Dr. Clark was responsible for bringing the significant researchers together.

Segment 13  
*The Emerging Need for an Ambulatory Care Clinic*  
B: Building the Institution

Story Codes  
B: MD Anderson History  
A: Overview

D: Understanding Cancer, the History of Science, Cancer Research  
D: The History of Health Care, Patient Care  
B: Controversy  
B: MD Anderson Culture  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches

In this segment, Dr. Hill explains that the need for a new clinic grew in part with the increasing use of (the controversially) aggressive chemotherapy promoted by Dr. Emil J Freireich [Oral History Interview], Emil Frei and others in the new Department of Developmental Therapeutics. He talks about the tension created between MD Anderson's "Old Guard" as this "New Guard" increased the institution's reputation and patient volume.

#### Segment 14

*Setting Up the New Ambulatory Clinic (Mays Clinic) –And ReDesigning It*

B: Building the Institution

#### Story Codes

B: MD Anderson Culture  
B: MD Anderson History  
B: Building/Transforming the Institution  
B: Multi-disciplinary Approaches  
C: Portraits  
C: Professional Practice  
C: The Professional at Work  
C: Patients

In this segment, Dr. Hill offers a comprehensive view of his work setting up the Ambulatory Care Clinics and serving as Director from 1974 to '79 (noting that he learned to work with Dr. Clark's leadership style effectively during this period). A new Clinic was needed to serve the crowds of patients standing around as if "in feedlots." Dr. Hill discusses several topics: MD Anderson's acquisition of the land and money to build the new clinic; the challenges of dealing with a new building whose architects had not planned well for specific medical uses and needs; personnel upheavals; evaluating the function of the building and staff once the departments moved in; his work writing educational materials for patients on the procedures they would undergo; change in the policy of allowing patients to handle their records. Dr. Hill also describes his working relationship with Dr. R. Lee Clark, president of the institution at the time. He talks about calling a key meeting held to address design elements of the clinic that resulted in dehumanizing treatment of patients that was "not the way that anyone here wants to practice medicine."

#### Segment 15

*Remembering MD Anderson Presidents and Dr. Eleanor MacDonald*

B: Key MD Anderson Figures

#### Story Codes

C: Portraits  
B: MD Anderson Impact  
B: MD Anderson History  
C: On Texas and Texans

C: Leadership

Dr. Hill begins this segment by noting that Dr. Clark supported any change that would improve efficiency and positive effects for patients. He then goes on Eleanor MacDonald [Oral History Interview], an epidemiology specialist with a visionary sense of records organization: she established a system of data and records-keeping for MD Anderson that influenced the entire medical system in Texas. Dr. Hill notes that Miss MacDonald's work guaranteed the quality of MD Anderson research. He then offers additional observations about Dr. Clark, comparing his leadership style to Dr. Charles LeMaistre's [Oral History Interview] and discussing the transition as Dr. Clark stayed at MD Anderson during the beginning of Dr. LeMaistre's presidency of the institution. He recalls working with Roman Arnoldy, an engineer who organized the building of Rotary House (built on the model of a hotel attached to the Cleveland Clinic), which provides convenient and medically appropriate accommodations for patients. He also evaluates Dr. Mendelsohn's [Oral History Interview] leadership style with the previous presidents, praising his science as well as his administrative and fundraising skills.

Segment 16

*Preserving the MD Anderson Brand Despite Global Growth*

B: Institutional Change

Story Codes

B: Beyond the Institution

B: MD Anderson Culture

B: Building/Transforming the Institution

B: Growth and/or Change

B: The Business of MD Anderson

B: The MD Anderson Brand, Reputation

C: Portraits

In this segment, Dr. Hill discusses financial challenges that MD Anderson currently faces: challenges in expanding the MD Anderson culture beyond Houston while preserving the culture of care; competition between service providers. He also speaks about the new president, Dr. Ronald DePinho –what he appears to offer and also his lack of experience in the operation of clinical services.

Segment 17

*The Texas Cancer Council and the Texas Cancer Pain Initiative*

A: Professional Service beyond MD Anderson

Story Codes

A: Overview

A: The Clinician

A: The Administrator

A: The Educator

A: Activities Outside Institution

A: Career and Accomplishments

A: Post Retirement Activities

A: Definitions, Explanations, Translations

D: The Healthcare Industry

D: Politics and Cancer/Science/Care  
D: Fiscal Realities in Healthcare

In this segment, Dr. Hill talks about his appointment (by Lt. Governor Bill Hobby) to the Texas Cancer Council (President, 1992-94, 1994-6) and sketches his work starting up the Texas Cancer Pain Initiative (which began in the 1980s with an organizational meeting funded by the Hobby Foundation), an organization that lent its name to the attempts Dr. Hill and others were making to revise legislation with an impact on pain management. Reviewing the organization's educational efforts (in the late 80s or early 90s), he explains the political and financial reasons why it is more difficult to change pain management practices now than in the past.

Segment 18

*The Open Door Mission for Rehabilitation and Recovery; Awards*

A: Post-Retirement Activities

Story Codes

A: Contributions

A: Activities Outside Institution

A: Career and Accomplishments

A: Post Retirement Activities

A: Professional Values, Ethics, Purpose

C: Patients

In this segment, Dr. Hill talks about his involvement with the Open Door Mission for Rehabilitation and Recovery, where volunteers his time now that he is retired. He talks about his various awards, hoping that they bring attention to issues that need further attention and funding. He speculates that his interest in relief of pain came from his upbringing. [The interview cuts off]

Interview Session Four: 28 February 2012

Segment 00C

*Interview Identifier*

Segment 19

*A Southern Baptist Background Inspires a Life of Service*

A: Personal Background

Story Codes

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Inspirations to Practice Science/Medicine

C: Faith, Values, Beliefs

C: Formative Experiences

In this segment, Dr. Hill speculates that his commitment to care is rooted in his upbringing. He notes that he was raised Southern Baptist by practicing parents who had basic beliefs in a religion of love and service to others. (Dr. Hill believes all religions share these values; he is studying comparative religion now that he is retired).

Segment 20

*Hospice and MD Anderson*

A: The Clinician

Story Codes

B: MD Anderson History

C: Portraits

C: Patients

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

D: The History of Health Care, Patient Care

D: Cultural/Social Influences

A: Overview

A: Professional Values, Ethics, Purpose;

In this segment, Dr. Hill focuses on his work with the Hospice Movement. He describes the beginning of the Hospice movement in the U.S. (Dr. Hill attended the movement's first meetings; he serves on the Board of Houston Hospice.) He explains why Dr. Clark was anti-Hospice at the time. He describes some basic beliefs of the group he worked with, primary psychologists, and shares a number of stories that show how he helped shape how Hospice in Houston functioned and evolved into a centralized institution. He again notes that Dr. Clark was against Hospice and such efforts as "Reach to Recovery." He contextualizes Dr. Clark's attitude in the anti-MD Anderson movement in Texas (fueled by MD Anderson's fee-for-service policy) and explains why his attitude eventually shifted, though he stresses that MD Anderson "does not exist to preside over anyone's death."

Segment 21

*Expanding MD Anderson's Reputation*

B: Building the Institution

Story Codes

B: MD Anderson History

C: Portraits

C: Patients

B: The Business of MD Anderson

B: The MD Anderson Brand, Reputation

A: The Researcher

A: The Clinician

Dr. Hill begins this segment by explaining why so many ENT cancers were referred to MD Anderson to have the successful, less disfiguring surgeries for people "who were supposed to be dead." (He vividly describes the process of "walking a flap [of skin]" to perform reconstructive surgery.) He recalls that MD Anderson's reputation was secured via non-surgical interventions of radio- and chemotherapy, and compares it to the more surgical focus of Memorial Sloan-Kettering. He also illustrates Dr. Clark's "political moxie... that doctors in

general don't have" –a key factor in MD Anderson achieving prominence. Dr. Hill next returns to his own work on thyroid cancer, offering two specific cases in which he and other MD Anderson physicians were better able to diagnose cancer than others. He talks again about how he started up studies of families.

Segment 22

*An Endowment for Education, More Research, and a Think Tank*

A: Post-Retirement Activities

Story Codes

A: Contributions

A: Activities Outside Institution

A: Career and Accomplishments

A: Post Retirement Activities

A: Professional Values, Ethics, Purpose

A: Character, Values, Beliefs, Talents

B: Philanthropy, Fundraising, Donations, Volunteers

C: Donations, Gifts, Contributions;

During this segment, Dr. Hill talks about the endowment he made (1998) to MD Anderson for education in Pain Management that would show the complexity of pain associated with cancer. He talks about current plans to discuss toxicities from cancer treatment, "the backdoor of treating symptoms from cancer treatment," and hopes that the money will be used to support a "think tank" about symptom relief tied to individualized therapy.

## **C. Stratton Hill, MD**

Interview Session 1: February 14, 2012

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

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (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 and audio file in compliance with HIPAA and/or interview subject requests.

### **Chapter 00A**

#### Interview Identifier

***Tacey Ann Rosolowski, PhD***

0:00:03.2

I'm Tacey Ann Rosolowski interviewing Dr. Hill, Professor Emeritus, for the Making Cancer History Voices oral history project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Dr. Hill came to MD Anderson in 1963 as an oncologic endocrinologist. By the 1980s, his career expanded to include pain management. Dr. Hill retired in 1996.

***Tacey Ann Rosolowski, PhD***

0:00:56.9

I want to make sure that I have your current titles correct. You're Professor Emeritus and Internist Emeritus in the Department of Symptom Research at MD Anderson.

***C. Stratton Hill, MD***

0:01:08.7

Yes.

***Tacey Ann Rosolowski, PhD***

0:01:09.2

You are also a member of the Pain Research Group at MD Anderson.

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***C. Stratton Hill, MD***

0:01:13.9

Yes.

***Tacey Ann Rosolowski, PhD***

0:01:14.6

You're also Vice President for Health Affairs at the Open Door Mission Foundation for Recovery and Rehabilitation in Houston.

***C. Stratton Hill, MD***

0:01:26.7

Yes, alcohol and drugs, treatment, rehabilitation and recovery program.

***Tacey Ann Rosolowski, PhD***

0:01:34.0

Is this part of the same institution, Director of the Russell M. Scott Convalescent Care Center?

***C. Stratton Hill, MD***

0:01:43.3

Yes, that's what our convalescent care center is called.

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Interview Date: February 14, 2012

## **Chapter 1**

### **A: Personal Background**

#### **Early Experiences with Physicians and Illness**

Story Codes

A: Character, Values, Beliefs, Talents

A: Personal Background

A: Professional Path

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

A: The Patient

D: The History of Health Care, Patient Care

***Tacey Ann Rosolowski, PhD***

0:01:48.5

I want to begin with a little bit of background information, so please tell me where you were born and when and where you grew up.

***C. Stratton Hill, MD***

0:02:09.7

I was born on July 28th, 1928, in Humboldt, Tennessee. It's in the western part of the state. I was educated in the public schools of Humboldt and did my undergraduate work at Rhodes College in Memphis, Tennessee, a liberal arts college associated with the Presbyterian Church. I did one year at the University of Virginia Law School, decided to switch, and moved over to the University of Tennessee Medical School.

***Tacey Ann Rosolowski, PhD***

0:02:59.4

I noticed that you had started out in a law program. What was that about?

***C. Stratton Hill, MD***

0:03:04.2

At that time, the men who had been in World War II— I barely missed World War II, and every one of the veterans were coming back and going to school under the GI Bill. It was very much of a competition to get into medical schools, and they didn't have nearly as many medical schools as you do now, so I was delayed in getting into medical school. Actually, I wasn't really absolutely sure I could get into medical school, so I decided I'd try to get a degree in law in the meantime, and that's what I did. I went to the University of Virginia for law school. Went there at the same time that Robert Kennedy was in school there, in the law school, and so then I graduated from the University of Tennessee, College of Medicine and interned at the University of Texas Medical Branch in Galveston. And following that, I went into the US Air Force and was stationed in Plattsburgh, New York, and did a temporary duty stint at RAF base Greenham

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Common in southwest England. Following that, I started training at Memorial Sloan-Kettering Cancer Center in New York, which is associated with Cornell Medical School, and I finished training there and was recruited to MD Anderson.

***Tacey Ann Rosolowski, PhD***

0:05:14.2

I wanted to go back just for a second and ask you a couple of questions. First of all, was anyone else in your family involved in the sciences, and how did you end up deciding to go into medicine?

***C. Stratton Hill, MD***

0:05:29.8

Well, I think that was mainly related to me developing osteomyelitis in my left leg. When I was in—I guess it was around medical school—I mean—middle school. (audio pauses 0:05:53.4)

***Tacey Ann Rosolowski, PhD***

0:05:56.0

Okay, so you said you developed osteomyelitis in middle school.

***C. Stratton Hill, MD***

0:05:59.2

Yeah, I was probably in the middle school range at that time, and it was just when the sulfa drugs were coming out, otherwise that was a severe sentence medically at that time.

***Tacey Ann Rosolowski, PhD***

0:06:18.5

Can you tell me what osteomyelitis is?

***C. Stratton Hill, MD***

0:06:21.3

That's an infection in the bone. I had known several of my acquaintances there in the little town that had that, and they spent years in bed and had to have the— There were no antibiotics, so they'd keep the bone actually exposed. It had to be dressed with certain solutions and so forth, and that was very disturbing to me. But the sulfa drugs that had just been developed, basically by the Germans, were just coming out. I think I better get some water. Excuse me.

***Tacey Ann Rosolowski, PhD***

0:07:11.1

Okay, I'll just pause this. (audio pauses 0:07:14.0) I'm turning the recorder back on. Okay, we're recording.

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***C. Stratton Hill, MD***

0:07:19.3

Well, the sulfa drugs had just come out, and so I was treated with sulfa drugs, and that made all the difference in the world because the antibiotic course was very short. I didn't have to go through the surgical drainage, and I recovered and went back to school and so forth.

***Tacey Ann Rosolowski, PhD***

0:07:42.7

How quick was your recovery time?

***C. Stratton Hill, MD***

0:07:44.3

Oh, I was probably in bed a couple of months even then.

***Tacey Ann Rosolowski, PhD***

0:07:49.9

But even so, that was much quicker than—

***C. Stratton Hill, MD***

0:07:51.6

Oh, yeah. Everybody that I knew that had that was in bed for one to two years with this open drainage, and so it was a miracle, relatively speaking. Now, of course, you may or may not—still, osteomyelitis, when you get an infection in the bone—we see a lot of that at the mission where I work, and that's a big problem.

***Tacey Ann Rosolowski, PhD***

0:08:28.7

How do you get that? How do you contract that?

***C. Stratton Hill, MD***

0:08:31.7

Well, it's usually blood borne, and maybe sometimes it's a contiguous infection. It will be a soft tissue infection, and it will involve the bone, but the blood supply to the bone is not all that good, and so it's difficult to get the drug there. But now it's a lot better than it was, and you pick up on it a lot quicker. You don't see that long period of time that may—progressive when there's nothing that can be done about it.

***Tacey Ann Rosolowski, PhD***

0:09:13.0

How did that experience affect your thinking?

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***C. Stratton Hill, MD***

0:09:16.9

I had a lot of contact with the doctor at that time, and also, actually, when I was smaller, I had malaria—relapsing type of malaria—and so I can remember in the days when I would have that in the summertime. They'd call the doctor, and my mother was—she didn't like to call the doctor because the doctor would come to your house, and he'd sit and talk, and he wasn't very busy, and she needed to get things done. So he would sit and talk for a long period of time, and she didn't like that. And I can also remember one time I got cut in the leg, and they took me to the doctor, and he was asleep on his examining table when we went there. So doctors didn't have a whole lot to do in those days. There wasn't much they could do anyway.

That was in the days when you would—people had lobar pneumonia and they would— In this small town, people would gather at the person who was sick's house, and you would sit and wait for the crisis. And the crisis was when you either died or you got over the pneumonia yourself. That broke up the infection, and you were able to get rid of all the pus and everything that was in the lungs. People would sit until that was the course of that disease. The doctor didn't do it. I mean, there's nothing you could do except to give them support, treat the fever and the symptoms, and try to make them as comfortable as possible. And you hit a point at which you either died or you had this crisis where your body actually overcame the infection pretty much on its own. I mean, you could give them fluids and different things, but it was all nursing care, basically. There was nothing to it. And I remember that at the time, they'd organize, or your friends would organize. "We're going to sit between 10:00 and 12:00, midnight, and we're going to sit between 12:00 and 2:00," or whatever the shift was.

I had some contact like that, and then I had relatives, not in the immediate family. Actually, at that time, they would be probably going to medical school or hadn't even started going to medical school. But I've got a lot of cousins that are physicians. And then on my grandmother's side, on my mother's side, they all had to do with academic careers. At one time I had my cousin on a program that we put on here in 1984, who was professor and Chairman of the Department of Psychology at Stanford.

***Tacey Ann Rosolowski, PhD***

0:13:04.9

And what is that person's name?

***C. Stratton Hill, MD***

0:13:07.4

His name was Ernest Ropiequet Hilgard, spelled R-O-P-I-E-Q-U-E-T.

***Tacey Ann Rosolowski, PhD***

0:13:20.4

And the last name again was—?

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***C. Stratton Hill, MD***

0:13:22.2

Hilgard, H-I-L-G-A-R-D. They were German. He was from Belleville, Illinois. He became the Dean of American Psychology. He wrote the standard textbooks for—he and his wife. His wife was also a psychologist. They both went to Yale, and they both had PhDs. And when he took the job at Yale—I mean at Stanford—they would not let his wife work because of their rule against nepotism, so she just decided she'd go to medical school and become a psychiatrist. She was a child psychiatrist, and unbeknownst to me— It had nothing to do with me going into pain, but then Ernest—and he was called Jack—and I asked him one day, I said, “Why do they call you Jack?” And he said, “Well, when I left the University of Illinois”—and I think his degree at the University of Illinois was something like chemical engineering, something like that, and then he went on to get his PhD in psychology.

He said at that time, before computers, you would line up in front of a card table or something and go to sign up for the different courses. So he said he asked somebody there, “Where do you get in the line for this particular course?” And the guy gave him some instructions or something, and he went over, and he got in the wrong line. And the guy said, “Hey, Jack! I told you to get in this line over here!” And he said, “You know, I thought I liked that name,” and so he just started calling himself Jack. And so anyway, he went on to great heights, and he died just probably five or six years ago. He was 90-something years old when he died. I had him on the program here in 1984. What they did—what he did—he was an experimental psychologist, and they did a lot of work in hypnosis for the treatment of pain. His wife was named Josephine, and she collaborated with another psychologist, and they did pain treatment in children, hypnosis in children. Well, anyway that's—

***Tacey Ann Rosolowski, PhD***

0:16:28.2

When did you know that you wanted to be a physician?

***C. Stratton Hill, MD***

0:16:31.4

I kind of just thought that was something I'd like to do right after I had that contact and—

***Tacey Ann Rosolowski, PhD***

0:16:42.8

With the osteomyelitis you mean?

***C. Stratton Hill, MD***

0:16:44.6

What?

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***Tacey Ann Rosolowski, PhD***

0:16:44.9

With the osteomyelitis?

***C. Stratton Hill, MD***

0:16:47.3

That, and then my association with— And also, I had a lot of sinus trouble, and that was another thing. This was the pre-antibiotic days, and actually the osteomyelitis is a treatment with the sulfa drug—treated the sinusitis. But that's after I've had several surgical procedures.

***Tacey Ann Rosolowski, PhD***

0:17:14.9

You had a lot of challenges yourself.

***C. Stratton Hill, MD***

0:17:17.4

I did, and they put these things that they call windows, and basically it's just a hole in the sinus so it would drain out. But before they put that in there, they would actually put a big trocar with a syringe and force it through the bone and then pump saline solution and force all of the pus and everything out of the sinuses through the natural opening, which was swollen. They'd have to use a lot of force to do that.

***Tacey Ann Rosolowski, PhD***

0:17:52.9

It sounds painful.

***C. Stratton Hill, MD***

0:17:54.1

And they would anesthetize me with cocaine. And after hearing all these guys out at the mission there that do crack cocaine and all the things you hear about cocaine, I was either too dumb or it didn't affect me, because I don't remember anything but getting numb, as far as the cocaine was concerned. But they would take a piece of cotton and put it in your nose to anesthetize the mucosa in order to do this procedure, so I did have a lot of involvement with— And I had severe headaches with that sinus problem.

***Tacey Ann Rosolowski, PhD***

0:18:41.0

Did that experience—I mean—you had personal experience with pretty severe pain. Did that give you a different perspective when you went into pain management later, do you think?

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***C. Stratton Hill, MD***

0:18:52.1

I don't really know. I think making the connection between that would be— I'd have to have some sessions with Sigmund Freud to really figure that out. (laughs) But that's such a hiatus between my experience— I was in elementary school. I got interested in that because— I got interested in the pain part of it because of two things, I think. One was the fact that I became head of the clinic, and I knew that they were making some effort to see if they could have a pain clinic, and also—and I realized that we didn't do a very good job with pain at that time. Those were the two factors, and then, of course, I was working in brain peptides in my work in endocrinology. I worked with Roger Guillemin, who subsequently won the Nobel Prize, he and a couple other doctors that had to do with the hormones of the hypothalamus. All of that kind of came together later on.

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**Chapter 2**  
**A: Professional Path**  
**Developing Interests in Oncology and Pain Management**

Story Codes

A: Professional Path  
A: Military Experience  
A: Inspirations to Practice Science/Medicine  
A: Influences from People and Life Experiences  
D: The History of Health Care, Patient Care  
B: Personal Background  
A: The Researcher  
C: Mentoring  
C: Evolution of Career  
C: Professional Practice  
C: The Professional at Work

***Tacey Ann Rosolowski, PhD***

0:20:22.8

Well, maybe we can get back on track with your chronology then. I guess there were a couple of questions I wanted to ask you just before we get to the details about you coming to MD Anderson. I noticed the clinical clerkship you did in Scotland, and then you were Chief of Professional Services in the Air Force. I was wondering if those two experiences had any effect in developing your skills that you would use later. I've asked that question of some other people and was kind of surprised in the answers that they gave. I was just curious because it seemed like interesting experiences to have.

***C. Stratton Hill, MD***

0:21:02.5

Well, they were. They were tremendously interesting experiences, both from the disease and the practice point of view as well as the societal experience and working in a— At that time, they had the National Health Service, which we'd call it socialized.

***Tacey Ann Rosolowski, PhD***

0:21:37.6

And this was in Scotland?

***C. Stratton Hill, MD***

0:21:39.3

Yeah.

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***Tacey Ann Rosolowski, PhD***

0:21:39.7

And you were there in 1953.

***C. Stratton Hill, MD***

0:21:41.4

Right. And they also had diseases that we don't have in this country. They still had a lot of bovine tuberculosis, and see we had—in the United States, we controlled that by slaughtering any animals, and not using them, that tested positive with a tuberculin test. If they were tuberculin positive, they just would slaughter and throw them away. Britain was slow in doing that, so I got to see bovine tuberculosis, which actually has a predilection for the bones, and so you'd see a lot of people with a lot of scoliosis and kyphosis secondary to chronic tuberculosis because they were— At that time, anti-tuberculin drugs were available, and they were able to control it, but they still had the consequences of the deformities, and they still had some active cases.

***Tacey Ann Rosolowski, PhD***

0:23:02.3

How did that shape your experience, seeing those?

***C. Stratton Hill, MD***

0:23:04.4

Well, I just think it made me have a more—a greater appreciation for how far we've come in medicine, how epidemiology works to control diseases that impact society, like tuberculosis, and also from that point of view— I don't relate the two, but up at Saranac Lake in New York, when I was in the Air Force, probably the most famous tuberculosis sanitarium was in the Trudeau Sanitarium in Saranac Lake. All the socialites and famous people who got tuberculosis went to Saranac Lake. I mean, they could go anywhere they wanted to, but that's where most of those people went. Dr. [Edward] Trudeau was world famous, and he did a lot of experiments. It was thought that the cold itself was beneficial, so they built the sanitarium with these great verandahs and porches and things out there that would be screened in, and people would sit out, bundled up, in the cold. And they even did experiments in rabbits by giving them tuberculosis and putting them out in the cold, and then take other rabbits, give them tuberculosis, and not put them out in the cold. The rabbits in the cold did better than the rabbits—

***Tacey Ann Rosolowski, PhD***

0:25:12.8

So there was something to it.

***C. Stratton Hill, MD***

0:25:13.7

Well, I'm not sure about that. I mean, nobody was really, absolutely—I mean—nothing— It was

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just like the other part of medicine at that time that didn't have anything for osteomyelitis. They didn't have anything for tuberculosis either, and they didn't understand the epidemiology either. I read about people who nursed people who had tuberculosis. They didn't quite understand how you could catch it, all that kind of stuff. I was glad to see things like that. And then they had a lot of people up there that had rheumatoid arthritis, and so I got to see things like those diseases, and this had sort of a chronic disease component to it. That was really my first introduction to clinical medicine, where I actually went on the floors and did the work. It was interesting because the British system is much different from the American system—I mean—the educational system. Along about the eighth grade, you have to decide which track you're going to go on, whether it's a university track or whether it's the technical track, and if you get labeled in those tracks you have a hard time switching from one track to the other. I think they put Churchill in the wrong track to begin with. I think they said the only thing he could do would be the military, and that's where he was. But it was a problem with how you classified them was the problem.

But anyway, you go from what we would call high school; you go right into medical school. They had changed the curriculum from a five-year program to a six-year program, and I was right in there that year when nobody was graduating from the British schools—that year that they had to go the extra year before they graduated. I got to do a lot of things under the supervision of what they call a house officer, and that was a good experience, too, to do that. Then I came back and finished medical school. Then after that, I came to Galveston and did a—at that time, it was a classic rotating internship—and then went into the service. My assignment to Plattsburgh was interesting. I'd never been to that part of the world before, and it was just a brand-new base. It was just being built, and it was part of the 8th Air Force and the Strategic Air Command. So this was during the Cold War, and that was the part of the service that played war all the time. We had a lot of— They were building housing for enlisted men and their families. The town was not big enough to supply housing otherwise, so during that time there was a lot of stress on young families, young mothers who had to stay in a motel with two or three kids in one room.

***Tacey Ann Rosolowski, PhD***

0:29:37.2

Stress with a capital S.

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***C. Stratton Hill, MD***

0:29:38.1

That's right, and actually, this was an army base that was commissioned—I mean—that's what the Air Force took over, so it was an army base from the war of 1812. And I subsequently learned that people from the New York National Guard, for their summer camps, went to Plattsburgh, and that was where they did their summer training. But I got a letter from the air force saying, "We don't have much housing. You're going to have a hard time," so I decided to write a letter to the editor of the newspaper. I said, "Would you pass this letter on to the people who advertise in your newspaper that we're coming to Plattsburgh?" Well, he then put it in a little column he writes about different things, and so I began getting letters from people. He put my address in there, and I began to get letters from people, so I said, "Well, we're going to look at this place and this place."

***Tacey Ann Rosolowski, PhD***

0:31:02.1

You had your choice.

***C. Stratton Hill, MD***

0:31:03.1

I had a whole passel of places to choose from, and we decided on a place in West Chazy, New York. It was about 20 miles from the base. It was a family's home that there was only a daughter and a son left, and neither one of them had any children, so the daughter lived downstairs, and the son and his wife lived upstairs. The town was a post office and one—and they had the general store. The store had everything. They had meat, and he was the butcher, and then they sold televisions. But there was sort of a dry goods store there and the post office, and that was it.

***Tacey Ann Rosolowski, PhD***

0:32:10.7

It's a real small town.

***C. Stratton Hill, MD***

0:32:11.6

It was really a small town, and he was the local politician. Everybody up in that part of the world was Republicans. He was the bridge commissioner, the bridge across the northern part of Lake Champlain, and they had a big family—I mean—the wife, and they kind of took us over. We were just married, and they took us over as their children. They had decided to go— They had a house down on Lake Champlain, and they had decided to live down there year round. It was weatherized. So they decided they'd rent out this place. It was totally furnished, with all kinds of antiques, fabulous furniture, and everything.

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***Tacey Ann Rosolowski, PhD***

0:33:05.3

That was pretty deluxe for a young couple.

***C. Stratton Hill, MD***

0:33:06.7

Oh, it was really deluxe.

***Tacey Ann Rosolowski, PhD***

0:33:09.9

Now, this was 1957, 1958, right?

***C. Stratton Hill, MD***

0:33:14.8

It was basically— Yeah, end of '56. No. No, it was about— I got there in the spring of '56, I think.

***Tacey Ann Rosolowski, PhD***

0:33:27.4

And you were Chief of Professional Services?

***C. Stratton Hill, MD***

0:33:29.5

Well, not right off. There was the— I forgot now. There was a guy that was— There were just three or four doctors there, and then more and more doctors came. They already had a hospital that had been there for a long time, but it needed to be refurbished and modernized in terms of— and it had a huge parade ground with all these mansions around it and so forth. And so then, as it finally got larger and larger, they sent a bird colonel there as commander of the hospital. That's when he made me Chief of Professional Services there, which is kind of the provost of the one who runs the— He was kind of the politician. He didn't do much of— He didn't do any medicine. He was a doctor, but he just ran the hospital. He did most of the stuff with the general and other people. There were two wings at that base.

***Tacey Ann Rosolowski, PhD***

0:34:49.2

Was serving in that role a good professional experience for you?

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***C. Stratton Hill, MD***

0:34:53.5

Oh, yes, because at that time I really didn't know what I was going to do, so I really wanted—I mean—I didn't decide I was going to be a specialist, and so I wanted to have as much experience in just treating everything as I could. So we had obstetrics. I delivered babies. We had everything, except we didn't have any specialists. We didn't have people like orthopedic surgeons, and we had to use the local people. That was my job; I had to be the liaison with all the local community, so I got to know all the doctors. And through the family where we lived, we had a great big passel of friends up there that we kept up with them until they died, actually, and they were really fantastic. It was a fantastic experience social-wise and professional-wise because I had to deal with things that we couldn't take care of at the hospital. Basically, it wasn't necessarily we couldn't take care of them, but because most of our guys were just out of medical school and everything—one guy had one year of surgery, residency, and he did a few things like appendectomies and stuff like that—but we'd have to farm that out to the local community. I'd have to see to it that that was done properly, and I had to look over the billing because we had to pay them for that. We had all kinds of experiences in that regard.

***Tacey Ann Rosolowski, PhD***

0:36:53.6

So it was really a complete experience in running a service.

***C. Stratton Hill, MD***

0:36:56.3

Oh, yeah. It was something that you'd never get otherwise. And we had a lot of—like I said—a lot of stresses on not only the young married people but the young men who had nothing much to do. They'd go up to Montreal and get in all kinds of trouble. Plattsburgh was about 65 miles south of Montreal, so it's way up there. Then it's how are you going to keep them down on the farm once they've seen Montreal? And so we had—I had to do a lot of administrative work, and I had to look at people that they were going to separate for psychiatric problems and so forth. At that time, we had the military transport services. It was called METS. They would come around. We'd send people to military hospitals that could take care of elective stuff, and they'd fly and pick up everybody one day a week and take them to— We had to refer them. I had to do things like that. I had to set up the—make sure that the laboratory for the hospital was set up. We applied for accreditation for their hospital while I was there, and I had to oversee that.

***Tacey Ann Rosolowski, PhD***

0:38:55.5

So there was a lot of management and administration.

***C. Stratton Hill, MD***

0:38:57.6

Yeah. I got it started, but then I left before— You have to do a lot of stuff over a period of time and have stuff to show the accrediting people when they get there, and I started it, but then I left.

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Somebody else finished up with it. And then, of course, they were building a new hospital, and I didn't stay for that.

***Tacey Ann Rosolowski, PhD***

0:39:23.5

How did your career evolve and take you to your specialty?

***C. Stratton Hill, MD***

0:39:29.1

Well, my thinking was— We had a couple of patients who had cancer.

***Tacey Ann Rosolowski, PhD***

0:39:36.9

Was this at the air force base?

***C. Stratton Hill, MD***

0:39:38.2

At the air force base, and most of them were far advanced. I realized— I was taking care of the inpatients, and most of the other doctors were doing the outpatient work, so I got to see people who were sick, and then I'd have to maybe send them off to another hospital or something. Several people came in there with cancer, and I just figured I don't really know very much about cancer. It just struck me that maybe I'll go to Memorial Hospital in New York for a year and get a year in cancer and then finish the residency someplace else. So I wrote a letter, and I got a letter right back. I was going to be separated like in the spring or some time, so I thought, well— And they said yeah, they'd like to have me, but they wanted me to take— The residency year traditionally goes from July 1 to June 31 or June 30, and so I thought if I can get out at the end of the year, then maybe I could do six months in something else. So Memorial said, "Yeah, we've got a fellowship in clinical physiology, and this has to do with fluid and electrolyte balance."

I thought, well, that's great, and so I went down. Rulon Rawson was Chief of Medicine at Memorial, and he was a renaissance man, first class. He showed me around, said, "I can get you in here as a fellow in clinical physiology, and then we'll start the residency." The program was with Cornell because Memorial is associated with Cornell, so it was a Cornell program. It was a combination with the Memorial Sloan-Kettering Cancer Center, Bellevue Hospital, and the Manhattan VA Hospital. And so I thought, well, that sounds like— And he said, "Okay, I'll get you into the residency program beginning"—let's see, that was in '58. So I went from January 1, '58, to about the end of June of '58, as clinical physiology, and then I started my residency, which was nine months at Bellevue and three months at Memorial, and then the second year was— I don't know what the petitioning was. Then you had the VA in there somewhere. All that was over there on 1st Avenue at about 23rd Street to about 29th Street, over on the east side, and the Manhattan VA was right next to the Bellevue complex and everything.

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Then I thought, well, I had pretty good luck with writing the letter, so I decided that I would write a letter to the Atlantic Monthly. They had a little want ad section in there, and I think I bought a want ad and said I was looking in the vicinity of 68th Street, where Memorial was. I get this letter back from a woman that says, "I've got an apartment on 67th Street, between 1st and York." (laughs) We said, "Well, we'll look for it." Now, I had married Charlotte, my wife. She was a nursing student down at Galveston, and we got married during that year I was down there. So she was a nurse, and when we went to New York, she got her New York license and did some private duty in Plattsburgh, but she didn't do very much.

Then when we got down there, we looked at that apartment on 67th Street, and not having any experience with New York apartments we thought, well, this is kind of unusual looking, but it was probably a good apartment for New York. We decided we wouldn't take that one. And then the hospital, Memorial, hired Charlotte as a nurse, and they had housing for nurses. They had apartment houses around 68th, between 1st and 2nd and so forth, and so we got an apartment through the hospital. She worked on a pediatric floor in Memorial, and she didn't particularly like it with the children because at that time, if you had leukemia, you were dead. I mean, the kid was dead. I think the median survival rate from diagnosis to death at that time was like three weeks, and so she wanted out of there. So we thought, "We've got to move." We can't move until we get another apartment, so we would go down to where they sold the New York Times. And on Saturday, they have all the want ads and all that part, then the news part comes on Sunday morning, and they put it all together. You could go down there and get the want ads. You could buy that. So I'd go down, and we'd get the newspaper, and we would look through there. And I never will forget, I called this guy, and it was pretty early in the morning. I said, "I'm calling you about your apartment," and I could tell I woke him up. He said, "What took you so long?" because he wasn't expecting it to be out until Sunday. (laughs) I said, "Well, we'd like to come look at it," but I couldn't get off until that evening, so we— I don't know whether you want to hear all this or not, but anyway, we went down there. It was a brownstone. It was on East 30th Street, between what was 4th Avenue, but then they changed it to Park Avenue South, south of 34th Street, and it was nice. It was a floor-through, and it was rent controlled.

***Tacey Ann Rosolowski, PhD***

0:48:20.3

You just have housing luck.

***C. Stratton Hill, MD***

0:48:26.1

We knocked on the door, and this girl opened it just a bit, and she said, "It's okay." She let us in, and her boyfriend was in there, and he said, "We're going to sublet this. We're going to get married." But the reason I was cautious is because she apparently was some married guy's girlfriend, and they were going to skip. So anyway, we took that apartment, and we noticed— I was looking through Time magazine or something some time later, just a few months later, and

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there was a big article in there about this girl that had posed nude down by that old Treasury building down on Wall Street, where the statue is of George Washington. She posed nude, and the policeman arrested her. She beat the rap because the photographer was taking her picture but nobody else saw her, so nobody was offended, so the judge dismissed the case. And that was great because I could walk over to Bellevue, and I could catch the subway. There was a subway station at 33rd Street, and I could go up there and catch the subway, and actually they didn't even have— The first stop after Grand Central Station at that time for the express was 86th Street. It went all the way from 42nd to 86th Street. Then they were building the stop at 59th Street, where Bloomingdale's was.

***Tacey Ann Rosolowski, PhD***

0:50:29.0

Getting just the convenience of life all ironed out in New York is really important so you can get on with living. How did—? What did you end up doing during those years?

***C. Stratton Hill, MD***

0:50:41.1

Well, it was so interesting to me that time with physiology, and you won't believe this, but— Well, maybe you will. I was in that responsibility for two Cornell medical students, and they followed me around to see the patients that we were seeing. We had the first artificial kidney in Manhattan. It was at Memorial. We got all kinds of cases, people who had been run over by the subway and all kinds of trauma. The kidney occupied almost a whole room, and we'd even take that kidney over to Roosevelt Hospital sometimes. It was just a great experience. And of course, Memorial got patients from all over the world. There was a guy that I met there that was a clinical pharmacologist named Ray Houde, H-O-U-D-E, who I became great friends with, and he was studying analgesic drugs. He had a nurse that worked with him who I became great friends with, Ada Rogers. Everybody called her Little Red Riding Hood because she walked around with a basket. She was doing all these studies on analgesic drugs. That's how I got interested in pain drugs. And then when I finished— This is skipping over a little bit because it gives my relationship with Ray Houde a little bit more. I finished my residency there. Actually, I did two years there, two and a half years, because one was physiology. But I was going to tell you I had two students. One was Gordon Douglas, and the other one was Vincent Guinee. Both of them ended up here in Houston.

***Tacey Ann Rosolowski, PhD***

0:53:29.7

How amazing!

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***C. Stratton Hill, MD***

0:53:31.7

Gordon's father was Professor and Chairman of the Department of Obstetric Gynecology at Cornell and New York Hospital. Vincent Guinee became an epidemiologist. When I moved here, I would go over to grand rounds at Baylor, and there was Gordon Douglas sitting over there. He'd gone into infectious diseases. He was here two or three years, and then he took a job with some pharmaceutical company or some industry job, but then he became Chief of Medicine at Cornell. And when I was at— During my residency, part of our rotation was through New York Hospital, and there was a fellow over there who was a fellow in endocrinology. He was from some— I can't remember his name, but he was from some wealthy family. I remember, after I came to Houston, I saw him at a meeting once. I must have said something to him. I said, "What are you doing?" He said, "I'm Dean of Cornell Medical School," and before I could grab it I said, "What?" But anyway, I had a great experience there, so I decided to stay. I mean, forget that one-year business. And then about that time—

See, I said earlier that there weren't as many medical schools back then as there are now. In Manhattan there was NYU, Cornell, Flower and Fifth Avenue, which now is called New York Medical College, and that's just a standalone private. It was a homeopathic school for a long time. And you had Columbia Presbyterian. I'm not sure; I think they had SUNY and Brooklyn State University of New York. Brooklyn had a medical school at that time, and that was it, so New Jersey had no medical schools. They had some kind of antivivisection law over there, so they couldn't have a medical school. They got that law changed, and then the Bishop of Newark decided he wanted a medical school at Seton Hall, so he got all the priests to preach against approving the referendum to make a state medical school at Rutgers. I think Rutgers had a two-year medical school. I'm not sure about that, though. But anyway, I think that's what the state planned, but then the Catholics decided they wanted a medical school, so he put it at Seton Hall, and they put that in Jersey City. They were just getting that started, and they had no graduates, so it was sort of like the situation in Britain. They didn't have any residents. They had to go get the residents from different places. They had no chief residents, so Dr. Harold Jeghers—who had been Chief of Medicine at Georgetown, which is a rather prestigious medical school—he was a big Catholic, and he was born in Jersey City, so they prevailed on him to start a medical school—I mean—to come there as chief of medicine.

Well, that was pretty good. They assembled a fantastic faculty, because they got Dr. Jeghers, and he was well known as Peutz-Jeghers Syndrome and all that kind of stuff. He was kind of the physician in the Oslerian tradition. He was going around getting chief residents from different places, so he came over to talk to Dr. Rawson at Memorial, and said he would like to have a chief resident. Could he recommend somebody? He recommended me, so I went over and talked to him and decided I would do that. He had already gotten another guy who was born and raised in Queens, graduated from NYU. He was kind of the angry-young-man-without-a-cause, and his cause was that he didn't like the reputation that Italians had that was Mafia oriented. He also had a problem because of the tightness of getting into medical schools.

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The guy that I was in the Air Force with—one of the guys—was named Leo Krauss. He was Phi Beta Kappa, and he didn't get in. He had to wait for a year. The year I went to law school, he started as a lab instructor at NYU. Then he went to medical school there. It was tough in those days to get in.

So this guy, his name was Bill D'Angelo, and he went to school in Bologna, and he was the original bon vivant. But he was very committed to being a physician, and he took his lumps with all the things you had to do, but he didn't hurt for having a good time, too, and he took full advantage of being at Bologna. And then he got into— Oh, yeah, and Dr. Jeghers had trained a lot of people during the years, and there was a guy that wrote a book called *The Diseases of Medical Progress*. It used to come out every year, but it hasn't been out in a long time. I think probably that guy died. But anyway, he was one of Dr. Jeghers's students and Dr. Jeghers said—I mean, this guy—I can't remember his name—said, "This is a guy you ought to give a chance to," this Bill D'Angelo. Bill had made a contact because he had gone to— He began to see, well, these are the problems I'm going to have when I get through medical school here, and so he went to some of the local American military hospitals in Europe and met this guy. He let him work in the hospitals every summer that he was out. He was my assistant.

***Tacey Ann Rosolowski, PhD***

1:02:48.5

Oh, interesting. I was wondering how Dr. Jeghers influenced you. Was he a mentor to you or was there someone else there who—?

***C. Stratton Hill, MD***

1:02:56.8

He was a—like I say, in the Oslerian tradition of you are always a student. So was Dr. Rawson. Dr. Rawson told me a story one time about—he went to Northwestern, and he went to Boston to do this training. He said, when he went up there, he and his wife were looking for an apartment. They got an apartment, and they were getting ready to sign this thing. He signed it, and this guy says, "By the way, what do you do?" And with great pride he said, "I'm a student of medicine." "Give me that goddamn contract." He said, "I'm not renting anything to any students," and he tore the contract up. (laughs) That was the ultimate putdown. Anyway, he preached that you've got to keep up with the literature. He gave a lecture to everybody. Your knowledge starts going down the minute you graduate from medical school. If you can just keep it even, you're going to have to work at it, and if you want to push it up, then you've got to go into research or something like that.

***Tacey Ann Rosolowski, PhD***

1:04:38.4

What was going on for you at that time with oncologic endocrinology? Were you getting into that field at that time?

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***C. Stratton Hill, MD***

1:04:47.0

Yes, yes.

***Tacey Ann Rosolowski, PhD***

1:04:47.6

And what was going on in the field at that time?

***C. Stratton Hill, MD***

1:04:49.6

See, Dr. Rawson was an endocrinologist, and he had an international reputation in the thyroid, so that rubbed off on anybody that he trained. But I had rotations through the general endocrine service over at New York Hospital and at Bellevue, so I had all kinds of exposure to—because I thought that that was a subspecialty that I wanted to get into, and so it was channeled. This was before the days of things being as structured as it is now. I mean, now you pretty much have got to commit to endocrinology or gastroenterology or subspecialty a long time before you— It's almost like committing to your life profession when you're in kindergarten because there's so much competition. And you can just kind of amble along and then pretty much decide that that was the way you wanted to go, so I got rotated through all those services in my second year mostly in— And Dr. Rawson had been instrumental in using radioactive iodine in treating thyroid cancers and so forth, so he was very much versed in that. And we had a nuclear medicine section at Memorial at that time, and the guy from up there ended up down in Galveston later.

***Tacey Ann Rosolowski, PhD***

1:07:05.0

What was the connection between cancer and endocrinology at that time? What was the thinking about how there was an interface there?

***C. Stratton Hill, MD***

1:07:13.3

Well, see, that was— Chemotherapy was in its infancy at that time, and Memorial took up the whole block between First Avenue and York Avenue, 68th and 67th Street, and they had the Strang Cancer Prevention Clinic there. They had the James Ewing Hospital, which was a city hospital that was run by Memorial. That was where all of the surgeons got their practice was in the James Ewing Hospital because the staff for James Ewing and Memorial was the same. But you actually took care of the patients in James Ewing, so your medical floor that you were in charge of was in James Ewing Hospital. It's no longer there. James Ewing was a famous pathologist at Cornell. Ewing Sarcoma is named for him. His son was an attending at Memorial when I was there, and so it never was—but then—in James Ewing— And actually, you had some beds in Memorial, but that's a private hospital, so you only had a few beds that were designated for indigent patients. Most of them are over at James Ewing, and so to run those beds, they had

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to either be on those indigent beds in Memorial or in James Ewing. That's where you got to be when I was senior resident.

Then I got to know a lot of the attendings. Many more— Well, actually, I knew probably most of them anyway. Memorial was—I mean—we had people coming there all the time. I had one guy there that was dating Kim Novak, and she'd come eat lunch there, things like that, and the Rockefellers were all around Memorial. They were on the board and the whole thing. So that was my first taste of a little boy from Tennessee playing with the big boys. And the contrast of the food between Memorial and Bellevue was striking. I mean, we had lobster and stuff like that at Memorial, and you had casseroles of everything down at Bellevue.

Anyway, I realized that people were very much interested in cancer cure, getting over this stuff, but you had all kinds of— It was called Memorial Hospital for Cancer and Allied Diseases, so we had stuff that you only dream of on the floor, on the wards, at Memorial. And then we'd do— It would take you all day long to do a dialysis. When I was in that program, we had one guy that fell off the subway platform right in front of the train. The train ran right across both of his legs and cut them off. All that dead tissue and everything, the kidneys have to handle that, and that oftentimes would shut the kidney down, so they would die under ordinary circumstances. With the kidneys, we'd get those trauma cases, and we had all kinds of blood dyscrasias, hemochromatosis, things like that, which is kind of—they weren't routine. But then I can't even remember some of the unusual diseases that we had. Lots of times they would be chronic diseases, so every resident would—the patient would be in and out of the hospital, and there would be some times that patient would come in on your rotation, so you'd get to see the thing.

It was the same way pretty much down there at the Manhattan VA Hospital. You got to see lots of different things from all over, and we had things that were interesting. We had people that had—I think it's the fish tapeworm. I believe it's called *Clonorchis sinensis*. We would have people that were infested with the fish tapeworm, and they were Jewish people. And the epidemiology there was that they had fled Europe through China and eaten raw fish that had the fish tapeworm, and they had the fish tapeworm.

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### **Chapter 3**

#### **A: Joining MD Anderson/Coming to Texas An Evolving Specialty and Coming to Texas**

Story Codes

A: Professional Path

A: Influences from People and Life Experiences

D: The History of Health Care, Patient Care

B: Personal Background

A: The Researcher

C: Evolution of Career

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

1:13:19.4

It sounds like you had a lot of experiences that really exposed you to just an unusual range of disease and conditions and trauma. How did you end up going from there to coming to MD Anderson? How did that all happen?

#### ***C. Stratton Hill, MD***

1:13:36.8

Okay, well, when I finished my residency, after I finished residency and I went over to Seton Hall, then— I could tell you a story from Seton Hall, in New Jersey, that would make the hair stand up on your head. I decided that— I made a lot of good friends over there, too. One cardiologist was just a prince of a guy. The political boss of New Jersey was Frank Hague, and he built the Jersey City Medical Center. I learned that in New Jersey you're not just Catholic. You're either Polish Catholic or you're Irish Catholic or you're Italian Catholic or Ukrainian Catholic or something. You're not— It's a double name. When I went there, the hospital—as a chief resident—the hospital was about to lose accreditation because we weren't getting any autopsies, and I said, "Come on, we're right here on the piers of New York." This is where all the ships came in from Europe and all over the world, and there were huge railroad yards there, but that had all changed.

What had happened was that Frank Hague, he had delivered New Jersey for Franklin Roosevelt—the first time that New Jersey had ever gone Democratic—and so he had a lot of political capital with Franklin Roosevelt. And when Frank Hague wanted to do something for his own sake, the Catholic Church says, "No schools. We take care of that," so he built this huge medical center. You've probably seen Columbia Presbyterian up on the west side, huge complex. He built the same thing over in Jersey City, and the question was, when Seton Hall was going to have a medical school and a hospital, whether to use the Jersey City Medical Center as a warehouse or the medical school, because it was 10 times too big for what Jersey City needed. The medical school moved into it.

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Well, politics were unbelievable. To make a long story short, the local doctors would not let the medical school doctors be on the staff of the Jersey City Medical Center and the Bishop of Newark had planned to have just the—they were going to have a full-time faculty, and they were going to have a geographical full-time practice, and then they would generate their own income. Well, if they couldn't get on the staff of a hospital, they couldn't have the practice, so that shot that down. That was a big, big problem, and so at the end of— When I finished the residency, the mayor of Jersey City had appointed one of his—his name was Tom Gangemi, a good Irish name.

*Tacey Ann Rosolowski, PhD*

1:17:32.5

What was his name again? Tom—?

*C. Stratton Hill, MD*

1:17:34.9

Gangemi, very Italian, and he appointed a guy that was head of the medical center. His name was Crisanino. Then Dr. Jeghers got this **Dr. (???) Crisanino** to appoint me as the Assistant Director of the Jersey City Medical Center. That didn't sit too well with some of the local politicians because they had my picture in the paper of me giving some kind of an immunization that they were going to do for the whole city. I remember there were several things that got back to me about this guy from Tennessee. What's he doing up here? And then, too, I realized that the Mafia was infiltrating all through Jersey City Medical Center and over in Secaucus and Hoboken and Bayonne. Boy, those guys took me over there to some of those places that I wouldn't have been there if the Mafia hadn't been in control, but the food was fantastic. (laughs)

Anyway, after about six months, I decided I better get out of this, so I went over to Dr. Rawson. I said, "Hey, you got anything for me to do here in these six months? I want to see what I can do." And he said, "Yeah, you can help Ray Houde." He's the guy that was doing the clinical—he runs what's called T-17. That was the Tower Clinic. Memorial had an outpatient clinic for walk-ins. People from the street could walk in, and you only took people with cancer, so what this clinic did was to sort of screen to see if you were suitable. The people who actually did the work were board certified surgeons, because Memorial is mostly a surgical hospital.

I worked with him, and we supervised this, and we would check these guys out and so forth. So during that time— You've heard of the Kelsey-Seybold Clinic here? Well, Mavis Kelsey was a good friend of Rulon Rawson, and so he came to New York and got with Dr. Rawson and said, "I need somebody to come to my clinic." And so Dr. Rawson, since I'd left Jersey City, recommended me. I met with Dr. Kelsey. It was right before Christmas, about in November. We were coming here to visit Charlotte's parents in Galveston, so we came over and visited with Dr. Kelsey, and I realized then that what he wanted was a chemotherapist. He wasn't looking— He's an endocrinologist, and so he really didn't have a— But then I had some friends that were attendings in Memorial that said, "Oh, I've got a guy over at MD Anderson. I want you to go by over there and see him." I went over. My contact there was Dr. Clifton Howe. You've probably

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heard of him. So I went over there. The guy that was my attending at Memorial, his name was Felix Wroblewski. He must have been Polish.

***Tacey Ann Rosolowski, PhD***

1:22:05.0

I think that's probably true.

***C. Stratton Hill, MD***

1:22:07.6

He was a fabulous guy, and he and— Let's see, what was that guy's name? John LaDue. They did the first studies on enzymes, elevation in the blood for heart attacks, SGOT, SGPT, things like that. You see, that's what I was talking about, serendipity, coming out of a cancer institution. Here these guys, they were doing all kinds of work with enzymes for cancer, and these guys said, "Well, let's study these people who have heart attacks while they're in the hospital." They're the ones who started that, so it was LaDue and Wroblewski. Their original article is one that first put enzyme studies for heart problems on the map. It was Felix that knew Cliff Howe, and that's why I went over and talked to Cliff. Cliff said, "Come on. We want you to come over here." Then I thought, well—

***Tacey Ann Rosolowski, PhD***

1:23:36.3

What attracted you to the institution?

***C. Stratton Hill, MD***

1:23:39.9

Well, it was more of what I had been doing and what I looked at as a continuation of this, and I thought, well, if it's— And then he told me a lot of the things they were doing, and Mavis had a lot to do with Anderson. Have you ever read his books?

***Tacey Ann Rosolowski, PhD***

1:24:13.7

No.

***C. Stratton Hill, MD***

1:24:14.3

You ought to read that because he and Dr. [R. Lee] Clark were at the Mayo Clinic together, so they've known each other from way back, and he's got that in his book. Dr. Clark enlisted Mavis to help get things going, and Mavis worked at the clinic over at MD Anderson until—oh, up until the '70s and '80s. He came over every week to the thyroid clinic.

4

A: The Researcher

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Thyrocalcitonin –Confirming the Marker for Thyroid Cancer

Story Codes

A: The Researcher

A: Joining MD Anderson

A: Definitions, Explanations, Translations

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

D: The History of Health Care, Patient Care

C: Discovery and Success

***Tacey Ann Rosolowski, PhD***

1:24:52.5

You came in 1963, right?

***C. Stratton Hill, MD***

1:24:55.4

In 1963.

***Tacey Ann Rosolowski, PhD***

1:24:56.7

As Assistant Professor of Medicine, and so what department was your home department at that time?

***C. Stratton Hill, MD***

1:25:04.9

It was just the Department of Medicine. It was a traditional department. What they have now is totally different. I was just in the Department of Medicine. Everybody was in the Department of Medicine. There was a guy there named was Bill Cole. His name was V. William Cole. And there was the endocrinologist they had just fired at Endocrinology because he had— There was some sort of incident with a female or something, so he got fired, and this guy took over. He was not really in charge. They just kind of left it.

***Tacey Ann Rosolowski, PhD***

1:26:01.7

What was your role when you first came?

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**C. Stratton Hill, MD**

1:26:04.4

Well, I was to work in Endocrinology, but the slot that they put me in that they had a slot for salary was in Infectious Diseases. All I had to do was just oversee a technician that worked in the lab that did studies on infections that were unusual or something like that, so that was kind of a supervisory role. So I had to do that, so I really wasn't under Bill Cole, but he and I shared the work. Then I got interested, and I realized that we had a treasure trove, or a mother lode, of diseases of medullary thyroid cancer, because we had families— It's a hereditary disease, and I took that on as kind of my interest. There was a guy named David Anderson, who was a geneticist, and he and I worked together. He was a PhD, and we went down to— I began to do pedigrees on these families, and I collected that over the years. I did other stuff too, but Bill kind of turned all the thyroid over to me.

**Tacey Ann Rosolowski, PhD**

1:28:14.3

What were the first studies that you did?

**C. Stratton Hill, MD**

1:28:17.4

We did epidemiology studies on the family.

[REDACTED]

**Tacey Ann Rosolowski, PhD**

1:29:35.2

What were the trends you were seeing as you collected this genealogical information?

**C. Stratton Hill, MD**

1:29:40.3

We knew pretty much that it was autosomal dominant.

**Tacey Ann Rosolowski, PhD**

1:29:45.5

I'm sorry, what was that? Auto—?

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***C. Stratton Hill, MD***

1:29:47.2

Autosomal dominant inheritance. In other words, it's not sex linked. It's a somatic gene that it's linked to, and you're going to have some people in every generation that are going to have it. I began to collect this. We've had patients that come in at—There's three things that it's associated with. It's pheochromocytoma, which is a tumor of the adrenal medulla, parathyroid adenomas and parathyroid carcinomas, and then thyroid cancer. So I began to do that. Then about that time, there was a doctor, a scientist in Vancouver, British Columbia. I've forgotten his name. I thought I'd never forget his name, but I've forgotten his name. But he was true serendipity, and Dr. Rawson was great on serendipity. There was a restaurant called Serendipity 3. You know that one?

***Tacey Ann Rosolowski, PhD***

1:31:24.9

No, I don't.

***C. Stratton Hill, MD***

1:31:25.7

It's on 60th Street, between 2nd and 3rd, I believe. No, maybe it's Lexington and 3rd. Well, it's on 60th Street, because Bloomingdale's— It's on the north side of Bloomingdale's. Well, it's the next block over, so it must be 2nd and— Anyway, it's fabulous. I don't consider me really having been to New York unless I get there. They have what's called a frozen hot chocolate. It's the greatest thing you've ever had.

Anyway, about this time, there was something, a hormone that had not been identified that everybody thought came from the thyroid gland, and it was named thyrocalcitonin by this doctor in British Columbia. This had to do with calcium metabolism, so it didn't fit with the thyroid gland. I began to see this information about this particular tumor in the literature, and so I read up on it, and there was a pathologist—I remember his name, [John] 'Beach' Hazard—at the Cleveland Clinic who was interested in the pathology, morphological pathology. This was long before the days of the electron microscope. You needed to get into mitochondria and all that kind of stuff. He wrote a big article on that, and so I thought, well, if this cancer is a producer of calcitonin—well, thyrocalcitonin—then if it has to do with calcium metabolism, we ought to infuse calcium into these patients and then take blood at a certain time and we could see—if it ever gets to where you could measure thyrocalcitonin, we could see what happens to it.

I began to do that, and in those days you didn't have IRBs. You could just do it, and so I did that. I would get the blood, and I'd freeze it and save it. And so about the time that this was happening, unbeknownst to me, there was an accident in the laboratory in British Columbia. They were studying this calcium metabolism, and they were doing it in rats. They got rid of the parathyroid glands by opening up the neck, and then they would zap the parathyroid glands with an electric current and destroy it. But they noticed that—and they were having to use a biological

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assay at the time—that every time they did that there was a dip in the calcium in the rats. By the way, if you need to take a break, we could take one.

***Tacey Ann Rosolowski, PhD***

1:35:45.8

Would you like to?

***C. Stratton Hill, MD***

1:35:47.5

Well, not right now.

***Tacey Ann Rosolowski, PhD***

1:35:49.6

Just let me know, and it's a quarter of 4:00. Do you want to go for another half hour or 45 minutes?

***C. Stratton Hill, MD***

1:35:56.9

We can.

***Tacey Ann Rosolowski, PhD***

1:35:58.8

Would you like to stop right at 4:00? That's fine.

***C. Stratton Hill, MD***

1:36:00.9

No, it doesn't make any difference to me. They told them, they said, "Well, you can't use this cautery anymore in the lab, so you're going to have to surgically excise the parathyroids." Well, they noticed that when they did that, they didn't get that dip in the calcium level in the blood. So then they thought, "Well, wait a minute. This might be due to damage to the thyroid gland by the cautery." So then knowing what the embryology was, they then said, "Wait a minute. Everybody has gills in embryonic development, so there are six clefts that may have vestiges of the cleft left." That's the so-called branchial cysts because these are called branchial clefts, and it may incorporate a little fluid, and you'll have a branchial cyst in the neck or something like that, and that's just because it didn't close up right.

They realized that something called the ultimobranchial body was incorporated into the body of the thyroid gland, so then they started looking at that to see if the substance that accounted for this change in the calcium level was in both cells that were mixed in with the thyroid or the thyroid glands themselves. They said, "Well, what animal is it that the ultimobranchial body remains the ultimobranchial body separate from the thyroid gland?" Well, the one that was obvious to them was the salmon fish. The ultimobranchial body is not incorporated into the

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thyroid gland. So he started making extracts of the ultimobranchial body, and lo and behold, found out that calcitonin comes from those cells, and so then the first calcitonin meeting. Then they changed the name. It's not thyrocalcitonin. It's just calcitonin, because it comes from a different set of cells. So I thought at that time, well, wait a minute.

When you do a laryngectomy, or any kind of head and neck surgery practically, they will take out half of the thyroid gland as part of the surgical procedure. So those were the people that we would do these infusions on, and we wanted to identify ultimobranchial cells within the thyroid gland. By that time the— What am I trying to think of? The electron microscope had come into play, and there was a guy right down the hallway from where—that's the lab—that was doing electron microscopy for somebody else. I said, "Hey, let's see here what these cells look like." A chicken also has ultimobranchials, so we got a bunch of chickens.

***Tacey Ann Rosolowski, PhD***

1:40:20.3

Chicken and fish. (laughs)

***C. Stratton Hill, MD***

1:40:21.1

We started looking at the ultimobranchial body, and we could see these granules in these cells. Then we could give them a high-calcium diet, and that would deplete those cells of those granules. We thought, "Well, now we've kind of got an idea of what this looks like. We'll do these people that are going to have surgery the next morning. We'll just go in there that night and start them on IV with some calcium, or if they already have an IV going, we'll just add calcium to them." As far as we could tell, it didn't hurt them, and you didn't have to have any permission or anything; you just did it. So we did a study on that and presented that to one of the meetings to show that there were actually ultimobranchial cells within the substance of the thyroid gland. It was not 100 percent, because to have it 100 percent, you'd have to take biopsies of the thyroid. Nobody in their right mind is going to let you do biopsies of their thyroid just for laughs. As far as they were concerned, they got no benefit from it.

So we did that, and then the first thyroid— The calcitonin meeting was in London in 1969. I went there to that, and at that time, we only had a biological assay. For a calcitonin meeting, you have to inject that in animals and then measure the calcitonin in the animals—I mean, the calcium level in the animals—and that is tough. That's labor intense. At that meeting, there were two guys that had a radioimmunoassay for calcitonin. One was at the Royal Postgraduate Medical School at Hammersmith in London, and the other one was at the Harvard Dental School. So I made appointments for them and said, "Hey, I've got all these frozen samples of blood of people who have had medullary carcinoma of the thyroid that I have done calcium infusion tests on. Would you like to try your assay out on this stuff?" And they said, "Absolutely." I had a guy that was absolutely eaten up with medullary carcinoma of the thyroid, and he died, and I had saved a lot of his blood and a lot of his tissue, frozen, so I sent the same sample.

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I divided the same sample into halves and sent half of it to Hammersmith and half of it to Boston. I didn't hear and didn't hear and didn't hear, and finally I heard from—this guy was Armen Tashjian. That's a good Armenian name. He was at the Harvard Dental School. So finally I heard from him, and he said, "Well, when I first did this, the reading that we got was so high that I thought there was something wrong with the assay. Since this is a new assay, I thought there was something wrong with it. We had to check it, and we checked it, and we checked it. We checked it, and we checked it. We said, 'There's nothing wrong with that assay. This is a high level.'"

And then about a week later, I hear from Hammersmith, the same thing. "We just had to check that thing so much because we thought there was something wrong with the assay." So I thought it's easier to send this stuff to Boston than it is to London, so I got on a plane. I flew and got this all on dry ice and hand carried it up to Boston. And it turned out that it was— Everything turned out like we thought it was going to turn out. Armen wanted to present this. Still, there were people in the thyroid business that weren't sure this was not thyrocalcitonin, so he said he wanted to present it to the endocrine society that was going to meet in St. Louis that summer. I said, "That's great. I'll present it to the International Thyroid Meeting that's meeting in Vienna." He said, "Okay," so I presented it in Vienna, and he presented in St. Louis. I think I got the better of the deal.

***Tacey Ann Rosolowski, PhD***

1:45:53.2

What were the implications of all this knowledge?

***C. Stratton Hill, MD***

1:45:58.4

That's a marker for the disease. You can diagnose. We then got these families in and began— And you use that all over, everywhere for that particular disease. And then, of course, it had been found that calcitonin occurs in other parts of the body, so it's only specific for the medullary carcinoma of the thyroid. The question then arises— The problem that we had was we would have people that we were following along with calcitonin measurements, but they showed no evidence of disease and felt fine. How do you—? What do you do? Do you treat the laboratory results, or do you treat the person? And so we decided that we'd treat the person. So some of those people would have their calcitonin levels go up and no manifestation of the disease.

Now, I got out of that when Dr. Clark asked me to be the director of the whole clinic. I had pretty much done all of that. I tried to do some clinical stuff, but this was the first time that they had started expanding. We never had a clinic building separate before, and they were building the clinic building, and so I got administratively tied up. I did that for about five years. Then I decided there was too much administration, and then that's when I decided that we'd get into the pain part.

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***Tacey Ann Rosolowski, PhD***

1:48:09.0

Let me ask you, before we—because certainly that next phase, when you’re setting up the clinic, is really an important—as you said, one of the three parts of your story.

***C. Stratton Hill, MD***

1:48:20.2

Yeah, that was what I had the most notoriety in was in the pain part, and so this other I dropped out.

***Tacey Ann Rosolowski, PhD***

1:48:34.7

Were there other dimensions of that clinical research that you were—? Was it primarily discovering this marker, or were there other dimensions to the research that you were doing?

***C. Stratton Hill, MD***

1:48:44.5

We didn’t discover it. Well, we validated it, basically, and that was published in the New England Journal of Medicine in 1970. I remember Dr. Clark was saying to order 1,000 copies of that, and I said—I thought, “Well, I’m not going to order 1,000 copies. Nobody’s going to want that thing.” We went through 1,000 copies in about two weeks. And I’m not sure. There’s something called a gene related calcitonin, and that’s a little bit different from just the calcitonin that we were measuring. Dr. [Naguib] Samaan, who we recruited here to be the laboratory— He became Chief of Endocrinology. He had gotten his PhD at the Hammersmith in London, and he was Egyptian. He was a great immunoassayist. I mean radioimmunoassayist. So he took over that. We were doing that here, but I’d already done the other stuff with Armen Tashjian. And it just so happens that Dr. [Robert] Gagel— Do you know Dr. Gagel?

***Tacey Ann Rosolowski, PhD***

1:50:46.3

No.

***C. Stratton Hill, MD***

1:50:46.9

He’s Chairman of the Division of Medicine here now, and he trained with Armen Tashjian, so he knew about me before he came here. I think he came to Baylor before he came to MD Anderson, and so I didn’t know that until he told me. He said, “Yeah, I did all my training with Armen Tashjian in Boston.” And then Naguib Samaan knew most all of the big endocrinologists here in the States because he trained at Hammersmith, and they knew each other. There was the guy that became head of endocrinology at Harvard at Mass General. What was his name? I worked with him some, too, in all of this stuff.

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5

B: MD Anderson Past

MD Anderson in the Sixties – A Culture of Innovation

Story Codes

B: Institutional Mission and Values

B: MD Anderson Culture

C: Portraits

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: MD Anderson History

B: MD Anderson Snapshot

***Tacey Ann Rosolowski, PhD***

1:51:55.1

What were your impressions of MD Anderson during those first years that you were here? I mean, was it a good place to work? Were there frustrations?

***C. Stratton Hill, MD***

1:52:02.0

Oh, it was fantastic. The thing that I thought about Memorial was this is highly organized. It's well run. It's a challenging atmosphere. Everybody at Memorial was—like Dr. Rawson—academically oriented. I remember one time— See, most of the people that were there when I was in clinical physiology were surgery residents, because it's a big surgical hospital. That was going to be— And all the big names of surgery came from Memorial. Hayes Martin put head and neck cancer on the map. George Pack operated on Eva Peron. And let's see, who else? Then you had (David) Karnofsky, who basically started chemotherapy. He was at Memorial. Who was the other guy? And then there was a guy named—oh, what was his name? He ran the Strang Cancer Prevention Clinic.

I began to have people there at Memorial.

[Redacted]

Then Dr. Rawson came in a little bit later on, and I had written down all the stuff that I'd done. He didn't say anything to me about it, but he agreed with everything and made a note that he agreed and everything. Then the guy that was in charge of that clinical physiology—because I was taking call with the medical people, and so he called me. His name was Parker Vanamee, and he said, "What in the world did you do over the weekend?" He says, "Dr. Rawson thinks everything you did was right, whatever it was." And the other thing was this was a Jewish

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family, so this person had hypercalcemia. That was one of the things. I really went through all the mechanisms of what could cause hypercalcemia and so forth.

This guy died about two o'clock in the morning. You don't get autopsies on Jewish patients. I decided I was going to try to get an autopsy, and I said, "We can limit this autopsy just to the neck because we really want to see about the parathyroid glands, if we missed a parathyroid adenoma or something." She granted me permission to do a limited autopsy on his neck, just to look at the parathyroid gland. Well, that was unheard of as far as Dr. Rawson was concerned, so that made a good impression. Several other times things came along that worked out where I insisted on some things that—I remember one time, down at Bellevue, I was— Of course, in those days, Bellevue still had direct current instead of alternating current, and you had to have all kinds of transformers if you wanted to do an EKG. And you had to do it yourself. I remember doing an EKG on a patient one time, and I thought "There's something wrong with this thing." I mean, there's hardly any electrical current coming out of the little—the graphs were just—I thought "I think this guy has got pericardial effusion." So I went and I said—I went to the Radiology Department, and the Radiology Department at Bellevue had been uncertified, it got so bad, so they had some guy from—I don't know where he was from. I woke him up, and I said, "I want to take an x-ray and see if he's got a pericardial effusion." The guy, he says, "I'll do it." He goes in there, and he won't let me come in. He comes out, and he says, "He doesn't have pericardial effusion." Well, we had a fluoroscopic room down in— Our part in the second division was the Cornell division, Bellevue, and I said, "We've got a fluoroscope down there. I'm going to call the GI resident. He's the one that does the fluoroscopy." I called him, and he came over. He lived down in— You remember Peter Cooper Village in Stuyvesant Town, down there at the Metropolitan Insurance Company, down south of 23rd Street and down almost to the Bowery? Anyway, he came over, and we looked in there. You couldn't even see the heart moving, there was so much fluid around that heart, so we decided to go ahead and do a pericardiocentesis. Well, that kind of made an impression on several of the people, too, that I persisted in going through all that trouble to get that done. The person had cancer and had metastatic disease of the pericardium, but he got tremendous relief of his symptoms by taking off all that fluid and everything.

***Tacey Ann Rosolowski, PhD***

1:59:39.8

How did the work situation compare at MD Anderson?

***C. Stratton Hill, MD***

1:59:43.9

Well, see, Dr. Clark was trained at the Mayo Clinic. He went up there and brought down some of the people from the Mayo Clinic administration, and they basically set the clinic up as a model after the Mayo Clinic. So when I was running the clinic, he used to send me to the Mayo Clinic all the time. I mean, I knew that Mayo Clinic upside down and backwards and administratively, and it was fantastic.

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***Tacey Ann Rosolowski, PhD***

2:00:34.1

What was so good about it?

***C. Stratton Hill, MD***

2:00:37.3

It was all organized based on the very best interest of the patient. Everything was geared to making it easy for the patient to get good care, and after several trips up there, I said, “Dr. Clark, the problem that we have is that we don’t have the discipline and the tradition of the Mayo Clinic.” The doctors are disciplined like crazy up there, and they make the rules, but they also enforce the rules, so they’ll give you anything you want, but you’ve got to take care of the patients. And taking care of the patients was from eight o’clock until noon and from one o’clock until five, or whatever it was in the clinic. Then they had two hospitals, St. Mary and—I forget what the name of the other one was that they ran. But each person was assigned so many new patients, and you can say, well, I’ve got this procedure to do or that procedure to do or this, that, and the other.

You saw that patient, and so nobody ever even thought about not doing it. Then, also, they had a situation in which what we would call classified personnel were trained to do specific tasks, but they were trained by the Mayo Clinic. You couldn’t get a job anyplace else because you were just trained to do— If you were an x-ray technician, maybe all you ever did was x-rays of the skull. You became the world’s greatest expert on taking x-rays of the skull. But if you said you were an x-ray technician and went to work in the general hospital, they’d say, “Well, what do you do?” “Well, I take x-rays of the skull.” “Well, how about the arm?” “Oh, no, I can’t do that.”

At the time, that was the thing that I thought—and I didn’t think you ever could get the tradition that they had because it was such a—I guess—a folklore with the Mayo brothers. They were so disciplined that you just did it, and you did it the Mayo Clinic way. They were for innovations, but you just couldn’t say, “Well, I’m going to do so and so.” You would have to go through the proper procedure. And at that time, they only had two big clinic buildings. They were huge, though, and they’d have things like they had no nurses at the Mayo Clinic. No nurses except in the emergency room. If you were doing a pelvic on a female, the doctor had to drape the patient. Now, they may have changed. I never knew that they changed, but with the liability and so forth and everybody accusing all this stuff— But they had a lot of funny things.

**Dr. (???) Plummer** designed this building, and he designed it so that the halls in the clinic building did not go anywhere except that hall. They were all dead ends. They were spokes out like this, so if somebody was on that floor in that hall, they had business on that floor. You couldn’t say, “I’m on my way over to this place.” And then, of course, the lights—I don’t know whether you’ve been in the clinic at Anderson—they’re like they are at— In other words, there were about five lights. They had different colors. My color was amber, so they’d turn the amber light on, and it meant there was a patient for me in that room. The chart would be on the rack,

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right out front. That's how you knew when there was somebody in the room, and up there—which I thought this was kind of interesting, because everybody realizes it's hard to stay on schedules. If a patient— When you went into the room, you turned the light out so the nurse would know that you were in there or somebody was in there or there was nobody in that room, theoretically. But if the light was not turned off after an hour, it began blinking, so you'd know that that patient had been sitting in that room for an hour. They had things like that. They had kind of a Rube Goldberg distribution for their charts. You know what a Rube Goldberg is?

***Tacey Ann Rosolowski, PhD***

2:07:34.8

No.

***C. Stratton Hill, MD***

2:07:37.2

Well, I'm not surprised. I've run into that with medical students and residents and so forth. There was a cartoonist named Rube Goldberg, and it was always a process that had to be done, and you had an outcome over here. Well, up here would be a bird that ate a seed that when he pecked on it would do something over here that would set something else off that would set something else off that would set something up like that. Finally, whatever you were trying to get done would be done over there. A Rube Goldberg apparatus is a complicated—

***Tacey Ann Rosolowski, PhD***

2:08:35.9

Kind of a domino effect.

***C. Stratton Hill, MD***

2:08:36.5 Yeah, a domino effect. It's not quite as simple as the domino effect. He'd have animals in there. A chicken would peck the corn, and then it'd do something to make a dog bark, and that would do something. Yeah, that dates me, because you used to have these cartoons that were Rube Goldberg. So they had a building that had all the records in it, and they had a guy that would put the records into a chute that would go down to where that thing should be. And when we were building the new clinic— Well, that was new at that time. You can't even see that building now, practically. Dr. Clark got the idea that he was going to make a tube system— vacuum tube system—that would take these charts that we have in there. I don't know how much they spent on that thing. It never worked a day, not once. Dr. Clark recommended a monorail for the medical center in the '40s.

***Tacey Ann Rosolowski, PhD***

2:10:14.6

Yeah, I remember reading that in the Making Cancer History book. It's really amazing, very visionary.

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***C. Stratton Hill, MD***

2:10:19.2

Oh, yeah, and he was for everything. Then we had another deal where you could write—I've forgotten what they called it—but I could write a message to another clinic. You turn this thing on, and you'd write it in the stylus, and that other clinic would write it out.

***Tacey Ann Rosolowski, PhD***

2:10:46.2

And that really was adopted, or was that just—?

***C. Stratton Hill, MD***

2:10:49.4

Oh, now that was adopted, but lots of times, what would be on that part of the paper where you were writing it only got half of it on the other— It wasn't 100 percent.

***Tacey Ann Rosolowski, PhD***

2:11:11.4

He was really concerned just about speed of communication.

***C. Stratton Hill, MD***

2:11:14.6

Oh, he was concerned about everything like that, and he said to me “What I want you to do”—and he was interested in the thyroid too, very much so. Excuse me; I'm going to have to go to the little boy's room. (audio pauses 2:11:37.2)

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## **Chapter 6**

### **B: The Researcher**

#### **Collaborations with Dr. R. Lee Clark and the Climate for Research at MD Anderson**

Story Codes

C: Discovery and Success

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

C: Collaborations

B: Institutional Politics

C: Portraits

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

2:11:37.8

Okay, I turned the recorder on after a brief break, and you were telling me about what Dr. Clark was saying to you.

#### ***C. Stratton Hill, MD***

2:11:48.9

He said to me—and this is the Mayo Clinic philosophy, too, is that you—basically, I'm paraphrasing. It's not a quote. You have your niche here. If you see something that you think we ought to do, it's a viable, doable situation, or I think it is, we'll make everything possible for you to get that done. That was basically what he told everybody.

And of course, the fact that I began to do things with the thyroid— See, he was a thyroid surgeon, and that was his main interest. I don't know what the other guys had done here, but I began to do things, and right off they made it known that I couldn't do that unless I got Dr. Clark's permission, because anything that had to do with the thyroid, he had to have something to do with it. That was no problem as far as I was concerned. It didn't matter to me. So one of the things that he was doing with the pathologists was studying whole organ sections of thyroids, because looking at thyroid cancer, there would be a nodule in one lobe of the thyroid, and you take that lobe out, and then they were finding that the other lobe would come up with thyroid cancer later on. They began to do total thyroidectomies and doing whole organ sections. He did that with Dr. Russell, who was the pathologist here, Dr. Bill Russell, and that was one of his main interests at that time. Well, what I was doing was more medically oriented, but that got into some pretty touchy situations politically because some of the things that they were espousing were maybe not necessary later on, as they found out later on. It was kind of— That was no big problem.

One of the things that I did that related to what we were doing at Anderson— And actually, Dr. Rawson, in New York, claimed that pregnancy was bad for anybody who had thyroid cancer.

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And I thought, “Hey, where’s the data on that?” And so when I began seeing some patients at Anderson, young women, they had been pregnant, and they’d had babies, and they seemed to be fine. So I did an epidemiological study, and basically it was a retrograde study. I wrote letters to— We sent out letters to women who had thyroid cancer to see if they’d been pregnant, if they were no longer coming to Anderson. Most of them were still coming, so we found out that there didn’t seem to be any relationship between pregnancy and thyroid cancer.

I said to him, “Well, wait a minute. That’s my boss.” But I submitted that paper to the—I think it was called the Fifth International Thyroid Conference in Rome in 1965, and it was accepted. So I presented that, and Dr. Clark presented one of the papers relating to whole organ sections of the thyroid. And we had simultaneous translations there. Dr. Clark had kind of a southern drawl to his talking, but for some reason he got to talking so fast that the guy had to say, “Hey, slow down.” I thought, “My gosh, if we have to slow Dr. Clark down—” (laughs) That was kind of—I had to—I didn’t mind putting Dr. Clark’s name on all the papers because he had basically made it so that we could do all this stuff, and he got very much interested particularly in the medullary carcinoma thing. There’s a pamphlet that Anderson put out. I think this must be in the ‘60s. You’ve probably seen it. It’s a blue one. I had an article in there that had—I’ve got it upstairs—where I’d drawn a pedigree of—

***Tacey Ann Rosolowski, PhD***

2:18:44.7

No, I haven’t seen that.

***C. Stratton Hill, MD***

2:18:46.9

And those are old, old things. I think it was the chancellor of the University of Texas at Austin was named Rawson, R-A-W-S-O-N, I think, or R-O-S-S-O-N. R-A-W-S-O-N was Dr. Rawson. That was my boss in New York, and there’s a chancellor at the University of Texas. I think it was called The Texan at Houston, which is a newspaper or something at the University of Texas in Austin, and that was in that particular thing. I may have some things that you don’t have that go back like that.

***Tacey Ann Rosolowski, PhD***

2:19:33.7

Yeah, I’d be interested, if you have those. I wanted to ask you, though, what came of that study about the connection between pregnancy and thyroid cancer? I mean, has it been borne out that there is no connection?

***C. Stratton Hill, MD***

2:19:45.1

No connection.

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***Tacey Ann Rosolowski, PhD***

2:19:46.0

No connection.

***C. Stratton Hill, MD***

2:19:49.9

Yeah. It's not mentioned anymore. Dr. Rawson quit doing that.

***Tacey Ann Rosolowski, PhD***

2:19:55.3

I wanted to ask you a theme that's come up in some of the other interviews. It's the difference between, or relationship between, basic research and clinical research. There are some physicians and some researchers who have felt that it's almost as though clinical research is a bit of a poor cousin, and I'm wondering what your thoughts are or what your experience was with that.

***C. Stratton Hill, MD***

2:20:23.1

I think basically— You were talking about the poor cousin to pure bench research? Yeah, well, the two things that I see is there is a lot of clinical research, and it may seem non-molecular to the basic scientists when you're studying mechanisms of action and things of that sort. I think they are co-equal myself. I don't see that there's any— I mean, we were doing electron microscopy, but it was like the poor cousin. I'd just go in and talk to a guy and say, "Hey, will you do this for me?" And it was kind of a personality-basis-type of thing. Mike Ahearn [Oral History Interview] is still around. He's the dean of sciences now.

***Tacey Ann Rosolowski, PhD***

2:21:44.2

Actually, he retired.

***C. Stratton Hill, MD***

2:21:47.0

Oh, did he?

***Tacey Ann Rosolowski, PhD***

2:21:47.6

He did.

***C. Stratton Hill, MD***

2:21:48.2

He ought to. (laughs) He's the one who did the electron microscopy on those things. His name is on those papers.

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***Tacey Ann Rosolowski, PhD***

2:21:58.9

So he was your—? You collaborated.

***C. Stratton Hill, MD***

2:22:02.3

Yeah, but it was no real formal thing. I mean, he was in the Department of Pathology, but he had a lab right across the hall, and we'd go to lunch every day. They had a— Well, there used to be a building that Anderson had over there called the Anderson Mayfair, and that imploded several years ago. It's where the faculty building is now. But we set it up as a hotel later on, and there was a faculty club over there. We'd go over there and have lunch almost every lunch at the faculty club, and that was a great experience. Mike Ahearn was the guy that did the electron microscopy, and he did that along with the other stuff, just had to kind of push it in and do that.

And heck, my gosh, when we first got here, we didn't have the pharmacy, all the fluids and everything. We had to mix those up ourselves. I mean, if I wanted a 20 percent glucose solution, I made it up, and I usually made it up on the floor. I'd take some vials of glucose, calculate out how much glucose I needed to put in that vial, and just squirt it in there and get it done. So we didn't have this pharmacy that did all that stuff for us at that time.

We did all kinds of things like that, collaborating and all that business, with David Anderson, the geneticist. We traced that family back to Czechoslovakia. That one time, I was going to Europe, and I was going to go to Czechoslovakia, but that was after the Communists came in there. I remember we were going through Bratislava, but we decided we were going to do that when I went to give that talk in Vienna. I drove—no, no, no. Oh, yeah, went to Budapest. We drove from Vienna to Budapest, and we were going to stop in Bratislava, but then they were stopping you, and you spent hours and hours and hours at the border. I remember when we got to the Hungarian border; we had to go off over here, and there were guys with machine guns, and they said, "Open up the hood of the car." It was a rental car, and I didn't know how to get it open and things like that. I didn't get to see the people in Czechoslovakia. We did go back through— We then drove to Budapest, stayed there a while, and then drove down and went through Yugoslavia. That was when Tito was in power. I guess that kind of brings us up to when I went into the administrative stuff.

***Tacey Ann Rosolowski, PhD***

2:26:09.0

Well, do you want to break off for today then, and we can take up with that subject next time? It's getting pretty late.

***C. Stratton Hill, MD***

2:26:15.1

Yeah, and we're going to have to go to see a friend whose granddaughter had triplets.

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***Tacey Ann Rosolowski, PhD***

2:26:22.2

Oh, well, that's nice.

***C. Stratton Hill, MD***

2:26:23.5

We're going to Mercury Baroque tonight. Do you know about the—? There's a baroque music group here.

***Tacey Ann Rosolowski, PhD***

2:26:29.7

Yeah, I think I'm going to be going on Sunday.

***C. Stratton Hill, MD***

2:26:33.3

Oh, you're going Sunday? That's going to be at the—

***Tacey Ann Rosolowski, PhD***

2:26:36.1

At Rice.

***C. Stratton Hill, MD***

2:26:37.5

Oh, at Rice [University]?

***Tacey Ann Rosolowski, PhD***

2:26:38.1

Yeah. Well, let me just turn off the recorder. It's about 25 minutes of 5:00, and turning off the recorder for today. Thank you very much for spending the time.

***C. Stratton Hill, MD***

2:26:47.3

Well, you're quite welcome.

2:26:49.7 (end of audio session 1)

## **C. Stratton Hill, MD**

Interview Session 2: February 17, 2012

### **Chapter 7**

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

#### **Publishing the First Book on Pain Management**

Story Codes

C: Research and Success

B: MD Anderson Impact

A: The Researcher

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

D: The History of Health Care, Patient Care

#### ***C. Stratton Hill, MD***

0:00:00.0

—all the major players. There were just a couple that in retrospect didn't turn out very well, but what we tried to do was get a lot of different viewpoints, so to speak. This was the first attempt at bringing in all the players, like this guy, Charles Schuster. He was head of the division of—oh, I mean the National Institute on Drug Abuse. A lot of people called it the National Institute of Drug Abuse, but he didn't like that. And then Kathy Foley, I mentioned her before. Her talk was the decriminalization of cancer pain. Then I had an ethicist on moral values, healing pain and suffering. Then I had this anthropologist, "Contradictions in the Cultural Construct of Pain in America: A Pharmacologist's Concept of Narcotics and Physicians' Attitudes Toward Narcotics." He was a psychiatrist. He still is a psychiatrist at Yale, and he wrote sort of the history of how controls on drugs came about in this country. It's called American Disease. I don't know why he called it that.

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

0:01:49.1

What's his name?

#### ***C. Stratton Hill, MD***

0:01:49.7

David Musto, and I don't know; I think the second edition came out about the same time as this conference.

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

0:02:09.2

Now, did you know all of these people personally?

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**C. Stratton Hill, MD**

0:02:12.8

No, I just called them up. Well, I knew Kathy. I knew Roy Martin. I called up people to see, who can I get to do this? And I remember I called a guy at Harvard, and he said, “There’s a guy at SMU that you ought to get, Thomas Johnson,” so I got him.

**Tacey Ann Rosolowski, PhD**

0:02:34.9

Let’s see, when was the book published again?

**C. Stratton Hill, MD**

0:02:38.4

In 1988 or ’89.

**Tacey Ann Rosolowski, PhD**

0:02:41.2

And when was the date that you said that you should have published it?

**C. Stratton Hill, MD**

0:02:44.8

Well, we had another conference in 1984 that we should have published, but we didn’t. This is—the date is here somewhere—1988. This was— Yeah, we—

**Tacey Ann Rosolowski, PhD**

0:03:20.4

And the title of this book is Advances in—

**C. Stratton Hill, MD**

0:03:23.7

No, that’s the series. Drug Treatment of Cancer Pain in a Drug-Oriented Society, and Louis Lasagna—

**Tacey Ann Rosolowski, PhD**

0:03:35.0

That poor guy must have gotten terrible teasing when he was in high school. (laughter)

**C. Stratton Hill, MD**

0:03:40.1

He’s brilliant. I got him to do the foreword.

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***Tacey Ann Rosolowski, PhD***

0:03:46.3

Okay, and what was his specialty?

***C. Stratton Hill, MD***

0:03:49.9

Let's see. He presented here—well—oh, yeah, “Regulations from the Perspective of a Researcher and Clinician.” He was just a pain researcher, but he was Dean of Tufts—I think—Medical School at the time. Here are all their credentials.

***Tacey Ann Rosolowski, PhD***

0:04:55.6

Were these all individuals who took part in that conference, and then you gathered their papers?

***C. Stratton Hill, MD***

0:05:01.0

Yeah, exactly. At Tufts University Sackler School of Graduate Biomedical Sciences. The Sacklers are a very interesting family. They own a lot of— They're very rich. There's the Sackler Graduate School of Biomedical Sciences at Tufts. There's the Sackler School of Medicine in Tel Aviv. There's a Sackler wing in the Metropolitan Museum.

***Tacey Ann Rosolowski, PhD***

0:05:39.6

Oh, yeah. I was wondering if it was the same family.

***C. Stratton Hill, MD***

0:05:41.0

And the Sackler's wing at the one in Washington.

***Tacey Ann Rosolowski, PhD***

0:05:49.7

The Smithsonian.

***C. Stratton Hill, MD***

0:05:50.6

The Smithsonian. I think that's on Pre-Columbian stuff there. But this was a very heavyweight faculty that we had for this, and this was the first time we really tried to put everything together in terms of what impacted the treatment of pain. For instance, Eric Cassell, he's an ethicist at Hastings Center for Ethics, I think it's called, or something like that.

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***Tacey Ann Rosolowski, PhD***

0:06:42.8

Was there any other publication like this at the time?

***C. Stratton Hill, MD***

0:06:45.7

No, absolutely not. “Pain, Suffering, Addiction and Cancer,” H. Tristram Engelhardt. That’s some patrician name, isn’t it? He’s over at Baylor. And then I had Charlie Cleeland, and he wasn’t here at that time. He was at Wisconsin. This was another guy, “Pain Management and the Values of Healthcare Providers.” He wrote a fantastic article. He’s a philosophy professor.

***Tacey Ann Rosolowski, PhD***

0:07:24.8

What was the process by which the conference was established? I mean, was this the standard thing? Did everybody submit their papers, and you balanced it out?

***C. Stratton Hill, MD***

0:07:33.2

No, I put the whole thing together, and I called up these specific people and said, “This is what I want you to talk about.” I remember this guy, John Morgan. When I told him about what the conference was all about he said, “You mean I get to participate in a conference like that?” I mean, he is the one that’s coined the term “opiophobia.” He’s a clinical pharmacologist in New York. I think he was at the City—used to be CCNY, but I guess it’s CUNY now.

***Tacey Ann Rosolowski, PhD***

0:08:15.1

What was he so excited about? You said he said, “I get to participate in a conference.”

***C. Stratton Hill, MD***

0:08:20.2 We were addressing issues that he thought were pertinent. In other words, everybody was saying, oh, we’ve got to teach our—education is what we’ve got to do, and we were saying lots more than just education. You can’t do it without education, but education alone won’t do it. That’s proven to be absolutely correct because it’s increased the education. But even right now, the Institute of Medicine has just published a monumental book basically on the problems with pain management in the United States—or maybe just all over, but mainly in the United States. Since I’ve been retired, what I’ve tried to do is to try to get my arms around the whole problem, and I’ve written tons of stuff on it but have never gotten anything that satisfies me. It’s because we haven’t really identified all the— Well, it’s almost like trying to pick up a greased watermelon out of a swimming pool. There’s just so much of it that is so subjective. What I’ve tried to do is— What I’ve always said is it’s a societal problem. It’s not education, and this Institute of Medicine thing— Just today, I was looking on something and saw where in the New England Journal of Medicine there’s an article written by the guy that was the head editor of that

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Institute of Medicine talking about how education—we've got to do the education. We've got the education. It's just the doctors won't do it because of the cultural attitude towards pain and its treatment.

*Tacey Ann Rosolowski, PhD*

0:11:00.6

Can I interrupt you just for a sec? I want to pause this. (audio pauses 0:11:04.2)

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**Chapter 00B**

Interview Identifier

*Tacey Ann Rosolowski, PhD*

I turned on the recorder a little bit earlier because Dr. Hill was talking about the book that he and others published in 1989, but I just wanted to record the identifier a little bit late. This is Tacey Ann Rosolowski interviewing Dr. C. Stratton Hill. This is our second interview session, and we began at about five minutes after 2:00. The date is the 17th of February, 2012.

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## **Chapter 8**

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

#### **Understanding the Problem of Pain Management in the 70s and 80s –at MD Anderson and Beyond**

Story Codes

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

A: The Researcher

A: The Clinician

A: Overview

A: Definitions, Explanations, Translations

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients

C: Cancer and Disease

B: MD Anderson Impact

B: Critical Perspectives on MD Anderson

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

Okay, so why don't we talk a little bit about the— We'll talk about the ambulatory care a little bit later. I mean, I was wondering, could I just ask you just to—? You were saying it's like picking up a greased watermelon out of a pool, which is an amazing metaphor for a complex problem, I have to say. When you began work in this area, which was in the late '70s, early '80s, it sounds like— Tell me about what you saw at that time and then how you're seeing it now.

#### ***C. Stratton Hill, MD***

0:12:10.0

Well, what I saw at that time was that we—when I say we, I'm talking about Anderson—had no real organized approach to pain treatment, and actually that was not, shall we say, on the front burner at that time because it was just about that time that cancer patients were beginning to live longer and chronic pain was becoming a problem. And so that was what made me— And in my dealings with the clinical aspect, or at least the administrative aspect of running the clinic, was that we had a pain clinic that was kind of run by the anesthesiologist but not really. If they didn't have anything else to do, which they almost always had something else to do, then they would have a pain clinic, but most of the time they didn't. They then got some people to come over from the medical school and Psychology, so it was just a haphazard approach to pain. I realized that, from what I was seeing before I'd gotten into the administrative job, a lot of people were having chronic pain that didn't seem to get it adequately—

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***Tacey Ann Rosolowski, PhD***

0:14:02.3

I wanted to ask you just because I think we're talking about a period of time that maybe a lot of people who will be listening to this, they weren't around then or they weren't professionals at that time. What were you seeing? How do patients—? How did patients at that time experience chronic pain? What was it like for a cancer patient? What were you seeing?

***C. Stratton Hill, MD***

0:14:26.9

I was just seeing what you'd call in general the undertreatment of pain. I can remember some of the early patients that we had would say, "I wonder why my doctor didn't do this?" because it wasn't anything magic that we were doing. "I wonder why my doctor didn't give me this medication."

***Tacey Ann Rosolowski, PhD***

0:14:57.7

What medications were you giving?

***C. Stratton Hill, MD***

0:14:58.7

Well, I can remember specifically, at that time, that was before they had the longer-acting drugs like MS-Contin and OxyContin and delivery systems that lasted over eight to twelve hours. But the half-life of methadone was much longer, so it was the only drug that we had that would last longer periods of time that would allow the patient not to have to take medication so frequently. But because of the long half-life, it made it difficult to manage, because you built up a level over a period of time, and you had to figure out at what time that was going to plateau out to where you wanted it. You oftentimes got into too much medication, and they got real drowsy about a week after they started taking it. It was kind of hard to manage. I remember I gave this patient methadone, and she was saying "I wonder why my doctor didn't give me this?" Now—

***Tacey Ann Rosolowski, PhD***

0:16:24.9

Can I ask you just for a sec—I mean—this may sound like a very ignorant question but—

***C. Stratton Hill, MD***

0:16:32.2

No questions are ignorant. (laughs)

***Tacey Ann Rosolowski, PhD***

0:16:36.9

Well, I wonder if you could talk a bit about what the sources of pain are for a cancer patient.

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***C. Stratton Hill, MD***

0:16:47.0

Yeah, they're basically divided into three different categories. First is the cancer involves pain-sensitive structures in the body either by pressure of the tumor growing and putting pressure on a nociceptive nerve or just infiltrating into that tissue, just related to the presence of the tumor itself. It can be related to treatment, particularly chemotherapy, because at Anderson we started doing regional perfusions of particular extremities for melanoma and things like that, trying to save the extremity because the method of treatment. Like at Memorial, if you had a melanoma on your leg, you got your leg amputated.

Well, John Stehlin, at MD Anderson, was one of the early pioneers in regional perfusion. He would isolate the extremity with certain pressure controls of the blood supply, and it was almost like a heart/lung machine. You would perfuse that—or possibly a lethal concentration of the drug into that extremity and recirculate that blood into the extremity over a period of time. But that would also perfuse the nutrient arteries of the nerves, and so they got a whopping dose of this medication that was actually toxic to that nerve, so then you had what was called neuropathic pain. The difference between neuropathic pain and nociceptive pain is neuropathic pain occurs in the setting of a damaged nervous system, whereas nociceptive pain, which is the most common type of pain that everybody has, is in the setting of an intact, or normal, nervous system. The big difference there is that neuropathic pain does not respond to the ordinary analgesic drugs like nociceptive pain does. For instance, if someone comes in with a broken leg into the emergency room, you can give them a shot of morphine, and it takes their pain completely away. In the case of neuropathic pain, that helps some, but then—I mean—usually analgesic drugs—but then you have to use different drugs that are not ordinarily classified as analgesic drugs, such as the anticonvulsant drugs and the antidepressant drugs. You hear these advertised on TV all the time now. Those are the two big categories of the types of pain.

With treatment, you usually end up with a neuropathic type of pain because all you've got to do to damage the nerve is to cut it, and that in and of itself caused neuropathic pain. That took a long time to get through to surgeons. They had the tendency to say, "Wait a minute. I know what nerve that is. I'll just cut that." And they'd cut it, and then the patient would have neuropathic pain. Their pain was worse than it was before, so you don't see them doing that much anymore. So it can be due to the tumor per se, due to the treatment, and then the third type is unrelated to both. That's pain for anything else. A diabetic can have a diabetic neuropathy. A rheumatoid arthritis patient can have it, joint pain secondary. A patient who has had a back injury can have back pain, all that, so there are three general categories.

We saw all of that, and so we were very reluctant to say or call it cancer pain because pain is pain. We would say it's pain in the cancer patient. Basically, we saw all kinds of pain. Another type of neuropathic pain is pain that's seen in shingles and so-called postherpetic neuropathy that can be a chronic pain. Because of the depression of the immune system in cancer patients with

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cancer therapy, you often get increased incidence of shingles in those patients. We saw all the different kinds of pain.

***Tacey Ann Rosolowski, PhD***

0:22:45.3

Now, when did you begin to realize that you had to do something about this in an institutional way and in a research way?

***C. Stratton Hill, MD***

0:22:58.5

Well, I don't know that I looked at it as I had to do something about it. It was that I thought that we needed to just look at the problem, see what it is, try to define it. And when I looked at it from my own standpoint, about my own knowledge, even when I was up there with Dr. Houde at Memorial, it wasn't broken down into these different categories. We didn't quite do it that way at that time, I think mainly because cancer patients didn't live long enough, so you didn't have a chance to look at the cancer patient very long. The first thing I noticed was the fact that patients would come in, and they would simply not be given enough medication. That was related to what was in the literature about what the usual doses were for severe pain, but those studies were done in acute pain that was self-limiting, so nobody had any notion about titrating a dose of pain medication to an effective level, and that would be relief of pain. And so one thing that I developed was what we call the morphine test. I would simply put a little butterfly needle into a vein and give patients medication until their pain went away. It seemed to be pretty simple to me.

However, there were some people who didn't get complete relief, so I realized that my knowledge about pain was deficient in this regard. So we started doing that on practically every person that we saw because it gave us some idea about what dose of medication that we were going to prescribe for the person that was an outpatient. In other words, if we know that if you're going to use morphine, the difference between giving the patient oral morphine as opposed to parenteral, like we were giving into the vein—that there's about a three to one ratio. You've got to give three times more orally than you do intravenously because of the first-pass effect through the liver. Oral medication has to be absorbed. It goes into the portal vein and goes through the liver before it gets to the binding sites where the action takes place, so you have to give the patient enough to know that after it passes through the liver, the dose is adequate to relieve. So if you had to give them 10 mg of morphine intravenously to relieve their pain, and that would last about four hours for immediate release morphine, then to get 10 mg into the veins systemically you had to give them 30 mg orally. Then you would prescribe that. If you had to give them 20 mg intravenously to relieve the pain, then you'd have to give them 60 mg orally.

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***Tacey Ann Rosolowski, PhD***

0:27:28.5

I have another question. In terms of the management of pain—I mean—there certainly is the immediate benefit of relief to the patient and just their experience of their own—the relief of suffering. Is there something about pain management that actually helps—or how does the pain management help their long-term healing and survival? Is there a mechanism in there?

***C. Stratton Hill, MD***

0:27:53.1

Oh, God, have you got a couple of weeks? (laughs)

***Tacey Ann Rosolowski, PhD***

0:27:58.2

I imagine you'll have to boil it down, but I'd love to hear some of the ways.

***C. Stratton Hill, MD***

0:28:02.5

Well, one of the guys that is a contributor to this book, Dr. [John] Liebeskind, he was a fantastic guy. [Redacted] but he wrote—and there's a library out in—I think it's at UCLA. He wrote an article, an editorial, one time, "Pain Kills." Actually, he was a psychologist, but he was very much of an experimental psychologist, and in mice he showed that when you created a painful stimuli in a mouse, that if you injected cancer cells into the vein of a mouse, the ones that— Say, for instance, you ligate a nerve to cause the pain, so the animal had chronic pain. They had a lot more metastasis in the lungs, or a lot more of those cells grew in the lungs, in those animals who had that painful condition, chronic painful condition, than the ones who did not have that.

Now, granted, that's an animal experiment, but there had been some studies done whereby they've looked at some patients. But it was very difficult to do this—to get it controlled where you can see in a human whether or not a person who has chronic pain has more metastases than a patient who does not have. But that's the short answer to your question is that there is evidence to indicate that lack of control of pain makes whatever condition you've got worse, cancer or any other condition. Chronic back pain due to motor vehicle accident or anything like that, patients just don't do as well because of probably a lot to do with the psychological effect that causes change in the immune system so that you're susceptible to a lot more things or vulnerable to a lot more things than you would be otherwise.

That's the short answer, yes, that failure to control the pain will cause the condition to be worse. I think there have been some hospice studies done where they've looked at patients whose pain is well controlled. They seem to have done better than the ones—they live longer, with a fairly decent quality of life, too, because just quantitative differences in how long you survive is not really what you're looking for. It's the qualitative—what quality of life do you have in that period of time?

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## **Chapter 9**

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

#### **A Pain Clinic for MD Anderson**

Story Codes

A: The Researcher

A: The Clinician

A: The Administrator

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

B: MD Anderson History

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

D: The History of Health Care, Patient Care

***Tacey Ann Rosolowski, PhD***

0:32:05.0

At this time, in the late '70s, in the early '80s, when you were seeing this need and others were seeing the need, how did you go about addressing this, and what led up to you establishing the pain clinic at MD Anderson in a formal way?

***C. Stratton Hill, MD***

0:32:26.4

Well, when I asked to be relieved of the administrative duties, I did that with the express purpose of starting a formal pain clinic, and since I was running the clinic, I knew how to set up—there were no—they would see patients once.

***Tacey Ann Rosolowski, PhD***

0:32:51.6

At the pain clinic?

***C. Stratton Hill, MD***

0:32:53.3

Through the pain clinic the way it was run and that was it, and no return appointments or anything like that. It was kind of an orientation. You're going to have a little pain or a lot of pain. You've got to kind of adjust to the pain, and then we had people who were giving them some instructions in relaxation and things like that but no real formal thing that was set up where you come back and follow up and set up a program. I set that all up, and then it was just actually empirical. When I saw that— And another important part of what happened during that time I was running the clinic, I was still keeping up with the medical literature and so forth, and of course, we had been working in endocrinology with a guy over at Baylor by the name of Roger Guillemin. Don't ask me how to spell Guillemin, but it's French. He subsequently got the Nobel

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Prize, he and a couple other physicians, for the discovery of the hypothalamic hormones. We were interested in the hypothalamic hormones because we thought that might be a good way to treat thyroid cancer, with radioactive iodine.

If we could stimulate the cancer cells to take up more radioactive iodine, that would kill more cancer cells. So I'd started working in the brain peptides before I took that administrative job. Then about that same time, the binding sites for naturally occurring opioids were discovered, the endorphins and enkephalins, and that created quite a bit of excitement. So that came along, and that kind of encouraged me to continue looking at if there were binding sites, there must be a natural ligand that will hook on to that binding site. That's when they discovered the enkephalins and the endorphins and so forth. I thought that was a great avenue to explore because it would maybe obviate all of the adverse problems that you had with the use of opioids. So that was in the back of my mind all along. And so take that with my experience at the beginning of seeing patients and having them come back and giving them medication that wasn't doing them any good and realizing that, well, let me give them a little bit more, and that's what I did.

And then I got to looking at, well, why won't other doctors do this? And that's when I began to look at the things that I thought would be barriers to the use of opioids, because, in our case, we were dealing with people who had significant pain. We also had another guy that was working there with us that was a—I called him a defrocked Catholic priest, but I don't think he was defrocked. I think he just gave it up. He was a psychologist and he liked to— He was toying with hypnosis. We also had a guy in physical medicine who was using the TENS unit, which is sort of the American version of acupuncture. It's a—TENS stands for transcutaneous electrical nerve stimulation, T-E-N-S, and so we had a guy that was interested in that. So I pulled all those people together.

***Tacey Ann Rosolowski, PhD***

0:38:06.3

Do you remember the name of the man who left the Catholic priesthood and then the name of the man who did the TENS unit?

***C. Stratton Hill, MD***

0:38:17.2

I think the guy— His name was Villarreal, but I can't remember the name of the priest that was a psychologist who was—he was just more of a—I suppose you'd have to call him a behavioral modification person. He was just going, "Sorry, you're going to have to live with it," because that's about all they could do. Anyway, we got all those, and we had a physical therapist and an occupational therapist that was interested in doing relaxation. So I got all of those people together, and we would have them see each one of those to see if there was some kind of a way that they could add to the person's comprehensive problem, because it is a complex experience and a negative experience.

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***Tacey Ann Rosolowski, PhD***

0:39:44.7

Can I ask you—because I'm just really struck as you're talking about these individuals that you brought together in this team approach—I mean—this is basically the kind of approach that we think about with treating pain now. Was that unusual to be looking at the problem from so many different directions at that time?

***C. Stratton Hill, MD***

0:40:08.4

Well, the granddaddy of all pain in the world is John Bonica. He died several years ago, but he is the one who organized the International Association for the Study of Pain. He was quite a character. I had him on that 1984 program, and I was able to get all those people on my program because of Ray Houde, in New York, who knew all these people. So I had him. John Bonica was one of the first ones to put all this stuff together, and he had a guy that was a psychologist that was a major behaviorist. His name was Wilbert Fordyce, and that was a very strong part of their program at the University of Washington in Seattle. So they were the ones that were really beginning to put together the multidisciplinary approach. And they had a guy named John Loeser, L-O-E-S-E-R, who was a neurosurgeon out there. He's still out there. Bonica died. Fordyce is dead. They were ones— But this was not confined just to cancer pain. This was more or less pain in general. They approached— we sort of came into it with— We'd taken all comers. After they'd gotten into more of the behavioral stuff and the multidisciplinary approach, they screened their patients. You had to really qualify for their pain clinic because their concept was that there were certain people—it's sort of like hypnosis. You'd say, "Well, this person, you can't hypnotize this person." They're just not "constitutionally" fit to be hypnotized, and so they would say, "It won't work in you, so you can't come." They were the ones that were really starting the multidisciplinary approach, the people at the University of Washington, and they had a lot of good people up there.

***Tacey Ann Rosolowski, PhD***

0:43:19.4

What was the reaction when you began to put together this multidisciplinary team at MD Anderson?

***C. Stratton Hill, MD***

0:43:27.2

Well, most of the reaction was that the doctors that were taking care of those patients were happy to get rid of them because they were probably not coming back for anymore treatment of their condition. But they had the pain, and so they were very happy to have somebody treating the pain, and particularly when we started using larger doses. That was one of the things that I took a lot of heat from. I was making everybody a drug addict, and they even said that I was giving them industrial size doses of narcotics. But you'll see, if you look at that My Word Against Them, I have five patients on there that describe their condition, and by implication, you can tell

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that whoever was prescribing or having to follow our recommendations, sometimes they didn't do it.

One woman in particular— Because we would tell the patient what we were going to prescribe and how they could ask for medication, and we were breaking down the barriers of every four hours and— Let's see, what was that movie? They shot it right over here on Locke Lane. Who was in that movie? I've forgotten the name of it. [Terms of Endearment] Shirley MacLaine was in it, and her daughter had cancer, I believe, and she goes out and asks the nurse, and the nurse says, "Not time yet," and she just really lets that nurse have it. "My daughter has pain. You better bring it." And I ran into that a lot. I can remember one time I said to the nurse "Go get her a dose"—or whoever it was—"a dose right now because she's in pain," or he's in pain. And she went, and she said, "We don't have any on the floor." I said, "Well, get some." And so she had to go get it, but it was kind of like a triumph. "We don't have any."

***Tacey Ann Rosolowski, PhD***

0:46:27.1

Why did she react that way?

***C. Stratton Hill, MD***

0:46:29.9

You tell me. That's the cultural part that I'm talking about. These drugs have a bad name, and that's what I said on 60 Minutes that you'll see.

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## **Chapter 10**

### **A: Overview**

#### **Pain Management and Opioids: Today and in Historical Perspective**

Story Codes

D: Cultural/Social Influences

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

D: The History of Health Care, Patient Care

A: Critical Perspectives

A: Overview

A: Definitions, Explanations, Translations

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

0:46:44.7

Maybe could you outline—since we’ve gotten to that issue, really kind of in our face right now about the cultural and social barriers against these drugs. What are some of the larger problems, the ones that come from outside of the hospital or clinic setting, that have prevented adequate pain management, the greasy watermelon stuff?

#### ***C. Stratton Hill, MD***

0:47:09.4

Well, My Word Against Theirs deals with that. We were lucky to have a young lady who had worked for one of the TV stations here, so she was able to get clips of a narcotic raid. So one of the things that— And I got one of the anchors from the TV—she got one of the anchors from one of the TV stations. He’s dead now, but he narrates it. She’s the one that would say, “Say the word, say the word, say the word,” and so one of the things that I say and probably the most—well, I don’t know what the most is, but one of the major problems is we don’t distinguish between the abuse of these drugs and the legitimate use. You hear guys on television now still perpetuating all of this confusion between someone who—particularly here, when you’ve got this Whitney Houston. It’s like “They ought to put those doctors in jail that gave her this medication.”

And so that’s what I’ve been preaching all this time, and My Word Against Theirs—I mean—the 60 Minutes is about this Dr. William Hurwitz. That’s what this is all about. And at the end of that 60 Minutes thing, they have a guy who was a patient of Hurwitz, who was able to get him under control, and then when they pulled his license, the guy had been trying to get a doctor for years and years and years, and he couldn’t. He finally got one, and he says, “I finally get a doctor and what do they do? They take his license away from him.” He said, “I don’t want to commit suicide, but I’m at my rope’s end,” or something like that, and he did commit suicide.

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***Tacey Ann Rosolowski, PhD***

0:49:34.9

And this was because Dr. Hurwitz was willing to prescribe the medication.

***C. Stratton Hill, MD***

0:49:38.7

Right, he was. I got involved with him long before. That was in 1996. I first got involved with him in 1991. He had prescribed— And he got into it with the usual non-information about how to treat pain from his medical school. He got his license taken away from him by the Consumer Regulation Board or whatever it is in Washington, DC. He practiced in that area. In this tape, they're interviewing the people from the Virginia Medical Board because he then moved his practice over into Virginia and practiced in that Washington area and the Virginia board took the license away from him and also of the pharmacist who filled the prescriptions. And his first encounter was a patient who had bilateral aseptic necrosis of both hips, and he was about 30 years old. He needed hip replacements, but nobody wanted to do hip replacements on him because they considered him to be too young.

They didn't know how long these hip replacements were going to last at the time, and so they wouldn't do them on patients like that. So Hurwitz gave him enough medication to control the pain, but he used a drug that is a combination of oxycodone, which is the narcotic that's in OxyContin that got such a bad name later on. He combined that with acetaminophen or Tylenol, and in the old days, people didn't realize that—they'd say, "Well, take two of those," and there would be 5 mg of oxycodone in that pill along with, say, 325 mg of acetaminophen. And then they'd say, "Take two of them." Well, that gave them 10 mg of oxycodone and then whatever, 650 mg. Then they'd say, "Well, you still got pain, take another one." What he did, he continued to up that dose, and he got toxicity from the acetaminophen, not the narcotic.

See, what people don't realize, narcotics are the safest drugs that we have in terms of organ toxicity. They don't have any organ toxicity. It doesn't do anything to the brain. It doesn't do anything to the heart, the liver, the kidneys, but where you get into trouble is the amount of acetaminophen that's in the combination drugs. So he produced a chemical hepatitis in this guy, and they had to take him off of that. Then they finally got somebody to operate on him, and the guy got off of all drugs. They had another patient who was in the Foreign Service, and he had a pain problem. Hurwitz would send him these drugs all over the world, and so he got into trouble with that. That's how he got into trouble the first time, and then the second time was when he was writing for the medication in northern Virginia. This one pharmacist was filling it all, and you'll see all that in the—and that's what this is all about is the cultural part of what's gone down on this.

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***Tacey Ann Rosolowski, PhD***

0:54:05.8

So one of those cultural elements is the myth that narcotics are very easy to abuse, and they're thought of only as drugs of abuse, not drugs of treatment.

***C. Stratton Hill, MD***

0:54:17.1

It's a misunderstanding about what addiction is. The World Health Organization took that word out of their lexicon in about 1960 or 1950, maybe. It's either a physiological dependency or psychological dependency.

***Tacey Ann Rosolowski, PhD***

0:54:40.8

So they don't use the word addiction.

***C. Stratton Hill, MD***

0:54:42.2

No. Physiological dependence occurs in everybody who takes these drugs chronically because the cells adapt to the presence of this drug in the system. When you take them away, there's a physiological response, so-called withdrawal response, or abstinence response, cold turkey and stuff like that, and you have the physiological reaction by your body. All you've got to do to avoid that is just to taper them off of the drug, and so physiological dependency is no problem. Psychological dependence is when you have a compulsion or a craving, or both, to take the medication or take the drug or take anything when you know full well it's going to cause you harm. That's the so-called addiction.

The complexity of what goes into that entity is not well understood. We think that— Our society thinks that if you take this drug, you will ineluctably be drawn into addiction and fall over the cliff into a depraved antisocial behavior, and you have no control over that, that in spite of all that you can do, that's what's going to happen if you take that, and it happens 100 percent of the time. That's crazy. Most people who take these drugs do not get euphoria. They get dysphoria. They don't like it. They don't like the way it makes them feel, and so the vast majority of people who take the drug do not become psychologically dependent on the drugs. Now, physicians have—are somewhat responsible for some of this because they don't—these drugs have more than just euphoric or mind altering properties. They relax people. They're anti-anxiety drugs, and so you can have anxiety, and that relieves that. Your pain goes away, but you still have anxiety, so you say, "Well, I still need this drug," so you get the narcotic.

It's up to the doctor at that point to say, "Wait just a minute. If you've got anxiety, tell me how you feel. What is it that's bothering you? Your pain has gone away, so what's the problem?" "Well, I just get all jittery. I get nervous and so forth." "Well, okay, fine. Let's give you something else for that. Let's give you an appropriate drug." You get some people who take

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cough medicine that's got hydrocodone in there. You'll say, "How long you been taking this cough medicine?" "I've been taking it two years." "Two years? Have you got a cough?" "Well, yeah." They're not going to tell you they don't have a cough because they're afraid you'll cut them off, but nobody has stopped to ask them. They just refill it, refill it, and refill it.

Then you have to look at the history of drugs. Before the Food and Drug Act, which came into being in 1906—and all that did was to say that you had to say what was in drugs. You could put anything you wanted to in there, but you just had to say what it was. One of the things that they had was they had rectal suppositories that contained opiate, and of course, people got dependent on opium, and they would take rectal suppositories forever. And so when they said you've got to take that out of there, they didn't like that. See, you didn't get the Harrison Narcotic Act until 1913, so how we got control of drugs is a very fascinating story, and that's what David Musto researched in his book. He tells about that. It all came about after the Spanish-American War and the turn of the 20th century, right about 1898 or whenever that war was. And we got— From Spain, we got the Philippines. We got Puerto Rico. I think that's supposedly the least costly war in terms of men killed. I think there was like 350 or something like that total, and then we got all that property.

When we got the Philippines, there was an Episcopal bishop. His name was [Charles] Brent, and he was sent to be the Episcopal bishop of the Philippines, and the governor of the Philippines was William Howard Taft. When they got there, one of the things that they realized was that Spain was giving out opium to the Chinese that lived in the Philippines, so that meant that the government was in the opium business. Well, that didn't go over too well with this bishop, so he goes to Taft and says, "Hey, we've got to do something about this. We don't want to be in the drug business."

Before that, you could bring anything you wanted to into the United States. You could put it into medication. There was no control at all. So Taft then said, "Well, if we're going to do this"— Well, of course, they were held up from doing anything until the insurgency got over because the Filipinos thought we were just going to get rid of the Spanish and give them the Philippines, and we didn't do that. So there was about 10 years of insurgency in there. After all that was over, then they decided that we're going to go in there and set up things and find out all about this opium. Taft said, "Well, you're going to have to go see the British because they run India, and that's where all the opium comes from that goes into China." That's where the Opium Wars all came from. Then that means it's in the Department of State. So he did all that, and the British said, "You must be joking. That is the main cash source for India is selling opium. You think we're going to stop that? You're crazy." And he wanted him to regulate. He says, "Well, we've got to regulate this all over the world." Then they said, "Well, wait a minute. You don't regulate that in the United States. You're coming to us and saying we've got to regulate things?"

Then by that time William Howard Taft was president, so he was pushing to get this done. That's when it started all this business with The Hague and the World Councils, and they decided to set

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up treaties. It's a long, complicated story, but it never worked. However, we did get drug controls in the United States. The Harrison Narcotic Act was passed in 1913 and then even in that—I had a student one time. He was researching all of this. He was a law student. They had a combination program—they still do over at the School of Public Health—where you can get a Master's in Public Health and a law degree at the same time. He researched all of the congressional records of the arguments during that time. A lot of the senators were saying "Hey, wait a minute. We don't want to stop the legitimate use of these drugs. We've got to be careful about this," and so forth.

***Tacey Ann Rosolowski, PhD***

1:05:44.9

They foresaw the problem back then.

***C. Stratton Hill, MD***

1:05:46.7

Well, that's right, that this would be a problem. The Harrison Narcotic Act, nobody paid much attention to that, and so it was just a can of worms. The Public Health Service ran some addiction clinics where people who declared that they were drug addicts could come and get that from the US Public Health Service. They didn't close that down until the late '30s.

***Tacey Ann Rosolowski, PhD***

1:06:21.9

Interesting, so all those things contributing—

***C. Stratton Hill, MD***

1:06:25.1

All of this stuff has contributed, and if you go back and look in the literature, before the discovery of ether, the American Medical Association was coming up with a behavioral program where if you've got to have surgery, just expect to be held down to have the surgery. And so this guy, anthropologist, deals with that some in here.

***Tacey Ann Rosolowski, PhD***

1:07:03.9

I was going to ask you about the flip side, when you and others at MD Anderson were collaborating to set up the pain clinic and beginning to do some real treatment, because there's the cultural image of the drugs that you were using. But what about the theories of pain? What was the understanding about how pain worked in the body at the time?

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**C. Stratton Hill, MD**

1:07:29.0

Well people were getting—I mean—physicians were seeing more of neuropathic pain. They knew that people who had usually motor vehicle accidents or trauma where if they got those old washing machines that had the roller to dry—

**Tacey Ann Rosolowski, PhD**

1:07:55.5

Oh, yeah. The hand crank.

**C. Stratton Hill, MD**

1:07:56.8

People would get in the wringer, and they would pull avulsive injuries from things like that and getting into machinery, industrial accidents. What happened there is you would pull the nerve away from the spinal cord, maybe not completely, but almost completely. Well, then you got a condition that was called at that time reflex sympathetic dystrophy, and that is horrible. People would get that. Now they call it complex regional pain syndrome because it's more than just the sympathetic nervous system involved in that. People with that oftentimes committed suicide. It was just intolerable pain, and that is one reason why they said everybody—

When the Civil War came along, they said that was the first time that they really had morphine, and they just invented the hypodermic syringe. That was the first time that they were able to give morphine parenterally by injection. That's a long story, too, because those cannons, the ball did not explode. They didn't have anything like that. If you hit somebody— If a cannonball hit you, it generally mutilated you. In other words, you hit the arm, and it would just knock the arm off, and of course, that just pulled all those nerves out there. I've researched that, and I'm convinced— And of course, then they said after the Civil War, everybody came home addicted. They were drug addicts. They were dope fiends. That's what they called them. They were just in all kinds of pain, and it was neuropathic pain. They even had what they called stump hospitals. Do you have any idea what a stump hospital is?

**Tacey Ann Rosolowski, PhD**

1:10:31.7

For the amputees, I assume, or no?

**C. Stratton Hill, MD**

1:10:35.7

How many amputees? How many extremities?

**Tacey Ann Rosolowski, PhD**

1:10:38.5

I have no idea.

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**C. Stratton Hill, MD**

1:10:40.6

All four—all four extremities gone. There were enough people to where they had just hospitals for those people, and they were called stump hospitals. They got perfect descriptions of neuropathic pain that these guys— And there was a guy named Weir Mitchell.

**Tacey Ann Rosolowski, PhD**

1:11:05.0

Yes, Silas Weir Mitchell.

**C. Stratton Hill, MD**

1:11:06.7

Yeah, and he was the first one to—and he called that causalgia. That was basically phantom pain, and he was the first one to really describe that. But see, the misconception from a medical point of view and not understanding neuropathic pain, wait a minute, you're all healed up. You don't have an arm or a leg, but you're all healed. There's nothing there that could cause you that pain. So they didn't understand that. They didn't understand phantom pain either. It was causalgia. You've got a pain in the foot you don't have. You must be crazy. That's another thing that I call atypical complaint. I've got a pain in my right foot. Where is your right foot? Well, I don't have it. The guy's crazy.

**Tacey Ann Rosolowski, PhD**

1:12:12.2

Of course, now we understand—a neural understanding of how the brain is wired.

**C. Stratton Hill, MD**

1:12:16.9

Yeah, that's right, and not only that, then he'd say, "Where is your right foot?" "Well, it's sticking right out front there, and I sure would like to just relax it and put it in its normal place." They have an image that it's in this abnormal place. There's a guy that was a good friend of mine, Dr. Ronald Melzack. He and this guy, Pat Wall, came up with the gate theory of pain. That's a whole other subject, but that's the accepted theory of pain at the moment.

**Tacey Ann Rosolowski, PhD**

1:13:07.7

And what does that say?

**C. Stratton Hill, MD**

1:13:09.8

Well, that says basically if there is an impulse going in one pathway, that it will block another

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impulse from coming in there. This would be theoretically maybe the mechanism for acupuncture. Nobody knows what that is. It's about endorphins, gate theory, things of that sort.

***Tacey Ann Rosolowski, PhD***

1:13:39.5

Isn't that also the logic behind those hot and cold rubs you put on the body? To make the body—

***C. Stratton Hill, MD***

1:13:45.5

Oh, yeah, or just rubbing. See, in other words, you are stimulating—you're sending a message up for the brain to handle, and you're blocking these painful stimuli from getting in there. So that's what the gate theory is, and you can have that either going up to the brain, or the brain can send messages down to block that area from coming in there. It's sort of like if you got the freeway from here to Dallas, and Houston says, "I'm going to stop the people from getting on the freeway in Dallas," and it's because of something up here.

That was a whole other thing that happened with this Civil War. The other part of it was infections. Boy, they got infections like crazy, and they'd have to amputate. Then when the North blockaded the South, there was an article that they think was written by Weir Mitchell in the Atlantic Monthly or Saturday Review or something. I've forgotten the guy's name. But anyway, he became a stump, and so he describes—that's why I guess they think it was written by Weir Mitchell, because he described the pain. Now, the guy may have described that to Weir Mitchell but—

***Tacey Ann Rosolowski, PhD***

1:15:33.8

I think I remember reading about that, and I can't remember if it was narrated or if it was a fictional thing by Weir Mitchell.

***C. Stratton Hill, MD***

1:15:45.5

Yeah, I'm not sure. I'm not sure anybody knows, because it was in either—I think it was in the Atlantic Monthly. Actually, I have that someplace. He described this pain, and the description that he had was—I wish I could remember the exact quote. Something to the effect that my hand was basically dead except for the fire that was in the fingers. He couldn't feel his— He'd been shot in the nerve up here, and he lost the sensation. He couldn't feel the hand, but one of the descriptions of neuropathic pain is burning sensation, and he talked about that, and that was really a beautiful description of neuropathic pain.

***Tacey Ann Rosolowski, PhD***

1:17:01.0

And that's descriptions that you've heard from patients that you've worked with, too?

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***C. Stratton Hill, MD***

1:17:04.6

Well, not as poetic as that. I wish I could remember that. I think I'll try to look that up just to try to remember it, but, oh, yeah, burning pain is almost pathognomonic of neuropathic pain. And then, see, you'd have other— The other part of it is we saw this in women who had mastectomies, post mastectomy syndrome, post thoracotomy syndrome. I had this one patient, a young woman, and this was just a problem that we were up against. Some of the residents from Hermann would rotate through our service, and they had one anesthesiology resident from over there with a female. I sent her to see a consult in the plastic surgery clinic because she was 28 years old and had breast cancer, had the breast removed, but they had made her a new breast with a flap and so forth. It was an absolutely beautiful job, absolutely beautiful. She had nothing in terms of deformity. Both breasts looked the same, no scars.

She looked fine, but she was complaining of this terrible pain. Her surgeon, the plastic surgeon, didn't have a clue. He didn't have a clue, and she was just beside herself. And of course, then she had a mother-in-law who when she was complaining of this pain, she said that the mother-in-law would say, "Well, Betty had that, but she never had anything like that," like it's all in your head. I explained to her what it was, and I said, "Look, I think you ought to come in the hospital and let us try to get this straightened out because it's not going to happen right overnight. It takes a while for this medicine to take effect," because we know now that the neurotransmitters, basically the hormones that transmit the nervous impulse, have to readjust themselves, and you have to get a bigger concentration of a different one, and then it takes a while for this medicine to do that.

She said, "I can't do it. I've got to go home. I've got to take care of my son." She lives in Fort Worth. I said okay, so she went home, and about 10 days later I get a call from a psychiatric hospital in Fort Worth that she'd made a major attempt to commit suicide. They said, "She's okay now. Will you take her?" And I said, "Yeah, we'll take her." We brought her back, and we got her straightened out. I kept seeing her for—then she got—she then developed cancer in the other breast, and then she developed metastatic cancer. All of that was treated. I remember she felt this lump in her other breast, and so they said, "Okay, we need to get an ultrasound," and they couldn't do it for four or five days. She comes up bawling to me in my clinic and saying what's going on, so I go down and talk to the guy in the ultrasound clinic to see if I can get in. He says, "I'll take her tomorrow," so he took her, and she got treated.

She got treated, and she was one of the ones that I was still seeing when I left in 1996. She was 15 or 20 years after her diagnosis and so forth with all that problem. But after I explained the first time, she said, "That's all well and good, doctor, but give me something for my pain." And I said, "I'm telling you, we don't have anything to give you. You need to stay here. We can give it to you in the hospital to make you better, but it's not going to be better until—and we can actually give you this stuff intravenously. You can't take it on the outside."

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***Tacey Ann Rosolowski, PhD***

1:22:12.2

What were you giving her?

***C. Stratton Hill, MD***

1:22:14.2

We were giving her an antidepressant, amitriptyline or nortriptyline, and we would put her on a PCA pump at that time. And we would give her some morphine, but we knew that that wasn't going to do it by itself, and we could give her intravenous amitriptyline, too, in the hospital. Anyway, that's the type of patients that we— Well, she had a terrible time getting anybody to refill her medication. She couldn't get it refilled in Fort Worth. She had to come back, and I'd write it, and I made arrangements so I could fax a prescription or mail it up there, because we had triplicate prescriptions for that.

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## **Chapter 11**

### **A: Overview**

### **Pain, Opioids and the Challenge of Working with Patients –and with Government Regulations**

Story Codes

A: Overview

B: MD Anderson and Government

A: Activities Outside Institution

A: The Clinician

A: The Administrator

A: The Leader

C: Discovery and Success

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients

***Tacey Ann Rosolowski, PhD***

1:23:21.6

I was going to ask you about the triplicate issue because I was reading in some of the articles and editorials and also in the guidelines that you worked on that that whole issue of prescribing on triplicate forms was a huge barrier for physicians. Could you talk a little bit about how that was a barrier to the prescription of these drugs?

***C. Stratton Hill, MD***

1:23:43.6

Well, it was like every time you wrote a prescription it went to the police department, and that's what it— Ross Perot was the one that got that all put into effect. He gave— I don't know whether he gave them but he said— He's in the IT business, and so he said this ought to be automated and we ought to keep up with it and so forth. So he's the one that put that in. I mean, doctors didn't like it that one prescription went to the Narcotics Division at the Department of Public Safety. Well, that was just part of the overall issue of regulatory control and barriers. We realized that— When I realized that doctors said, "Wait a minute, we're not going to give medication outside of what the book says is the normal dose to give," that's when I first went to my friend Bill Hobby [former governor of Texas] and said, "Hey, we need to do something about the Medical Practice Act," because I got a copy of the Medical Practice Act, and there was nothing in it that said that there was a legitimate use for these drugs. Any reference to opioids related to the abuse of them. I started with the Texas Medical Association, and they said, "Oh, no. We don't want to do anything like that."

***Tacey Ann Rosolowski, PhD***

1:25:55.3

Why didn't they want to?

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***C. Stratton Hill, MD***

1:25:57.0

See, you open up the Medical Practice Act, and you're going to get all kinds of problems, because if you start messing with that, then the snake oil people will come in there and the rain dancers and all these different people, so let's don't touch the Medical Practice Act. I thought, "Well, how can I get around it?" Well, I get a call then from one of the lawyers at the Texas Medical Association. C.J. Francisco was his name, a super guy, and he said, "You want to help me write the Intractable Pain Treatment Act?" And I said, "What?" Bill Hobby, what he'd done, he just took the bull by the horns and he got the guy— See, the lieutenant governor is the president of the Senate, so he got the Dean of the Senate to sponsor a bill. He calls up the Texas Medical Association and says, "I need a bill." Then C.J. Francisco called me, and so we wrote the bill.

***Tacey Ann Rosolowski, PhD***

1:27:20.8

What was Bill Hobby's interest in pain? Why did he champion this?

***C. Stratton Hill, MD***

1:27:25.9

Because I talked to him about it. We had lunch together lots of times on Saturday, and I had talked to him about this, so he just took the bull by the horns and started that. We got this passed—I mean—we got this drafted. I didn't have a sponsor in the House of Representatives, so, boy, it sailed through the Senate. I mean, boom, it was passed.

***Tacey Ann Rosolowski, PhD***

1:28:08.2

And this was in 1980—?

***C. Stratton Hill, MD***

1:28:12.1

It was 1989. There was a doctor in the House that was from Centerville, Texas. I think Center or Centerville. He never practiced medicine after that. He became big in state politics. Anyway, at that time, the AIDS epidemic was just coming into play. The guy's name was [Dr. Michael] McKinney. That was the doctor's name. Somebody said, "Why don't you get"—I forget what his first name was—"Dr. McKinney to be your sponsor in the House." I went up, and I talked to him, and he said, "Okay, I'll do that," and so it started its journey through the House. Well, he also was the sponsor of a bill for AIDS treatment. The person who was chairman of the Public Health Committee in the House wanted a punitive bill, and the doctor just wanted a treatment bill because when AIDS first came out, it was mostly in homosexual males, and the evangelical right-wing, religious people wanted to punish anybody who had AIDS. The doctor just wanted something to treat the patient. Anyway, he got crosswise— Would you like another—?

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***Tacey Ann Rosolowski, PhD***

1:30:32.0

No, I'm good. Thanks.

***C. Stratton Hill, MD***

1:30:33.3

He got crosswise with the chairman of the Public Health Committee because he was on the Public Health Committee. Well, the doctor prevailed with his AIDS bill, and so the guy in the—now, this is real politics—the Public Health Committee said, “You’ll not get anything else passed. I’ll guarantee you that.” At that time, you could call up, and you could get a bill status number. I’d call up every day to see how that was coming along, and it wasn’t moving, it wasn’t moving, it wasn’t moving. And one of these guys that was a lobbyist for the Texas and New Mexico hospice, I had become friends with him. We didn’t have a lobbyist, so I said, “Can you find out what’s going on with this thing?” He said, “Well, there’s the chairman of the Public Health Committee.” And I said, “Who is that?” and he told me. It turns out that he’s the brother-in-law of one of my good friends, so I called up my friend and said, “Hey, I’ve got a problem here. We need to get this bill out of that committee.” And he just says, “Consider it done. I’ll talk to him.” I said, “Okay, that sounds good.”

What happened was he didn’t get it out of the committee, so the bill failed. I called up Bill, and I said, “Bill, there wasn’t anybody against that bill. Nobody was against that bill, but it failed.” He said, “How did that happen?” I said, “You’re the ones in this legislature. Tell me how it happened.” He found out that that’s what happened, and so he couldn’t believe it. And Bill Clements was governor, so he called a special session of the legislature that summer to deal with workers’ compensation because they had not been able to get anything done with workers’ compensation. I said to Bill, “You can’t do anything except what the governor asks them to do in a special session.” I said, “If you get a chance, see what we can do about getting this thing done.” He says, “Okay.” They were making zero progress on workers’ compensation, so the last week of the session Bill then asked Bill Clements “Can we do this bill?” He said yes, so bam, it goes through the Senate, and this time Bill had— See, the only person that can take a bill out of a committee is the Speaker of the House. If it’s held up in a committee, the speaker can reach over and say, “Here it is. We’ll talk about that.”

Gib Lewis was the Speaker of the House. That’s still when everything was in Democratic hands. Bill had it arranged with Gib Lewis that if it didn’t go right through the Public Health Committee, he was going to reach in there and get it. I remember I was at a meeting in Madison, Wisconsin, at the University of Wisconsin, and I knew that was coming up. I called down, and I talked to the senator’s aide, and she said, “Dr. Hill, your bill just passed.” We got it passed in that special session. That’s just some of the politics that you have to—

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***Tacey Ann Rosolowski, PhD***

1:34:56.3

What was the essence of the bill?

***C. Stratton Hill, MD***

1:34:58.7

It had about three or four parts. First of all, it said these drugs had a legitimate use and that people who had intractable pain could be treated with these drugs, and third was that no medical organization could interfere with a physician who used these drugs to treat intractable pain. Fourth, the Board of Medical Examiners could not sanction a person, a doctor, for treating intractable pain with these drugs. We thought, boy, we've got this thing all squared away. But we found out we didn't. The board kept acting just like it always did. So then we looked at the Medical Practice Act, and it was just really— It had such vague terminology and still does. But it's pretty much universal across all states because medical practice in the bailiwick of states is not federal. There's nothing federal on this, so we then went to the—let's see. The Medical Practice Act is subject to the sunset law.

***Tacey Ann Rosolowski, PhD***

1:36:51.5

To the—

***C. Stratton Hill, MD***

1:36:51.8

Sunset law. Texas has a sunset law. You know what that is?

***Tacey Ann Rosolowski, PhD***

1:36:57.6

I do not.

***C. Stratton Hill, MD***

1:36:58.9

Okay, any agency of the state that's subject to the sunset law means that that agency's authorization to exist ceases at the end of 12 years unless the legislature reinstates it. That doesn't mean that it can continue to exist under the legislation that's there. It stops at the end of 12 years unless it's been—and it's got to go through the sunset process, and actually, that is a very, very good thing. Every state ought to have that. I didn't know anything about the sunset, and it was time for the Medical Practice Act to come up for the sunset. There was a senator from Beaumont. The name was Carl Parker. He could have been Senator Claghorn because he was the typical good ol' boy senator. I met with him, and he even came to MD Anderson to see me one time. He said, "Well, I'll take care of that. I'll take care of that."

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I didn't know any better, so when I talked to his chief of staff, it had already been through— I kind of talked to him and said, "How's it coming along?" "Oh, it's coming along fine." And so when I found out, she said, "Yeah, it's ready to go," and I said, "Well, does it have this, this, and this and this in it?" She said, "No, it doesn't have any of that in it." I said, "Well, wait a minute. That's what we wanted. Can we change that? Can we get it changed?" "There's no way you can get that changed now." We missed on that thing, and talking to Bill Hobby he says, "You know, really, that's not what the sunset process is all about." It was to change the laws, but obviously, it can be used that way.

***Tacey Ann Rosolowski, PhD***

1:39:37.1

What were the specific changes you wanted to see made?

***C. Stratton Hill, MD***

1:39:39.8

Well, we wanted to see the way that physicians were disciplined, for one thing. They had what they called the Informal Settlement Conference, and it was anything but informal. I mean, they just raked those guys over the coals. And by this time, I had been doing enough work and talking, and the board would get involved. When it would get sanctioned by the board, lots of times they'd call me.

As a matter of fact, I got a call just a couple of days ago from a lawyer in Wichita Falls who said, "I had a case against a neurologist up here, and you were my witness." I didn't talk to him. He left a message. I've got to call him back. But it's kind of interesting how all of this comes about. He said, "I have a daughter who is in occupational therapy school down there in Houston, and she wants to have an internship at MD Anderson." He said, "You were my witness about 20 years ago, and we had a favorable outcome for that neurologist." I don't know whether he really meant this or not, but he said, "In all my 30 years of law practice, I think you were about the best witness I ever had." I don't know whether he wanted me to help him get his daughter in, but things like that. By that time, I was doing a lot of that.

***Tacey Ann Rosolowski, PhD***

1:41:48.2

Serving as a witness for physicians who were being sanctioned and you were—

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***C. Stratton Hill, MD***

1:41:52.9 That case was a— This was an interesting case. I'm pretty sure this was the case. This was a case of a guy who had migraine headaches. He was an oil man who was married to a girl whose father was a doctor. He could not get pain medication for his migraine headaches in Wichita Falls. He was an airline— He had his own airplane. He flew his own airplane, and he would go— He divorced his first wife, whose father was the doctor, but he kept on treating him. He moved to New Mexico or something, and he'd have to fly out to New Mexico to get something for his pain and then fly back.

He had gotten a doctor, a neurologist, in Wichita Falls who would treat him, and he was out of town. That doctor was out of town, and this guy hated to go to the emergency room because they treated him like a dog. He had a girlfriend who was a policeman there. So he had this terrible headache. The headache started, and he called the doctor, and the doctor was out of town. But he called him and got in touch with him, and the guy said, "I'm going to order this stuff at the emergency room. You go to the emergency room. I know you don't like to do that, but go there, and they're going to give you this." Well, he went there, and they gave it to him, and then the orders were if it was— And then the story is that the resident or whoever came in and quizzed him about this, and by innuendo he's a morally reprobate drug addict and all this kind of stuff, and so it was that he could have another shot if it wasn't out of there, if he didn't get relief.

He got the other shot, and he talked to his girlfriend. He said, "Call that ambulance." I don't know why he had to have an ambulance. He was very obese. He had to have an ambulance, and he signed himself out, and he went home, and she went with him. He was obviously pretty groggy, and it took two or three guys to carry him in because he was so obese. He fell down in the driveway, and they finally got him into bed, and she thought— His girlfriend thought he had stopped breathing. He may have, so she got on top of him and tried to resuscitate him and caused him to vomit, and he aspirated that vomitus and everything, and he died. The suit was against the neurologist. It was against the hospital, against all that stuff, and so I testified for that neurologist. He got off. So did the hospital. But that wasn't— It was probably the fact that she got on top of him and gave him that stuff and caused him to vomit that made him—but that just illustrates what people have to go through.

***Tacey Ann Rosolowski, PhD***

1:46:28.3

And it sounds like Texas certainly wasn't the only state in which this was happening. When you were doing this work on the pain clinic, the Intractable Pain Act, and trying to get the medical legislation changed in Texas, were there other states doing similar things? Your movements to kind of treat pain in Texas, how was that part of the trend nationwide?

***C. Stratton Hill, MD***

1:46:56.5

About that time, the people in Wisconsin— And that's the reason I was in Wisconsin at that time

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was they organized the Wisconsin Cancer Pain Initiative, and so I got in touch with them. We started working together, and out of that—and started working with Kathy Foley. In 1981, we put on— Dr. Clark wanted to put on an international program here, and we put on one at the Shamrock Hotel. It was still there at that time. I had Kathy Foley on that program to speak about pain. That was the first cancer meeting to ever have anybody to talk about treating pain.

***Tacey Ann Rosolowski, PhD***

1:48:07.4

Oh, I see, so this was an international program for cancer in general, but then it had a pain thing.

***C. Stratton Hill, MD***

1:48:13.5

That's right. So I decided I wanted that—because I was in charge of that program, and I was the coordinator, and that was another time we missed the boat by not publishing that particular program. We had two or three Nobel Prize winners on that program. That happened at that time, and then shortly after that— See, we were beginning to make some moves, because 1984 was when we had this program here on pain and—

***Tacey Ann Rosolowski, PhD***

1:48:56.4

Just to back up a sec, what was the reaction from the attendees at that conference of the international program to Kathy Foley's lecture?

***C. Stratton Hill, MD***

1:49:07.3

Well, actually, it was blasé. Nobody took pain seriously at that time, and actually, that was one of the first cable satellite programs. We were on HBO.

***Tacey Ann Rosolowski, PhD***

1:49:30.5

What?

***C. Stratton Hill, MD***

1:49:33.2

I had people from all over say, "Hey, I saw you on HBO." (laughs) But that kind of broke the ice, and then the American Cancer Society published a book on cancer. Art Holub was at Memorial when I was there. He was a surgery— He was in surgery at the time, and he had some kind of administrative job. Anyway, he came to MD Anderson and was kind of the head of education at MD Anderson for a while, and then he went back to be the head of the American Cancer Society. Then he moved back to New York. They wanted me to write the chapter on the thyroid in there, and by that time, I had already started doing this stuff in pain, so I said, "Okay, I'll do that. But guess what, Art?" I called him on the phone, and I said, "If you just mention the

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word cancer, what are words that come to a person's mind when you just throw out that word? Is it death?" "Yes, death." "Okay, pain?" "Oh, yes, pain." "Where's the chapter on pain in the book that the American Cancer Society is going to put out?" He said, "Do we have one?" I said, "No, you don't have one." I said, "You get on the phone over there to Kathy Foley at Memorial and tell her to write you a chapter on pain." That's the first time that the American Cancer Society ever had anything on pain.

***Tacey Ann Rosolowski, PhD***

1:51:39.6

Did that have an effect because the American Cancer Society suddenly recognized it as significant enough to put it in a—?

***C. Stratton Hill, MD***

1:51:44.1

The short answer to that is no. Nothing has had an effect. You still have a problem. That's what this thing from the Institute of Medicine says, that we are torturing patients with chronic pain. Anyway, after we saw that the medical board was going to keep on doing what they were doing, then I thought, "Well, we need to go to the medical board and give them some lectures." About that time, Ann Richards became governor of Texas. And one of her heroes was a woman out at Anderson by the name of Frances Goff. Frances was a legend at Anderson. Nobody knows who she is now, but she ran Girls' State in Texas ever since World War II up until she died about 10 years ago, maybe. Well, it's more than that, I guess, because she died when Ann was still governor. I was the token male pall bearer. The rest of them were girls from Girls' State, including Ann Richards. Ann had arranged for Frances to be buried in the state cemetery in Austin, and she's buried up there. And Ann gave the eulogy and the service at the grave site.

But anyway, Ann Richards was the governor, and Frances had told her—because Frances and I were great friends—had told her what I was doing, and she got real interested in it. And actually, she invited a bunch of people up to the governor's mansion for dinner, kind of a grassroots thing that Frances thought she ought to do. We got on a bus and went up there. I got to sit next to her, and I talked to her all about pain and everything. When she started speaking to everybody, she said, "Well, now, I've heard everything that needs to be known about pain, so I want some of the rest of you people to"—anyway, she made some appointments, recess appointments, and so we said, okay, the board has got to make some changes. We ran into—because we wanted—a doctor who was the executive director of the board at that time had trained with Bonica out in Washington, and he was a big behaviorist. He was an anesthesiologist, and here we were pushing narcotics, so he wasn't too happy with what we were doing. And I had this student that I was telling you about that was working on his Master's, and he was doing all this research on the stuff, and so I had to get— Let's see, Bill Hobby, I think, was still lieutenant governor. Yeah, he was, and he wasn't very cooperative until we kind of put a little pressure on him. And then we had another guy who was—on this doctor who was the chief of—who was the executive director of the board had developed a granulomatous disease of the sarcoidosis of the lungs, and he had to

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give up medicine, so he went to law school. He was a lawyer, too, but the legal counsel for the board then told him one day, “Look, I’m the lawyer. You’re the executive director. I’ll make the decision on how we do these things.”

Then we got them to change to adopt the rules that corrected some of the vagueness in there, like saying what is inappropriate prescribing, defined that, and also what is legitimate use of the drug and things like that. That was in 1995. So we got that passed by the board, and of course, it was really interesting because then that guy who was executive director of the state board became the executive director of the Federation of State Medical Boards, the organization for all the medical boards. Then he takes the rule that we had for that and puts it up before the Federation of State Medical Boards as if he was the one that did it. We couldn’t care less. I couldn’t care less, but it was interesting to have to make him do something, and then he decided it was a great thing and he goes up here and puts it up before the whole—

***Tacey Ann Rosolowski, PhD***

1:58:24.4

Did they accept it? Did they adopt it?

***C. Stratton Hill, MD***

1:58:26.8

Yeah, they did, they did, and they’ve come a long way too. We’ve had to go up and speak before them. I went up to Boston. They were meeting in Boston, and it was amazing. He was head of the thing. “It never occurred to me that pain is not treated adequately.” He was a surgeon and so—

***Tacey Ann Rosolowski, PhD***

1:58:51.9

That’s amazing. As you’re telling this story, I’m stunned because it just seems like such a no-brainer. I mean, here you have a disease that attacks the body in such dramatic ways. People are in pain. I mean, you watch movies, TV shows. You see people in agony. It’s like, okay, I get that that’s not fictional, and it seems like, don’t you treat the pain? It just never occurred to me that, A, it wouldn’t be done, and B, that trying to do it would be so difficult and be such a long haul.

***C. Stratton Hill, MD***

1:59:24.6

Well, the thing was they were faced with a book that said this is the way you do it, and they knew that the image that these drugs had in our society is drugs of abuse, so they were between a rock and a hard place. If I do that, they’re going to say, “What’s the standard of practice, doctor?” “10 mg.” “You gave them 100 mg. You gave them 10 times the amount that the book says you’re supposed to give.”

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***Tacey Ann Rosolowski, PhD***

2:00:09.8

So you really had to change the knowledge base to—

***C. Stratton Hill, MD***

2:00:12.3

We had to change the knowledge base, and you'll see back in that 60 Minutes thing, because that was the next thing. I remember one time I was testifying for a guy out in Los Angeles, and this lawyer said, "Doctor, do you realize that this doctor out there was giving him fifteen pills every four hours? That's six times fifteen. That's ninety pills a day." I said, "Yes, I realize that, but it's not the number of pills. It's the dose that's necessary to relieve the pain, and you have to use whatever you've got." And the strength of the pills at the time that he was prescribing it was 5 mg. The pharmaceutical industry has risen to the occasion now so that now there's a 30 mg tablet. So if he was prescribing for that patient now, he could give him two tablets and he would have the same amount. That was one of the big things that we had to fight.

I remember Abbott Laboratories. I was talking to their chief medical officer, who is a woman, and she was in some other field. I've forgotten what field she was in. They had a 4 mg tablet of Dilaudid, hydromorphone, and they were the chief makers of that at that time. I said, "We need a 30 mg tablet of Dilaudid." And she just—that's the most ridiculous thing she'd ever heard, and that was the milieu that we were working in. To get almost every facet of this thing, it had to be addressed. And then they would do all kinds of things like, okay, we're going to give twice as much oxycodone, and we'll put twice as much acetaminophen. No, no, no. Don't do that. But they didn't ask anybody. They come along, and Abbott comes up with Vicodin ES, extra strength, and they put more hydrocodone in there and more acetaminophen. I said, "Come on. What you're doing here"—they had one that was 500 mg, and they went to 750. I said, "If you take two of those, you're taking a gram of acetaminophen." Four grams is the beginning of a toxic dose a day in 24 hours, so if you take two of those tablets every four hours, that's six doses. You are already into the toxic range. Now you're going to put in that you've got a gram and a half into that. It's worse. Then there was some private little company, and when they heard me saying that, they came down here and said, "Oh, look here, we're just going to up the narcotic dose, but we're going to keep"—I said, "That's fine," and they do that now. And then you've got all kinds of sizes in this tablet. In this My Word Against His, one of the guys says, "I take fifteen of those in the morning and fifteen of those in the evening." They were 30 mg tablets. That's all we had.

We just made that film, and that was the Sackler family that owned Purdue Frederick. It's now Purdue Pharma, and they still own it. They got sued, and people I know got fines, big time, because of their claims that they knew that it was bad. It's crazy. But anyway, they were having their national meeting, and they asked me if they could take this tape up there and show them, and I said, "Sure." They were all there. Representatives from all over the United States were at their meeting, the United States and Canada. It was in Montreal. When they heard that that guy

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was taking fifteen of those twice a day, of course, that means that's good for them. Because if they get one of their doctors to do that, they use a lot of the drugs, and the more money they make for the salespeople. Those were the things that we were running into, and I testified for doctors all over the United States, still do. Well, I try to quit, but occasionally somebody— And I try to just do very limited stuff because it takes a lot of time. Okay, let's see, I don't know where that got us.

***Tacey Ann Rosolowski, PhD***

2:06:52.8

Well, let me look at the time. We're at ten minutes after 4:00, and I'm wondering if it's okay if we quit today, and then maybe we can make an appointment for a final session next week just to finish up, because we haven't talked about ambulatory care, which we really need to do. And maybe there are a few lingering issues with pain which we can follow up on as well. Would that work out for you?

***C. Stratton Hill, MD***

2:07:14.6

Yeah, I think that'd be okay.

***Tacey Ann Rosolowski, PhD***

2:07:16.7

Well, it's about ten minutes after 4:00, and I'm turning off the recorder now.

2:07:21.1 (end of audio session 2)

## **C. Stratton Hill, MD**

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### **Chapter 00C** Interview Identifier

*Tacey Ann Rosolowski, PhD*

0:00:01.9

Actually, let me quick put the identifier on. This is Tacey Ann Rosolowski interviewing Dr. Stratton Hill in our third session. Today is February 20th, and it's about three minutes after 2:00. Thank you.

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**Chapter 12**  
**A: The Researcher**  
**A Brookhaven Laboratory Study in the Marshall Islands**

Story Codes

A: The Researcher

A: Activities Outside Institution

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

D: The History of Health Care, Patient Care

You started to tell me about a project in the Marshall Islands?

*C. Stratton Hill, MD*

0:00:22.7

Yeah, the person who was the first Chief of Pediatrics at MD Anderson was Grant Taylor. Did you ever hear anything about him?

*Tacey Ann Rosolowski, PhD*

0:00:41.0

No.

*C. Stratton Hill, MD*

0:00:43.9

Just sort of a general question—

*Tacey Ann Rosolowski, PhD*

0:00:48.2

If I could just interrupt us for a second because I'm noticing that this leaf is really creaky, and maybe we could just move to a slightly more stable part of the table. Can I scoot this? Great, because I know all of that sound will read on the recorder. It can make life very difficult for people, sound editors. All right, great. All right, so you were saying Grant Taylor who was—

*C. Stratton Hill, MD*

0:01:22.5

Well, I'm not real sure about his background. However, he was in World War II, and I know that he was very much involved with what was at that time called Atomic Energy Commission. He had to do with the studies in Japan relating to the atomic bomb dropping there. And coming out of that from Brookhaven National Laboratory on Long Island was a study relating to the atomic bomb testing that the US did in the Marshall Islands in Bikini and Enewetak. That kind of a natural experiment was formed by the fact that the wind shifted unexpectedly, and it blew radioactivity over some of the smaller islands in the archipelago, and some people were exposed where others weren't.

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For instance, the two islands were Utrik and Rongelap. The wind shifted and blew over those little islands. They're very small. The men were out fishing, so they did not get exposed to the radiation. So you had a fairly uniform population, except for gender, that was exposed and the part that was not exposed, so it was kind of a natural experiment. The beginning of the Atomic Energy Commission began to follow people, the inhabitants of those islands. There weren't very many, like 400 or 500 people, so then it became the Department of Energy, Each year a group of physicians was selected from various parts of the United States to go out there and do this examination.

***Tacey Ann Rosolowski, PhD***

0:04:05.3

When did this start?

***C. Stratton Hill, MD***

0:04:08.3

I really don't know. I suspect if you pulled up Brookhaven and the Marshall Island study on Google that that might be in it. As a matter of fact, I think maybe I have a book on it. I'll look to see, and if it's in there, I'll give you a call. You can have it and take a look at it because I know of—I'm pretty sure that Dr. Taylor went out there and then Dr.—his name was Watu or Wataru or something—[Wataru] Sutow, S-U-T-O-W. He was Chinese, and Dr. Patricia Sullivan. Dr. Sutow and Dr. Sullivan were pediatricians. I went out there about 1980-'82, some time in there.

***Tacey Ann Rosolowski, PhD***

0:05:17.8

So this was really a longitudinal study.

***C. Stratton Hill, MD***

0:05:20.6

Oh, yeah. It was really longitudinal. It may still be going on. I don't know. That was something that would be of interest that MD Anderson physicians did, participate in that study.

***Tacey Ann Rosolowski, PhD***

0:05:41.1

What did you do when you went there?

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***C. Stratton Hill, MD***

0:05:43.3

Well, what we did was we went to Kwajalein. Kwajalein was the main base in the Marshall Islands. There was a huge battle during World War II of Kwajalein, and so it belonged to the Japanese. As a matter of fact, that's where the Japanese fleet stopped to refuel on the way to Pearl Harbor. The island is a speck in the ocean, and it took the—I'm told, and I saw some of the pictures out there, and there's a book on it, I think—it took the US—I don't know—Sixth Fleet or something, whatever it was, about a week bombardment. It's almost like bombarding an acre of land, or maybe two or three acres of land, for a week, with major battleships. What the Japanese had done was to say to these guys "You're there, and we're gone, and remember that the Americans are cannibals. They eat people. So it's up to you to fend them off."

Well, it took them about a week, and then I think the Sixth Army invaded, and it took them about a week to take these little—because they were dug in like crazy, and the only thing you got to dig in was the coral. It was just a coral reef on top of a volcano. We went on a ship from Kwajalein to these two islands, Rongelap and Utrik, and we anchored in the lagoon. Then we would bring the people on board to examine and take them back. It was a ferry-type of procedure. We had two little Boston whalers, and we went back and picked them up and so forth.

***Tacey Ann Rosolowski, PhD***

0:08:22.5

And what did you observe medically with these people?

***C. Stratton Hill, MD***

0:08:26.5

I was to examine the thyroid because the radioactive iodine was the thing that had poisoned the water on the island that the women and children were exposed to, and we had—I can't remember the surgeon's name. I knew him real well. He was from the Cleveland Clinic. What was his name? Anyway, he came out while we were there, and he'd been out there before, too. We would take those people, and if we found some abnormality, we then brought them back to the US for treatment. And we found a couple of people. We found one woman that had hyperthyroidism, so she went back to the Cleveland Clinic to be treated. Then they had found two or three cases of thyroid cancer, which in that population would be significant because it's such a small population. You wouldn't think any people would have it. That was the whole purpose, to see a long-term linear study as to what effect that fallout of radiation had.

***Tacey Ann Rosolowski, PhD***

0:10:02.7

And did you collaborate or individually publish any findings based on this?

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**C. Stratton Hill, MD**

0:10:08.1

Well, no. I didn't. In other words, I'm pretty sure it was published, and maybe what I've got is an interim report. I don't know how often they did reporting. I was not involved in the planning of it. It was just they needed some manpower, and so I just went out there and did it.

**Tacey Ann Rosolowski, PhD**

0:10:40.8

Was it a volunteer kind of thing, or were you selected?

**C. Stratton Hill, MD**

0:10:43.8

I was selected. You had to be selected.

**Tacey Ann Rosolowski, PhD**

0:10:46.6

And what were the criteria they used for selection?

**C. Stratton Hill, MD**

0:10:50.9

I just got a phone call. They said, "We want you to come." Whatever it was, I didn't apply. I didn't do anything, so whatever it was, I guess I fit it. It was all in conjunction with a lot of other stuff. The ship that we were on—and I use that term loosely, when I say ship—it was a converted garbage scow. I don't know if you know what a garbage scow is. I didn't know what a garbage scow was. But whenever the fleet would be in like at Pearl Harbor or in port, they had a garbage scow that would go up under the bow or the stern or someplace, and it was kind of like flushing the commode. All of the garbage would come out, and this container of ship—it was just an open hull of a ship—and it would fall in that. They'd take it out in the ocean and dump it out. Some entrepreneur from Los Angeles had bought some of those things, and they were never intended to go to sea. He then converted it to the clinic. They put a big boom on it that we could lift things off and on the ship, and we had kind of a clinic built on there. It took us about a day to get out to these islands from Kwajalein, and we stayed out there a month, and it was very interesting. I was convinced that the world was flat because you couldn't see anything except water.

**Tacey Ann Rosolowski, PhD**

0:13:20.1

Was there anything in particular you learned from that experience for your own practice?

**C. Stratton Hill, MD**

0:13:25.2

Well, one of the things that I thought I would do is to see if—see, these people are—this is really Micronesia, and so the natives are black, but they don't have the negroid characteristics of big, thick lips. They really have Anglo characteristics physiognomy-wise and anthropologically-wise.

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On the way out there, I remember I was so busy at the hospital that this all—I mean—it suddenly was on me. My children were small, and my wife just stayed here with the children. So we made all those kinds of arrangements. So I thought, “Boy, here I am. I’m leaving in the morning.” We flew to Honolulu, and it was a couple of days there. I got on the telephone. I looked up in the telephone book the Department of Anthropology at the University of Hawaii, and they had listed there Pacific Island Study Group, so I called it up. I called up that number, told the secretary who I was and what I was doing and that I’d like to talk to a faculty member. This guy answers the phone, and I told him. And he said, “How long are you going to be here?” I said, “Well, we’re leaving the day after tomorrow.” He said, “If you can come here tomorrow, I’m going to give you a crash course in Pacific Island anthropology,” so I said, “Okay.”

I went out there, and he did. I just sat down, and I got a 101 course, and it was extremely helpful because he explained to me that this was a matrilineal society, that everything came through the female, but that it was executed by the male. The female told what the action would be, and it was like it had to be a blood relative. It couldn’t be a woman’s husband. It had to be her brother. And they had a queen, and they had hierarchy. She decided what would be done, and her brother, if she had one, would be the one that would carry that out. In addition, I found out that they divide things up by what they call kitchens. I don’t know what they called them in Marshallese. Marshallese is not a written language. It may be now. See, they became a country after we gave them up, but at the time that I was there, they were a protectorate. It’s just a small, small atoll, and the kids run around naked all the time, and I’m sure the girls get pregnant as soon as they became sexually mature. So children belong to a kitchen.

***Tacey Ann Rosolowski, PhD***

0:17:52.3

I’m not sure I’m getting that word right. Is it kitcha?

***C. Stratton Hill, MD***

0:17:55.3

Kitchen.

***Tacey Ann Rosolowski, PhD***

0:17:55.9 O

Oh, like a kitchen. Oh, okay. Gotcha. How was this cultural information useful to you?

***C. Stratton Hill, MD***

0:18:03.2

It wasn’t. It just made me understand. I mean, it didn’t have anything to do with—I mean, you could say this was strictly trial marriages. They lived together, and they may have three or four kids, and they say, “Now I don’t want to get married. I don’t want to marry you.”

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***Tacey Ann Rosolowski, PhD***

0:18:28.5

It's pretty fluid.

***C. Stratton Hill, MD***

0:18:29.1

Yeah, and that's the reason why— And every woman was called a mother because if she couldn't get pregnant they'd give her a child. But all the children knew who the mother was, but then they knew who the effective mother was that they belonged to also. It was really a— I'm told that that's changed somewhat. As a matter of fact, on Kwajalein, there was another little atoll close by. At low tide, you could walk across the coral to the next island, and it was called Ebeye. Out there, they also had extended families. So if somebody had a job, like at the base on Kwajalein, a family member from Rongelap or Utrik, one of those islands, might come over and live, and you took them in. That was the custom, so they had a whole bunch of people over there on Ebeye. They wouldn't let anybody on Ebeye be on Kwajalein after dark unless they worked at the thing.

***Tacey Ann Rosolowski, PhD***

0:19:56.0

You mentioned that there were some certain things that you wanted to look at when you were there. Did you—? What were those in terms of your cancer work?

***C. Stratton Hill, MD***

0:20:06.8

I thought that— The thyroid gland is in one of the gills, and it migrates through the thyroglossal duct into the anterior portion of the neck. If that migration goes awry, the thyroid can be anywhere. You can have a thyroid gland in the mouth. We've had people sent to Anderson that said they had a tumor on their tongue, and it was a lingual thyroid. You could look through there, and there'd be a lump up there, and that was the thyroid gland. It wasn't bothering you. Most people just thought, "I can't stand it. I've got to get that out." But it would be okay.

***Tacey Ann Rosolowski, PhD***

0:21:14.7

And it's doing its job.

***C. Stratton Hill, MD***

0:21:15.7 It was doing its job until somebody, maybe a dentist, looked in there and said, "My gosh, you've got this." You may read that the thyroid gland can occur in the mouth, but nobody really sees enough of it. I thought, "Well, why don't I just examine all of these people to see if any of them had a lingual thyroid or if by some chance it was some genetic thing." It turns out not a single one of them did, but I got the reputation from the islanders that I was going to stick my finger down their throat. They didn't know who I was, but I was the doctor that would stick

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his finger down your throat. That didn't pan out to be of any significance, but it's just interesting that at Anderson doctors participated in that. That's all I wanted to do. Those are the three people that I knew who were involved, Grant Taylor, who was the epitome of the Spanish don, I would say, from Barcelona. He was a true gentleman, a Renaissance man of the highest order.

***Tacey Ann Rosolowski, PhD***

0:22:51.0

And was the fact that a number of MD Anderson doctors were invited to take part in this [the Brookhaven National Laboratory study in the Marshall Islands] —was that an indication of the increasing prestige of the cancer center?

***C. Stratton Hill, MD***

0:23:02.0

I think so. I think definitely because, see, the reason why this became a prominent thyroid center was that Dr. Clark was interested in the surgery of the thyroid. Dr. Kelsey was an endocrinologist, and he was trained at the Mayo Clinic. He was qualified to use radioactive iodine, so since that was a very early utilization of, let's say, avant-garde therapy— We were the only ones around that had radioactive iodine, and so a lot of thyroid cases got referred to Anderson. It didn't make any difference if it was a tumor or not. A lot of them were thyroid nodules, both benign and malignant, and just thyroid disorders in general. We began publishing, also, on the whole organ section that they were doing, things like that.

***Tacey Ann Rosolowski, PhD***

0:24:43.9

I'm not sure I understand what that phrase means, whole organ section. What does that refer to?

***C. Stratton Hill, MD***

0:24:50.6

That means if you take a tumor out of a lung, you just take the tumor out of the lung. If you did a whole organ section of the lung, you'd do the whole lung.

***Tacey Ann Rosolowski, PhD***

0:25:05.8

I gotcha. Okay.

***C. Stratton Hill, MD***

0:25:07.2

This was the whole thyroid gland. They were saying—the story that I get was, okay, the way they did this as therapy originally was if you had a lobe thyroid— Do you know what the shape of the thyroid is? It's kind of like a butterfly, so each side is called a lobe, and then the part that goes in the middle is called the isthmus. If you had a nodule over on the right lobe, just the right lobe was removed. They began to see, well, wait a minute. We took the right lobe out last year,

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and this year we're taking the left lobe out. Why don't we just take all of it out at the beginning? And so they were doing a study to see how often there was a tumor in other parts of the gland. In order to do that, you had to have the whole lobe. If you did whole organ sections of the lung, you'd have to have a big plate to put that on, and you'd have to have a big (???)tomo-section-type of thing, a (???)tomometer or something, whatever they call it. It cuts these things very thin. You embed them in paraffin. You know how to do that. What they did then, they said, "Okay, we're going to start taking the whole lobe, whole thyroid out."

The problem with that is the parathyroid glands are right behind, attached to the thyroid gland, and there are four of them. And if you just look at them real hard, they just up and die. The blood supply is so fragile. And of course, then we were seeing a lot of cases of hypoparathyroidism with the total thyroidectomy because the surgeons there— Dr. Clark was saying "Okay, now, we're going to do a careful extracapsular dissection so we don't disturb the parathyroids." But it was almost impossible not to disturb them, so we had a high incidence of hypoparathyroidism. Now they do an intracapsular dissection to prevent that from happening and then too— Now I'm not sure what they're doing, because of radioactive iodine. You can then ablate the rest of that with radioactive iodine and get rid of any tissue that you've got remaining. That's sort of that epic in our history there of thyroid diseases with the ones in the Marshall Islands added. And Dr. Taylor is dead, Sutow is dead,

[REDACTED]

***Tacey Ann Rosolowski, PhD***

0:29:07.3

That's going to be the end of an era.

***C. Stratton Hill, MD***

0:29:08.7

That's right.

***Tacey Ann Rosolowski, PhD***

0:29:11.9

Last time we were— I'm sorry. Did you want to make any other statements about that?

***C. Stratton Hill, MD***

0:29:17.7

No, I guess not. I think that's about all. Dr. Clark is the one that assembled all these people together. Well, I don't know about—I mean—the heads of the departments. He's the one that got Grant Taylor here, and then I'm sure Grant Taylor probably brought these other guys, Sutow and Pat Sullivan and the group of people that were pediatricians and so forth.

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**Chapter 13**  
**B: Building the Institution**  
**The Emerging Need for an Ambulatory Care Clinic**

Story Codes

B: MD Anderson History

A: Overview

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

D: The History of Health Care, Patient Care

B: Controversy

B: MD Anderson Culture

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

***Tacey Ann Rosolowski, PhD***

0:29:58.5

I wanted to ask you about becoming the—well, basically establishing the Ambulatory Care Clinic, because that was one of the topics that we haven't addressed yet.

***C. Stratton Hill, MD***

0:30:10.3

That was about 1974.

***Tacey Ann Rosolowski, PhD***

0:30:17.6

And you were in conversation with Dr. Clark about the need for that?

***C. Stratton Hill, MD***

0:30:23.3

No, Dr. Clark had— I mean, it was obvious that we needed more space. Dr. Clark, along about that same time, went to the National Cancer Institute, and he recruited [Emil] J Freireich [Oral History Interview]. You probably are going to talk to him.

***Tacey Ann Rosolowski, PhD***

0:30:57.8

I already have, actually.

***C. Stratton Hill, MD***

0:31:00.7 He ought to tell you a lot, J Freireich and Emil Frei. I think Frei is still living, but I heard he also had Alzheimer's.

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***Tacey Ann Rosolowski, PhD***

0:31:12.5

No, I think he's passed away, actually.

***C. Stratton Hill, MD***

0:31:14.6

Oh, did he? Okay. Anyway, they came together. They were the bright young stars of chemotherapy, and of course, they brought all the latest studies. I don't know whether it's come out about the tension, shall we say, that developed between the old guard and the new guard.

***Tacey Ann Rosolowski, PhD***

0:31:48.9

What was it about?

***C. Stratton Hill, MD***

0:31:51.0

It was just about basically the philosophy, and it was sort of a clash of values. For instance, Dr. Clark was very supportive of people who had been loyal to him, and he had Ed White and Cliff Howe. Ed White was the head of surgery, and Cliff Howe was head of medicine, and then they had several people there that they had recruited—Dr. Shullenberger, who was head of hematology—and this was really before chemotherapy was a prominent part of cancer.

See, Memorial Sloan-Kettering was a big surgical hospital, and when Dr. Clark organized Anderson, he had in mind that there was going to be a multidisciplinary thing. He was going to have radiotherapists. You were going to have the best radiotherapists, and then you're going to have the best surgeons in all the various surgical sections. Then as chemotherapy came along, that was the last major component of the treatment modalities—surgery, radiation, and chemotherapy. Now you've got a lot of different things, biological modifiers and all that kind of stuff. But chemotherapy was just kind of an afterthought at that point in time, and so you didn't have anybody that was very aggressive, and that was what Frei and Freireich had made their reputation on was the combined therapy.

When I was at Memorial, you did one drug at a time. Nobody ever actually combined therapies. Number one, they didn't know enough about them so that you could plug in a complementary drug. One drug was complementary to another one, and they just didn't know about it. They were finding out about it, but Freireich and that group at the NCI were really the ones that were pushing it for acute leukemia and things of that sort. I think I told you that when I was at Memorial, the median survival from diagnosis to death was three weeks for acute leukemia. Anyway, Clark brought that entire group into the old guard, shall we say, who were not into that. Internists were basically the ones who were— Since that was a drug, you would have to do the chemotherapy, and nobody did very much chemotherapy at that time. You had a few people who

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did breast work, but that was manipulating hormones and things of that sort for metastatic disease.

The main thing was surgery. I'll never forget seeing this one young woman. She got pregnant while she had breast cancer, and her father-in-law was a surgeon in Lufkin or someplace like that. Don't put Lufkin down. I don't know whether it was Lufkin or not. But he did the most god-awful surgery on her. He cut her to where you could— I mean, you'd have to graft her skin. There's just no way you could do it, but that was kind of what it was. You may or may not have heard people, surgeons say, "Oh, we got it all." I used to say, "You got all you could see. You couldn't see that microscopic disease that was already there." That was a big problem. But anyway, there was nobody there that really did much chemotherapy. You had nitrogen mustard and some of these crazy things that were just beginning to get—Karnofsky and that group up in Memorial. How they got into it was they were in the army poison section, whatever that was called. I think it was Fort Detrick, or something, Maryland. That was where all that came—and some of these—like mustard gas. That's where nitrogen mustard came from. They would see some people that had the tumor or something, and they got nitrogen mustard, and the tumor would shrink up a little bit. So they started working, and then that's how they got into it.

Anyway, we didn't have anybody, but then this group comes in, and Dr. Clark, he was torn between those people who had helped him start the whole thing and this other group that was very aggressive. That was just— Boy, they were going right ahead with things. As a matter of fact, Grant Taylor, the guy that was in pediatrics, he was in the Department of Medicine, Pediatric Department of Medicine at the time, and because of this aggressiveness and these new people that were coming in, he decided he'd like to be in— See, they called it Developmental Therapeutics, and he decided he'd like to be in that department. Boy, he didn't know what he was getting into. They came in, and they started treating those kids with this high-powered stuff and making them sick and all that kind of stuff, and he really became depressed. He asked to get out of that group and get back like he was, which Dr. Clark let him do that.

***Tacey Ann Rosolowski, PhD***

0:39:49.7

How long did that take him to become disillusioned with—?

***C. Stratton Hill, MD***

0:39:53.2

Not long. No, a few months.

***Tacey Ann Rosolowski, PhD***

0:40:01.6

Was that the source of the concern, that this aggressive treatment was making patients ostensibly worse?

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***C. Stratton Hill, MD***

0:40:14.6

Yeah, I think it was the fact that it was just new, and so they were applying aggressive chemotherapy. You see, you did get remissions from leukemia and the lymphomas that you didn't get with solid tumors like stomach tumors and other tumors. But they were very, very methodical. You put a person that had to qualify for a study, and you had to stick with it, and you have to have the temperament of seeing the little kids vomit a lot and things like that. That was very dramatic, because chemotherapy, boom, that's what they were doing. You radiate them, and it takes them a while before they start doing that, before they lose their hair and all that kind of stuff. And Dr. Clark would not—he didn't step up and say, "Look, I'm sorry, guys, but this is the way it's got to be."

You had these two camps that were at war with one another out there for a long time, and it just went on for years, but it became so—

[REDACTED]

And he became a very good friend of mine because his wife was from Tennessee. My wife went to interior design school in New York, and when we lived in upstate New York, we bought a lot of early American furniture. But then she got interested more in European style and so forth, so when we were moving to Houston, there was an antique dealer in Manhattan that she knew well. She said, "I reckon I'll sell this early American furniture," and she said, "Well, you're going to Houston, look up Jane Mosbacher." We thought she was an antique dealer, actually, but she was Bob Mosbacher's wife, who was a millionaire oilman.

I had had a friend from my hometown in Tennessee, who became the national sales manager for Squibb Pharmaceutical Company, and he was my parents' vintage. He would invite us over. They had an apartment over on Central Park South, and they'd invite us over for dinner from time to time. He was telling me about his friend that he went to the University of Tennessee with that, during the Depression in the '30s, went to school at University of Edinburgh because it was cheaper and that he stayed on and just became a British citizen. But he became the Regius Professor of Neurosurgery at the University of Oxford, and he told me about how he was a good friend of that family and so forth. So when we got in, we met Jane Mosbacher. She and Charlotte really hit it off, and so Charlotte came home one day and said, "You know, Jane Mosbacher was telling me that her brother was the Regius Professor of Neurosurgery at the University of Oxford." I said, "My gosh, that's Joe Pennybacker's sister," and it turned out that she was. My wife jumped on the phone and said, "Jane, was your name Pennybacker before it was Mosbacher?" She said, "Yes."

I was going to that calcitonin meeting in London in 1969, so Jane Mosbacher said, "Oh, you've got to go see my brother in Oxford," so we did. We went up. We caught a train and went up there. They invited us up for dinner, so we went up there, and we had dinner.

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[ ]

***Tacey Ann Rosolowski, PhD***

0:50:04.2

Were those kinds of successes really instrumental in putting to rest this tension between the old guard and the new guard?

***C. Stratton Hill, MD***

0:50:10.6

Well, it was just kind of overwhelming for the old guard. Like I said, they were getting all the money, and that's when it became so obvious that we couldn't handle everybody. The reputation then just exploded, and we just had people standing in—like I think I told you—like feed lots. They were just standing up because we didn't have enough room for them to sit down.

***Tacey Ann Rosolowski, PhD***

0:50:49.5

This was when the conversation began about the need for an ambulatory clinic.

***C. Stratton Hill, MD***

0:50:54.2

Exactly, and at that time, a guy down in Beeville or someplace like that wanted to give some money to Hermann Hospital, but at that time they had—I think it was called Hill. There was a senator from Alabama named Hill, I think, and he set up where they would match funds if you had matching funds, so the— What's that pavilion called? This was called the Lutheran Pavilion, but the family—Lutheran Pavilion at MD Anderson. There are portraits. Of course, now it's kind of lost in the shuffle, but it was called Lutheran Pavilion at one time. I think it probably still is. Then this Alkek put about eleven stories on top of that, and I don't know how they've divided it up out there now.

But this couple had some property in Florida, and they wanted to give it to Hermann. Hermann says, "We're not taking any government money." They said, "Forget you; we'll go take it over to Anderson." Clark said, "We'll take it." They matched that, and they built the Lutheran Pavilion and— Let's see. I think it was the Gimbel wing or maybe the— Anyway that's when the clinic— Oh, yeah. It was the Lutheran Hospital and the new clinic building. See, we knew they didn't have—shouldn't be called the new clinic building because we didn't have a clinic building. It was just in the building, and so it was a separate building. You can't even see it now. I mean, it's been modified and expanded so much that you can't identify where that was.

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## **Chapter 14**

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

#### **Setting Up the New Ambulatory Clinic (Mays Clinic) –And Then Re-Designing It**

Story Codes

B: MD Anderson Culture

B: MD Anderson History

B: Building/Transforming the Institution

B: Multi-disciplinary Approaches

C: Portraits

C: Professional Practice

C: The Professional at Work

C: Patients

***Tacey Ann Rosolowski, PhD***

0:53:29.2

How did you go about setting up the services and planning for the entire service?

***C. Stratton Hill, MD***

0:53:35.2

Well, Dr. Clark, when they started building that, he decided that he wanted me to be the director of the clinic. Well, Dr. Howe, who was head of medicine, was also the director at the clinic. He didn't like that at all. He really didn't like that, so that put me sort of at odds with Dr. Howe, although we remain friends and so forth.

***Tacey Ann Rosolowski, PhD***

0:54:16.0

Why did Dr. Clark select you for that position?

***C. Stratton Hill, MD***

0:54:20.4

I don't know. I guess he thought I could do it. (laughs) Dr. [Robert] Hickey was in on that too, so both of them were. They called me in one day and said, "We want you to run the clinic, and we want you to start Monday." At that time, I'd had an episode of diverticulitis, and it was something with my colon. I said, "Well, I'm going to have an operation on Monday," and they said, "Well, we'll have to put it off a while." I had that operation, and they put it off until I got— And they said, "We're going to make Dr. Howe"— See, at that time, he wasn't called a president. He was called a director, so I was going to be the associate director for the clinic, and they were going to make Dr. Howe the associate director for the hospital. There was no hospital. It was just a smaller hospital. It wasn't the new part.

But Cliff Howe just did not like that. He liked this other deal, but they went ahead and did that anyway. He never did do anything. He just kind of— And it took them longer to build the

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hospital, so what I did was I started planning, organizing, and about that time Dr. Clark hired a management consultant. I don't know whether you ever heard this name. His name was Pat Leon, and he came from Booz Allen. It's a big management consultant firm. It's still around. You can look it up, Booz Allen something and something. He hired him away from there. Well, he and I got along great because I had realized that Dr. Howe was just—it was too much for him. He just didn't realize what was going on. Then Dr. Clark got real interested in this International Union Against Cancer, and I remember one of the local civic leaders saying "You know, Lee Clark is just out there fiddling while Rome burns." He said, "He doesn't realize that the place is burning up right in front of his face."

***Tacey Ann Rosolowski, PhD***

0:57:06.5

What was burning up? What were they referring to?

***C. Stratton Hill, MD***

0:53:35.2

Everybody was just—I mean—it was so crowded. We were at the point of if somebody went to surgery, put somebody else in that bed, and sometimes you couldn't get them out of the recovery room because there was no bed. That's how bad it was. That's what I took over.

***Tacey Ann Rosolowski, PhD***

0:57:39.6

How did you work with Pat Leon to sort this all out?

***C. Stratton Hill, MD***

0:57:42.8

We started making the plans. See, you had—how are you going to use—and actually, I wasn't in on the deal of—the building was being built at the time that I took it over, and so I got together with the architects, and I said, "Wait a minute. Let's look at all the different things that have already been laid out," and nobody even asked us. Like for instance, nuclear medicine. What do you need for nuclear medicine? Well, we need a lot of lead. Now, for instance, on one of the floors, because of the radiation therapy run by Gilbert Fletcher—you've heard of him, haven't you?—those doors were leaded. They had thick lead because they used radium, and they would put radium in the uterus for uterine cancer. You had to calculate how long you were going to leave it in there, and then you had to come in there and take it out, otherwise they'd get a lethal dose of radiation. Anyway, they didn't make any of those plans to—

***Tacey Ann Rosolowski, PhD***

0:59:17.0

Whoops, let me just pause this. (audio pauses 0:59:20.7)

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***C. Stratton Hill, MD***

0:59:23.6

They hadn't done any of that stuff, so I got with these people, and we had to modify the plans. Then I said, "What kind of toilet facilities are you having for the pediatrics?" "Well, we just hadn't had the toilet facilities." "Okay, how about the drinking fountains?" They're up this high for adults.

***Tacey Ann Rosolowski, PhD***

0:59:51.8

Way higher than kids can reach.

***C. Stratton Hill, MD***

0:59:56.2

We did all that. That's how come I got to know this Frances Goff. I think I mentioned her. She had these special projects, and the building stuff, she did all of that. That's how I got to know her real well. We sat down—and then the closer we got to finishing the building— See, we'd have to have General Surgery, Urology, and maybe the Thyroid Clinic would all meet in the same place, so you had the nurses—one or two nurses is all you could have, and she had to do for all three of those services. Well, then the new building was going to be General Surgery here, Urology there, Gynecology here. Nobody thought about, well, they're going to have different personnel. You'd say to the nurse "Who do you want to go with?" "I want to go with Urology." And the guy from General Surgery said, "No, I want Ms. Smitherin." "Well, Ms. Smitherin wants Urology." "Oh, well, what am I going to do?" We had meetings every week on that part of how we were going to—all the things that we had to do about getting that organized, and then Dr. Clark— And then the other thing was people would come in to the—

When I first took over, it was before we were moved into that new place, so I began to look at how the thing was working. We had this woman who was the first one to greet the people as they came in. I think in the old days of one of the radio shows, the local undertaker was called Digger O'Dell. Well, she was Mrs. Digger O'Dell. I mean, she looked like the malach ha-mavis, the Jewish angel of death. She had this deadpan look, and I mean, here, fill this out, fill this out. She didn't say a word to these people. And I'd go in. I went down and looked at people sitting there, waiting to be called or something. Nothing—they were just sitting there, nobody saying anything. I decided, well, we're going to have to get some literature to say what's going to happen. We started developing that, but in the meantime, I went down, and I would address these people and say, "Welcome to MD Anderson. You're going to be here, and we're going to try to get you to your doctor as fast as we possibly can and take care of you." I gave them a little spiel like that.

Then I decided maybe we can make a videotape, which we did. I don't know whether I've got any of those videotapes or not, but we made videotapes, and they did a really good job of that. Then we designed cubicles for people to come into to be interviewed for getting everything done

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and so forth, and then I began to develop literature. One time, see, Developmental Therapeutics, they were using BCG, which is a Tim Burroughs-vaccine -type of thing, to do some testing. It took about a month to get the patient ready for this. And see, Dr. Clark wasn't keeping up with all of this, so I wrote all the copy for those brochures, and I wrote the ones for radiotherapy and diagnostic radiology and all that kind of stuff. I put in there that you're going to go into a room, it's going to be dark, and this is what's going to happen. You're going to hear these strange sounds, and that's just the machine doing this and this and this. Then I got—well, look, you guys do that. I said to Radiology “You guys write that up.”

Anyway, I put in there that we would work you up anywhere from one day to one month. Well, I soon learned that you really had— Dr. Clark was gone a lot, so I learned that nothing was final until Dr. Clark said that it was okay. But I went ahead and wrote that up. Marion Wall was his secretary. I don't know if you heard about her. She was his right-hand gal, and she got it, and she saw that one month. We were having a meeting up in Dr. Clark's conference room, and he looked over at me and he says, “Burn up every goddamn one of those brochures you printed up.” I said, “Why?” “You say it takes us a month to work somebody up.” I said, “Yes, sir, I do.” He said, “It does not.” I said, “Here, let me show you.” Okay, he was okay.

***Tacey Ann Rosolowski, PhD***

1:06:53.2

So you didn't have to burn them up.

***C. Stratton Hill, MD***

1:06:54.6 I

didn't have to burn them up, but—

***Tacey Ann Rosolowski, PhD***

1:06:57.9

Was it an advantage sometimes that Dr. Clark wasn't around keeping close tabs on things?

***C. Stratton Hill, MD***

1:07:03.3

No, because he'd reverse it. He would reverse it. So what I did, I thought, “Well, every time we have a meeting, I'm going to send him a memorandum of understanding.” This is what I understood we decided. That solved a lot of problems, because he could look at that and say, “No, no, that's not what I meant.” And then nobody had taken any action on it until that had happened.

***Tacey Ann Rosolowski, PhD***

1:07:46.2

It's always key to learn how to communicate with your boss.

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***C. Stratton Hill, MD***

1:07:51.3

That was a very essential part of dealing with Dr. Clark. And the other thing he didn't want to do, he didn't want to close the clinic down.

***Tacey Ann Rosolowski, PhD***

1:08:07.3

You mean the old clinic?

***C. Stratton Hill, MD***

1:08:09.0

He didn't want to close the clinic down to move. I said, "Dr. Clark, we can't do it without that. We've got to shut it down for a couple of days," because he didn't realize that there would be new nurses that would go into a section that the doctors would have to— I think some of the doctors told him. And another thing was—

***Tacey Ann Rosolowski, PhD***

1:08:39.8

So he finally agreed that you could shut down?

***C. Stratton Hill, MD***

1:08:42.7

Oh, yeah. He did.

***Tacey Ann Rosolowski, PhD***

1:08:44.0

What was that process like, when you shipped it over from the existing kind of ad-hoc clinic to the brand-new facility?

***C. Stratton Hill, MD***

1:08:52.9

Well, it was like a shakedown cruise of a ship. I mean, I think I told you about the fact that they built into this clinic—there was supposed to be a method of moving the chart from one section to the other automatically. That didn't work. And then, too, the distances of where we were before were not very great. It would be like almost from here to the room over there.

***Tacey Ann Rosolowski, PhD***

1:09:34.6

Only 25 feet or something.

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**C. Stratton Hill, MD**

1:09:35.9

So the thing that you wrote on here, and it transcribed it over there, worked pretty well.

**Tacey Ann Rosolowski, PhD**

1:09:41.0

That automatic transcription thing.

**C. Stratton Hill, MD**

1:09:43.1

Yeah, but then if you were on the second floor and you went up to the eighth floor, that was different. There were just a lot of bugs to— And some of the elevators didn't work. I mean, it had worked, but on the day that we opened there were still bugs in the thing.

**Tacey Ann Rosolowski, PhD**

1:10:14.0

How many departments were represented in the new clinic, and how many patients did you serve when you first opened?

**C. Stratton Hill, MD**

1:10:23.9

We were serving right at 1000 a day. I believe 1200 was probably what it was, and then, too, we had— Another thing that I did that Dr. Clark didn't like was that traditionally a patient was not allowed to see their record, so the problem I saw that we were running into was that in order to keep a patient from doing that— Say, for instance, you're going to have a radioactive iodine scan, and that's in the basement, and you've got to go to the X-ray Department, and that's on the second floor. Okay, you've got to have an escort to take you from downstairs to the second floor. Now, maybe after a day or two, somebody that was with that patient would say, "Well, I know where to take her. I can take her up there to the second floor." Oh, no. We have to have somebody take the chart, so you can't see it. I said, "Baloney." I said, "We're going to let the patient take the chart, and what we'll do, we'll buy some big envelopes, and we'll color code them, and from this part it will be this color. That part will be this color," and so forth. And they could put a little string on it. We did that, because they'd say, "I've been waiting here for two hours to take me to the X-ray Department."

**Tacey Ann Rosolowski, PhD**

1:12:23.0

And it's just there were no personnel available.

**C. Stratton Hill, MD**

1:12:25.5

It was just we didn't have enough. It would take a ton of people to do things like that.

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***Tacey Ann Rosolowski, PhD***

1:12:32.4

What was the rationale at the time behind not allowing the patient to see his own records?

***C. Stratton Hill, MD***

1:12:37.3

That was traditional in medicine. You hear about that now, that they don't want people to see their record. So finally we quit putting them in those envelopes. We just said, "Here, here's the record." Then Dr. Clark found out about it, and he was madder than hell. He called me up there, and I said, "Wait a minute, Dr. Clark. I've been doing that for a year and a half. You haven't heard a single complaint." He just said, "Okay." So then another thing that happened was that—I made it clear that people who had complaints come to me. I had a complaint one time from this lady who said, "I didn't like what that social worker put in my record." She had read it, and it said something about how she was sitting in the waiting room with her favorite son. This woman says, "I have three sons. How does she know that that was my favorite son? I resent that she put that in the record." I called the social worker in, and I said—not before her but later on. I said, "No editorials in the record." We got together with the social work people, and I said, "You put editorial remarks in there, it's your own peril, so just don't editorialize. If you think something is something, unless you've got some real proof and it's germane to your note, don't put anything in there extraneous to this." I had one guy tell me—one of the doctors said that back in the old days, when syphilis was around—what was that?—STS. That was the serum test for syphilis. You got a number. It gave a score. He said he devised a thing where he called it by his name and this name, and this score was higher than the STS, it meant that his STS score was higher than his IQ. (laughs) And he said he had to testify in court, and then he had to explain what that meant.

***Tacey Ann Rosolowski, PhD***

1:15:50.3

Did you find with the new policy of letting patients take their own records that a good many patients actually read them?

***C. Stratton Hill, MD***

1:16:00.4

Absolutely, and that My Word Against Theirs, David Baldrige, the manufacturer in jewelry, said that he saw in there where Dr. [Nicholas] Papadopoulos—well, we blanked that out—put in there—or one of the doctors said that he was a drug addict. He said, "I wanted that taken out of my record." Oh, yeah, you'd just see them walking along reading their chart or see them sitting there—usually when they got to the clinic station they would turn that record in. But they could read their— We never had any serious problems whatsoever with that. We had another incident, and this was before I was in charge of the clinic. It kind of upset Dr. Clark, but we had these guys— The University of Minnesota had a big Master of Hospital Administration program, so

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we hired—because one of the guys that Dr. Clark brought down from the Mayo Clinic had connections up there. He hired several of these guys that just had instead of an MBA it was an MHA. I'm not even sure they give that degree anymore. They were master's of Hospital Administration. Boy, we had one in particular that thought, "I know how to run a hospital. I know all about all this stuff." And I said, "You know, I never have heard of anybody that's got a master's of Exxon Administration that they made him, right out of college, president of Exxon because he'd learned how to do Exxon."

Anyway, this one guy decided, with the administrator of the hospital, that he had to have the configuration of the clinic sections so that the clerks could do their job and so forth. So he built a wall up so people that were sitting in the waiting area couldn't see anybody. Whenever the people would come out from behind, over there— And of course, we were having waiting areas like crazy. I mean, people standing up, like I said, and we didn't even have enough places to take chest x-rays. So we set up a thing in the clinic where we had a chest x-ray machine in there, and then we built these little cubicles. You'd undress and go and get this and come back and redress. We said, "You can't do that," because then you had to wait until they finished and come back and so forth. It just slowed us. I said, "Look, let's get some plastic garbage bags, and they're going to put their clothes in the garbage bag. They're going to come in, change, put on a gown, go get the chest x-ray, come back, and take the garbage bag with the clothes. When the one thing opens up, they go in there and change and so forth." That was how crowded we were, and it was ridiculous.

***Tacey Ann Rosolowski, PhD***

1:20:40.4

How long did it take before the bugs in the new clinic were really worked out and it began working pretty smoothly?

***C. Stratton Hill, MD***

1:20:49.5

Well, it got a lot better within the next couple of months. It never was where it was real smooth. The other thing was the same guy that built these things up— Oh, yeah. And what I did at that time I was—I mean—people would get lost, and they couldn't say anything to anybody or anything, so I looked up the bylaws, and I said, "Let's call a meeting of the staff," and we did. And to me, that was just the thing to do. It shocked the hell out of everybody else, and they said, "Are you sure you want to do it? You haven't talked this over with Dr. Clark?" "No, I haven't. Let's do this." And I got this [Richard] Dr. Jesse, who was head of Head and Neck Surgery. He was kind of a maverick, too, and he was very much against what all they'd been doing because the administrative people didn't talk to the doctors at all. They just did it, and you'd have patients that didn't get their appointment card until the next day. I mean, it was just horrible.

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***Tacey Ann Rosolowski, PhD***

1:22:47.1

Your idea was to get everybody in one room and kind of sort it all out.

***C. Stratton Hill, MD***

1:22:52.2

Well, we didn't have a room big enough to get everybody in, but we called that meeting and that was in the auditorium of the hospital at the time, and I had prepared a—well, whoever was chairman of the medical staff called the meeting, and we got it going. Then he called on me, and I laid out the reason why I called them. And then—

***Tacey Ann Rosolowski, PhD***

1:23:26.3

What did you tell them?

***C. Stratton Hill, MD***

1:23:28.0

I told them that— I cited a lot of the things that had happened and that this was dehumanizing, that this was not the way that I wanted to practice medicine—I don't think it's the way that anybody here wants to practice medicine—and that something has got to be done. Well, after I made that pitch, I was expecting somebody to come up. Nobody said a word. I said, "Hey, come on. What's the matter with you guys? I mean, I talked to you before." And then I sort of said, "Hey, how about you, Dick?" And then they started, started coming, they started coming, and they reversed everything. They tore down those walls, but still we didn't have the new building. But at least they could communicate. What this guy was saying, well, the clerks can't get their work done because the people are always interrupting them. That's who we're there to serve.

***Tacey Ann Rosolowski, PhD***

1:24:50.6

Did that meeting kind of set—I don't know—set a new tone, where people felt they could talk about these issues in a more open—?

***C. Stratton Hill, MD***

1:25:01.8

Actually, I don't know whether it did or not. I'll say this: We got results as a consequence of that meeting. But I remember being down there talking to Dick Jesse in his clinic, and Dr. Clark walked in, and he said to me, "You really want to do this?" And I said, "Yes." I said, "Dr. Clark, you wouldn't practice medicine like this." He didn't say anything. He came to the meeting.

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## **Chapter 15**

B: Key MD Anderson Figures

Remembering MD Anderson Presidents and Dr. Eleanor MacDonald

Story Codes

C: Portraits

B: MD Anderson Impact

B: MD Anderson History

C: On Texas and Texans

C: Leadership

***Tacey Ann Rosolowski, PhD***

1:25:44.9

Interesting. You've mentioned a number of instances where Dr. Clark had questions about what you were doing—

Female

1:25:53.8

You want to come in here now?

***Tacey Ann Rosolowski, PhD***

1:25:55.5

I think we're good. Thanks. But it seems like he was a real proof-in-the-pudding kind of person. If it worked it worked, and he was—

***C. Stratton Hill, MD***

1:26:03.0

Absolutely, he was. He said to everybody, "You get a niche here. If you've got a project, if that's a valid project, we'll see to it that it gets done," and that's what he did, the way he organized the clinic. That's the way the Mayo Clinic is organized. If you've got a project that looks like it has merit, they're going to give you full support, and that's the way Clark was. That's the reason we had the dictating of all notes, and they were typed. They were transcribed into the record, typed by the next day. We had a whole bunch of those things, and that evolved over the years with different systems, where every telephone was a dictating—still is. You just go in and put in your number, and then you get a tone, and then you put who you are. You put your number, and then you identify yourself and say, "I'm dictating a note on this patient." You put the patient's number in there. Dr. Clark was a guy that was always looking to make your time efficient. He definitely wanted to do that by the people that he hired. Another person that is dead—and I don't know if anybody had ever mentioned her—was Eleanor MacDonald. Have you heard of her?

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***Tacey Ann Rosolowski, PhD***

1:28:08.6

Yeah, she was interviewed and did one of the very early interviews many years ago.

***C. Stratton Hill, MD***

1:28:13.5

Oh, yeah. She would have. She lived to be 101 or 102 years old.

***Tacey Ann Rosolowski, PhD***

1:28:18.9

Because she was the one who did all the records, isn't that correct?

***C. Stratton Hill, MD***

1:28:21.7

She was the epidemiologist. Well, basically she was not an epidemiologist, but she'd done epidemiology at Memorial New York along with her sister. You're talking about a patrician family. She was a Massachusetts Catholic, and she never married. She and I were great friends because I was one that was doing a lot of work in the thyroid, and I used them a lot.

***Tacey Ann Rosolowski, PhD***

1:29:03.9

It was really enlightening to read her interview because I came of age when it was just normal that people had your records, and then to read about how there kind of were no records and it was really difficult to coordinate information collected by different doctors in different offices or different departments, and she coordinated all that.

***C. Stratton Hill, MD***

1:29:25.8

Not only that, but her vision. She numbered every laboratory test that was done long before there was any way of doing anything with those numbers. Every test at MD Anderson has a number.

***Tacey Ann Rosolowski, PhD***

1:29:46.7

She foresaw all of that.

***C. Stratton Hill, MD***

1:29:48.3

She foresaw all that, and when we first started doing this, and I started working with the thyroid data—and of course, she was sensitive to the fact that I had to have Dr. Clark's okay to do that. I guess that's one reason why Dr. Clark knew me talking about—deciding to have somebody run the clinic, because we worked together a lot. I have some pictures of Dr. Clark on my 60th birthday, so that's 24 years ago. He came to my birthday party [Redacted]. But we worked

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together, and so he knew me a little bit more than some of the rest of them. But he saw that quality in Eleanor MacDonald. I remember when the School of Public Health started here in Houston. I was associate director for the clinics at the time, so I did a lot of representing MD Anderson in the School of Public Health and then starting a medical school. The medical school didn't start until 1970.

***Tacey Ann Rosolowski, PhD***

1:31:46.5

In '73, I think it was.

***C. Stratton Hill, MD***

1:31:48.7

Okay. I was head of the clinic at that time, so I was on a bunch of committees over there at the medical school, getting it accredited and all that kind of stuff. The guy who came as dean of the School of Public Health, now I think the school is named for him—[Reuel] Stallones. He didn't like it because we called that department the Department of Epidemiology because epidemiology basically is to do prospective studies about causes of diseases, and basically what Eleanor did was retrospective follow-up studies, although she did do—and we didn't have a biomathematics department either. You might have seen that in the paper, where these people from Anderson discovered this flaw in this work that they did at Duke and so forth.

See, we didn't have anything like that when Eleanor was there, and I used to tease them. I said, "I designed this thing, and then I get all of this data, and you all run it." And then we had those sorting machines. Those cards ran through the sorting machines, and then they'd come up and say, "This doesn't work." And I said, "You've got to tell me that before I do all this stuff." That's when [Stuart] Zimmerman's department came in there. Zimmerman's department would have never let that thing happen that happened at Duke.

***Tacey Ann Rosolowski, PhD***

1:34:04.0

Which department is this?

***C. Stratton Hill, MD***

1:34:05.4

That was Biostatistics. If you were going to do a study, you had to run that through the Department of Biostatistics because they told you whether or not what you thought you were going to find out you actually were going to find out, had you designed it well enough to control all the variables so that that one variable that you're going to measure is actually what you're measuring, not that variable for this variable. You come out, and you've got three variables, and you do all this stuff, and you say, "What about this, this, and this? Why didn't you tell me that beforehand?" And so Stallones didn't— He said, "You can't call that the Department of Epidemiology." Then the guy that I was telling you about, one of the students from Cornell that

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became—Vincent Guinee became head of that department because he went on to Harvard or to Hopkins and got a master’s in Public Health. He was an epidemiologist, a real epidemiologist.

But Eleanor was solid as a rock. She was really solid. I’ll tell you a little story, one of the most tragic things I’ve ever known of in my life, about her. She was a renaissance woman extraordinaire. She played the cello, and she had friends, two of whom were a couple who became drug addicts, and they had a child. And I don’t know whether the courts got into this or not, but Eleanor adopted that child. They took that child away, either that or the parents gave her up, the child. Eleanor worshipped that child, and she took her everywhere. She was probably a preteen at the time that she became involved with her. She would tell me about taking her to Europe, and that was before we had children. And when our children came up, she said, “Oh, you’ve got to enroll them at the Catholic school over there on Travis.” I think it’s called Holy Name or something like that, and we did. He wasn’t potty trained at the time, so they said, “We’ll take him, and if he’s a problem, we’ll have to send him back,” And they did send him back to us.

Anyway, she was big on things like that. And so she raised that girl, and she was going to the University of St. Thomas. One evening, apparently they’d had too much to drink. She lived over there on University, which is that street that goes right by Rice. And so she had a date with this guy, and they realized that they should pull over and stop, so they pulled over and stopped and parked on a street that was just one street over from University, in that neighborhood in there. The police came along, and the police woke them up, said, “You’ve got to leave here, but you’re in no condition to drive.” And somebody said, “Where do you live?” And the guy said, so one said, “I’ll take him home.” This one says to Eleanor’s daughter, “Where do you live?” “I just live around the corner.” “I’ll take you over there.” Never heard from her ever, ever. Eleanor was—God, she was devastated.

***Tacey Ann Rosolowski, PhD***

1:39:20.2

Oh, I can’t even imagine having to go through something like that.

***C. Stratton Hill, MD***

1:39:24.8

And for years after that she would tell me, “I’m sure that”—whatever her name was—I’ve forgotten—Caroline or something like that. “Caroline was talking to me last night. She’s in Thailand,” or something, but I mean, disappeared from the face of the earth.

***Tacey Ann Rosolowski, PhD***

1:39:48.6

And the young man got home okay?

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***C. Stratton Hill, MD***

1:39:51.1

Yeah.

***Tacey Ann Rosolowski, PhD***

1:39:55.0

Amazing, and a terrible story.

***C. Stratton Hill, MD***

1:40:02.0

Well, anyway, that sort of gives you some idea about how Dr. Clark was loyal to people and he got into this bond of being—this loyalty to the people that had helped him to start this. Then this new group moved in, and so after he'd been there 25 years—I can't remember what year that was—but we began to have each year— As our finances improved, we would give ourselves a party. And this guy Klaffiken, who was one of the guys that Dr. Clark—spelled with a K— brought down from the Mayo Clinic, who was sort of one of the assistant administrators— His name was Art Klaffiken. He began to have these parties, and we'd have them at— At that time, it was the original Warwick Hotel, and that was the first one we had. And so it turned out to be a big— We had fine foods and wine and so forth. When Dr. Clark's anniversary came along, they decided that we wanted to give him his portrait. Dr. Clark knew some cowboy artist out in west Texas, and I had a good friend who was—among other things, he did the Eisenhower portrait in the White House that's in the White House now, and then he did all the big industrialists of the large corporations like General Electric, General Motors, all of those. He was practically doing all of those, and his studio was over here in— Would you like some more?

***Tacey Ann Rosolowski, PhD***

1:43:00.9

No, I'm good. Thanks.

***C. Stratton Hill, MD***

1:43:03.0

And so I said, "Dr. Clark, let me take you over there to Jim Wills's studio, and you can see what he's working on and see photographs of all the things he's done." We all went over there. Frances Goff was in on the deal. We all went over to the studio and made arrangements for him And went over there, and he saw Charles Wilson, head of General Electric. I think his name was Charles Wilson that was head of General Motors or something. They both had the same name. Then he had all of the presidents of big corporations. He was doing one guy that was some industrialist over in Alabama that had a big paper empire where they grew the trees and all that kind of stuff, and he was a big horseman and in the building— I never saw the building, but I saw Jim working on this. It was about as high as this wall almost.

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***Tacey Ann Rosolowski, PhD***

1:44:24.0

Oh, my gosh. It's like 10 and a half feet.

***C. Stratton Hill, MD***

1:44:26.9

Yeah, and he would get on his belly and paint the hoofs of the horse and all this stuff. He went over to the studio, and he decided this is the guy that's going to do it, and that's who did all of those portraits that are hanging in there. Senator Aiken and—it wasn't Preston. It was the other governor from Texas, Allan Shivers. They were hanging in the lobby of the clinic, the Clark Clinic Building, and also the couple who gave money for the Lutheran Pavilion. Jim Wills did portraits of all of those people after he did Dr. Clark.

***Tacey Ann Rosolowski, PhD***

1:45:32.8

What a great anniversary present. When Dr. LeMaistre came in, how was he different in his style and as an administrator? How was he different from Dr. Clark?

***C. Stratton Hill, MD***

1:45:48.1

He was totally different. Dr. Clark announced that he was going to retire, and there was a search committee that was appointed. Dr. [Charles] LeMaistre was chancellor of the whole university at that time, and he was an ex officio member of the search committee, but then along about—I don't know at what point in time; it was after the search committee had been meeting for some time—Dr. LeMaistre decided that he would give up the chancellorship, and he wanted to submit his name as one of the considerations.

Well, you might say he had the inside track and they selected him, so Dr. Clark then— But about that time, they thought— It was while I was running the clinic that we acquired the old Prudential Building that you just tore down. We paid a dollar for that, and I never will forget the time that we went over there to meet with the Prudential people. The guy who was head of Medical Breast at the time was named George Blumenschein. Have you heard of him? His son is out there now at Anderson, and his name is George Blumenschein, Jr. But George was head of Medical Breast at that time, and he was married to the daughter of a former dean of the Cornell Medical School who also was on the Board of Directors of the Prudential Insurance Company, and he was in town visiting his daughter. George invited him to come along with us up there, unbeknownst to the guys at Prudential, and when he walked in, and we all walked in together, those guys shot up to attention.

Oh, boy. Well, they solicited— But we had gotten— That was the way Dr. Clark was. He swung that whole deal, and then he moved to his office over there. They had a palatial office, and so he decided he'd move over there. He then was planning this colloquium that we had in 1981, and he

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wanted me to be the coordinator for that. He was doing that, and he called me over there one day, and we were discussing the whole thing. He said, “Let me show you. I’m making a little office down the hallway here because,” he said, “I’m sure that Mickey is going to want to be talking to me a lot, and I’m just going to make myself a little office down here.” Well, it didn’t turn out that way. When LeMaistre took over, he kicked Dr. Clark completely out of the place. Dr. Clark had the Cancer Bulletin, and he was publishing a little heart journal too, and that printing office was over on Crawford Street, I think, so he had to move his office over there.

***Tacey Ann Rosolowski, PhD***

1:50:57.8

What do you think was up with that with Dr. LeMaistre?

***C. Stratton Hill, MD***

1:51:00.3

Dr. LeMaistre’s personality was such that there’s no room for anybody else but LeMaistre in terms of any kind of credit for anything. His ego is pretty good, and I just decided earlier on—that’s when I decided I wanted to go back into clinical medicine, because he was trying to—rather than making an effort to sort of figure out how he could move into the thing gracefully, he was doing all kinds of funny things that were not bad necessarily, but they were just kind of stupid. I mean, why would you do that? He was saying, “I’m going to put a light over there for parking,” or something like that. Well, is that all you’ve got to do? And things like that in an effort I guess to establish that he was the boss, so I then requested that they get somebody else to take over.

***Tacey Ann Rosolowski, PhD***

1:52:31.9

What do you think Dr. LeMaistre’s impact on the institution was?

***C. Stratton Hill, MD***

1:52:37.3

It was considerable. It was considerable. He has tremendous connections. He did not— He knew— Well, first of all, he knew that he had to be more competitive salary-wise than Dr. Clark was. People came to work for Dr. Clark because they wanted to work for Dr. Clark. LeMaistre didn’t have that. He had to pay competitive prices, and he should have paid competitive prices. Dr. Clark was kind of stuck in what he knew about salaries and so forth, and back in the mid—well, post-World War II, I remember him telling me that when he came to work for Anderson they were going to pay him the salary of a full professor, which was \$9,000 a year. And he said, “Well, wait a minute. A full professor in an academic setting only works nine months. I’ll be working 12 months, so why don’t you give me \$1,000 a month. Give me \$12,000.” And they said okay. They gave him \$12,000, so he was kind of stuck in that category. I remember he developed a guy there that was kind of an anatomist that got interested in physical medicine. I’ll get this.

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***Tacey Ann Rosolowski, PhD***

1:54:43.6

Sure, I'll just pause it for a sec while Dr. Hill is answering the door. (audio pauses 1:54:49.1)

***C. Stratton Hill, MD***

1:54:50.0

About the time that LeMaistre came, Dr. Clark was getting that 1981 colloquium together. I'm the one that used that word. So we met with Dr. LeMaistre, and you could tell Dr. LeMaistre, shall we say, his heart was not in it. I mean, it wasn't his idea. It was just okay, and he hardly participated in the thing. I'm sure he'd probably give you a different story about it and so forth. It just wasn't his, and so he didn't really—(talking in the background) You all go in the other room, Charlotte, and talk. Can you go in the other room and talk?

Female

1:56:03.7

I'm getting ready to leave. She's going to be here and be quiet.

***C. Stratton Hill, MD***

1:56:12.8

He then was not enthusiastic about anything like that.

***Tacey Ann Rosolowski, PhD***

1:56:25.0

Did that influence your work with the pain clinic and other pain related issues after you left the directorship of ambulatory care?

***C. Stratton Hill, MD***

1:56:34.8

Not really. At that time, see, we were beginning again to run out of space, so we were beginning to look to expand the clinic even more, so it was just things have got to go on in that regard. That kind of distracted everything. And another thing, though, that happened about that time was that there was a guy that was interested in building the Rotary House, and his name was Roman Arnoldy. His son is still here. Rome died. He was in my breakfast club, or maybe I was in his breakfast club. He was quite a guy. He was an engineer and a graduate of the University of Minnesota. I mean, had a lot of patents and everything, and he was a real go-getter. I don't know who appointed me to work with him on that. Maybe it was in the interim. And there was a guy named Elmer Gilley who was kind of the financial officer. Have you ever heard of his name?

***Tacey Ann Rosolowski, PhD***

1:58:29.9

Yes, Dr. Becker mentions him.

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***C. Stratton Hill, MD***

1:58:33.9

Yeah. He was kind of— The guy before him was Joe Boyd. Have you heard of him? Well, he was the administrator, and he'd been sent down from the University of Texas at Austin for this job. He was a bachelor, smoked like a chimney—I mean—all the time. Elmer Gilley was the financial officer, so it could have been— And about that time, Joe Boyd died, I believe. He had lung cancer, and Elmer Gilley was, I think, appointed as interim. He may be the one that put me to work with this guy.

***Tacey Ann Rosolowski, PhD***

1:59:33.4

What was the mission to be of Rotary House?

***C. Stratton Hill, MD***

1:59:39.2

To be what it is now. So we got that thing going, and LeMaistre apparently didn't like that.

***Tacey Ann Rosolowski, PhD***

1:59:53.3

Why not?

***C. Stratton Hill, MD***

1:59:54.7

He took it over. He took it over because it was successful. I mean, it was going to be built.

***Tacey Ann Rosolowski, PhD***

2:00:02.6

And just for the record, the mission of Rotary House is to provide—

***C. Stratton Hill, MD***

2:00:09.1

Convenient and appropriate housing for patients at Anderson. There are several models that you can go by. The Cleveland Clinic is one, and that is they have a hotel that's connected to the— well, the Mayo Clinic too, but actually there's not a hotel connected right to the clinic. But the Cleveland Clinic, they even would take people out of there, out of the hospital, and put them in the hotel after a day or two, and that cut down on the expense. Although, they made a pot of money because these DRGs came in where the government paid on the Medicare for, let's say, a coronary bypass, and you got, let's say, \$250,000 for that. Well, if you didn't spend \$250,000, that was just that much profit. So they'd take those people out of the hospital and put them over there in the hotel, and the doctors would make rounds in the hotel. They just charged them the rate for the hotel, which is a lot cheaper than the rate in the hospital.

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***Tacey Ann Rosolowski, PhD***

2:01:46.4

How was it for the patients being there?

***C. Stratton Hill, MD***

2:01:49.6

Oh, they loved it. It was great, because just like the Rotary House, it's set up for toilets in certain ways, and they were designed to handle people who have some type of infirmity.

***Tacey Ann Rosolowski, PhD***

2:02:12.9

When you were planning all this, you were looking at the models like at the Mayo Clinic and Cleveland Clinic?

***C. Stratton Hill, MD***

2:02:19.8

We never got that far with it. We were taken off of it. When it got to be that the money was coming forth and so forth, then LeMaistre took it over.

***Tacey Ann Rosolowski, PhD***

2:02:35.3

Now, John Mendelsohn came in just around the time you retired, isn't that correct?

***C. Stratton Hill, MD***

2:02:39.2

Same year.

***Tacey Ann Rosolowski, PhD***

2:02:39.4

Same year, that's what I thought. And in your observation, how did he compare with Dr. LeMaistre? What were some similarities and differences between him and Dr. LeMaistre and Dr. Clark?

***C. Stratton Hill, MD***

2:02:53.9

Dr. Clark was the visionary person who was able to execute his visionary plan, and he got it to a certain point. He became interested in international affairs and was distracted towards the operational functions of the clinic as it had developed. He then did not keep up academically with the latest developments in the fields. The fields became too diffuse and different. Cancer was a surgical disease for a long time. Everybody up in Memorial was a surgeon, and surgery was the method of choice. You took the thing out. When it got beyond that, then it kind of got out of Dr. Clark's league. I never will forget the time that I went with him—

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I'm a member of the Society of Surgical Oncology, which is kind of strange, since I'm not a surgeon, but that grew out of actually the alumni association of Memorial Hospital. It was called the James Ewing Society for a long time, and then it was probably in the late '70s or maybe early '80s—I think probably late '70s—that the surgeons said, "Wait a minute. We're losing out on this," because there's an American Society of Clinical Oncology, and it's huge now. I'm one of the early members of that, and so because I was an alumnus of Memorial Hospital, Bill McComb, who was head of Head and Neck at Anderson—who came from Memorial—he came there because he was about the same age as Hayes Martin, who was probably the father of head and neck surgery in the United States. He knew Hayes Martin was going to be there as long as he was, so he came down here. Bill McComb, I was the only Memorial alumni besides him, and so we hit it off real well. He was a great guy, and he got me into the James Ewing Society. Then when they changed the name to the Society of Surgical Oncology, I just got in as a member.

Anyway, I remember I went to a meeting where Dr. Clark gave a paper, and somebody else had written it for him because he wanted to try to keep up with everything, and it was pitiful. It was bad. So he got out just about the right time because he was interested in this other stuff. Things were changing. LeMaistre came in. LeMaistre was more of a facilitator. He knew that— He'd been in administration of a large university, so he knew about different departments and how they develop and what it takes to move them along, so he was good at that. Science-wise, he was just there. But I don't think he pretended to. Then when he got into—well, John Mendelsohn came. That brings up a whole other political stuff that was going on when LeMaistre decided to retire. I retired in the same class that LeMaistre retired in.

Tacey Ann Rosolowski, PhD  
2:08:36.0  
It was 1996.

***C. Stratton Hill, MD***  
2:08:37.8

Yeah, '96, and then they made us an offer that you couldn't refuse, probably because LeMaistre was in that group. But anyway, I think there was some infighting about who it was going to be, and it ended up being with John Mendelsohn. At the time, I thought that's just kind of a compromise, but it turned out to be fabulous. John is a good administrator, and he's a scientist, so you've got the whole ball of wax with John.

But I was retiring, so they had a little party for me, and I met him. They didn't know anybody, so I introduced him to some of the— He's big in music, so we went to the opera and ballet and some musical groups and things of that sort. I guided him in that direction, and then they took off. They became interested in all kinds of civic affairs and did just everything.

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I remember one time I crossed paths with him in Cincinnati. I'd been invited to speak to the Rotary Club in Cincinnati, and I had finished and was coming back to Houston, and he'd just come to Cincinnati; he was getting off the plane, coming. We crossed in the airport. John is a solid scientist, and I think he did a magnificent job, and I think he is a fund raiser. Everybody likes him, magnetic personality. We've had a real good relationship with both he and Anne. I think he's taken Anderson soaring and will continue to. I mean, the Bush's, on two occasions that I know of, where they were fund raisers for us—and then Bob Mosbacher, my friend—all of them are friends. He was the fund raiser for that, and I think the first one was \$10.1 million. The other one was \$10.2 million, each time that they were in on the deal, and that was for this new program of tailoring treatment to specific cancers and so forth.

***Tacey Ann Rosolowski, PhD***

2:12:05.7

Individualized care.

***C. Stratton Hill, MD***

2:12:07.0

Right, and this new building that this sheik is giving is all about that, and so that's really three distinct, you might say, personalities. Dr. Clark had to start with scratch, and he was able to convince— And as I see it, he worked more at the state level, because it's a state institution. It was the Texas Cancer Hospital. It started in 1941. He realized that his strength lied in the state effort as opposed in contrast to Baylor, which is Houston's now. LeMaistre then began to hit the Houston scene a lot and continued to do that and did very well at it. Mendelsohn has done the local, state, and national level now. I remember when I was running the clinic our budget was \$300 million a year. Now it's \$3.5 billion a year. It's come a long, long way.

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**Chapter 16**  
**B: Institutional Change**  
**Preserving the MD Anderson Brand Despite Global Growth**

Story Codes

- B: Beyond the Institution
- B: MD Anderson Culture
- B: Building/Transforming the Institution
- B: Growth and/or Change
- B: The Business of MD Anderson
- B: The MD Anderson Brand, Reputation
- C: Portraits

***Tacey Ann Rosolowski, PhD***

2:14:11.4

I was going to ask you a related question about that because certainly under Dr. Mendelsohn there's this move toward global oncology and just the expansion of MD Anderson through outposts. I was wondering what your view of that was and what happens to standard of care with growth and if an institution like MD Anderson can become too large.

***C. Stratton Hill, MD***

2:14:37.2

Well, I think that's a good question. The model is not confined to MD Anderson. The Cleveland Clinic has operations in Fort Lauderdale. The Mayo Clinic has it in Jacksonville, Florida, and Scottsdale, Arizona, and I think maybe other places now. And other clinics have metastasized to different places. I don't know how people feel about that at the local level. In other words, "Oh, yeah, I'm going to MD Anderson, but I'm in Madrid, Spain." The culture has a lot to do with it, and so I don't think that changes the culture at all. You can have standards that you meet, but whether or not you have the warm and fuzzies, let's say, I don't know. I doubt that, depending on the culture that you're in.

I know that, for instance, I gave a talk in Jacksonville one time, and I had to give two talks. One was for the Mayo Clinic people, and the other was the non-Mayo Clinic people, and never the twain shall meet. Well, what they had was they had a hospital that was down there that was not doing well. When the Mayo Clinic moved in there, they said, "Hey, we've got a hospital here for you. You want to run it?" "We'll run it, but you staff it." That's the way they do up in Rochester, so they said, "Sure, we will." The local docs then say, "Hey, we don't like this competition," so you get that. I've had that happen up here in Lufkin, Texas, where a group of doctors don't speak to the other group of doctors in the same town in Lufkin, Texas.

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***Tacey Ann Rosolowski, PhD***

2:17:29.7

And it's all about competition for a limited pool of patients.

***C. Stratton Hill, MD***

2:17:33.2

Yeah, it is, and UTMB has that big time now because Galveston—the population in Galveston is 65,000 and the state gives them very little money. When I interned there, we would go down and get a list of cases that people were referring in from all over the state. That was practically the only state hospital that took charity patients at that time. Now they practically don't take any charity patients because the state doesn't pay for it, and so they've got to get out and scrounge up patients for their doctors, their teaching doctors, to make money so they can compete to bring in people like that. You have that part of it. The other part, as I see it, is just the culture. I don't know whether the people who, say, go to the Mayo Clinic in Scottsdale, Arizona, feel the same way if they went to the Mayo Clinic in Rochester, New York, or not, the top clinic or something like that.

I think it's good. If you don't have some control over the quality of the product, then you're going to have a problem because your reputation is going down. Now, they've had one, an Anderson in Orlando, Florida, for a long time, and as far as I know, that's doing okay. But again, it's just competition. The local docs are going to say, "We can do anything they can do." And that's true. That person may be able to do it, but whether or not they can do the coordinated thing—I've got to tell everybody that's coming—I say, "Look, the only real advantage of a specialty hospital is that we're going to do all of it. We're going to do the surgery, radiation, chemotherapy, biological modifiers, immunotherapy or anything, and we've got control of all of that." The surgeon may be the greatest surgeon in the world over here, but he knows his friend is in radiotherapy, and he's not too good, but he's his friend, so he's going to say, "Yeah, go over there to Dr. Smith to get radiation therapy." He convinces himself it's okay because he'll get just as good as he would anywhere else or something like that. There are a lot of factors that go into that. I don't think it detracts from the quality at Anderson per se, but it's a question of how much control they may have over the various disciplines that are needed to treat that person.

***Tacey Ann Rosolowski, PhD***

2:21:46.2

I was curious, looking ahead. MD Anderson now has a new president, and what are your observations? I know you're no longer there as you're retired, so your relationship is not quite as direct as it was, but what are your observations about Dr. [Ronald] DePinho?

***C. Stratton Hill, MD***

2:22:06.9

Well, the only time I've ever seen him was when he threw the baseball out at the baseball game. That's all. I have only the opinion of one of my colleagues, Dick Wainerdi, who runs the whole

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Texas Medical Center. He's high on Dr. DePinho, and he thinks he's going to be great. The only thing that makes me have any kind of questions is the fact that he doesn't have a lot of experience in the operational clinical side, but that's no judgment on whether or not he's going to emphasize the basic science over the clinical. You're concerned that that might get the bigger piece of pie as opposed to the clinical. However, from what I hear from him is that he understands that he doesn't have that bit, shall we say, but he wants to not let that slip. I think he's smart enough, from what I hear, if he just looks at the bottom line to see where most of the money comes from. You're generating 65, 75, 85 percent of your revenue for operations from clinical stuff that you better pay good attention to that, and I think he will. I just think from what I've heard about him that he'll do that, and that's just a matter of organizational skills. He can come in there and say, "These are the parameters we're going to be looking at, and I'm going to put you in charge of it, and we'll look at that."

And too, one of the things that happens in academia is that you have auditors by your peers, and depending on how those peers are selected, you could possibly say, "I'm going to get Joe Dokes over here," and he's your buddy. He's going to come in and say, "Oh, he runs this place just great." But on the other hand, most of the time it's not that, and so you have people who look at your program, and I think that management consultants, Anderson has matured enough that they do that. They've got the budget and funds to continue to do that. When I first came there, we had to shut parts of the hospital down because we didn't have enough money to operate.

***Tacey Ann Rosolowski, PhD***

2:26:15.2

I didn't know that.

***C. Stratton Hill, MD***

2:26:18.0

Yeah, we'd have to close—at the end of the fiscal year—close down a few floors because we didn't have enough money to pay everybody, and that didn't last long, but it did that.

***Tacey Ann Rosolowski, PhD***

2:26:35.9

Not in that position anymore.

***C. Stratton Hill, MD***

2:26:37.5

Not in that position anymore, and then, too, there's no question but that Anderson is on the map in terms of just about anywhere. I just saw, two or three days ago, an article by Andy von Eschenbach in the Wall Street Journal about the FDA. He was commissioner of the FDA, but he was head of the National Cancer Institute before that. He operated on me. I had prostate cancer, so he operated on me 15 years ago. Everybody knows he comes from MD Anderson, and so there's a lot of difference than what it used to be.

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## **Chapter 17**

### **A: Professional Service beyond MD Anderson The Texas Cancer Council and the Texas Cancer Pain Initiative**

Story Codes

A: Overview

A: The Clinician

A: The Administrator

A: The Educator

A: Activities Outside Institution

A: Career and Accomplishments

A: Post Retirement Activities

A: Definitions, Explanations, Translations

D: The Healthcare Industry

D: Politics and Cancer/Science/Care

D: Fiscal Realities in Healthcare

***Tacey Ann Rosolowski, PhD***

2:27:40.5

We're at about 4:30, and I was wondering if you have the energy to answer just a few final questions?

***C. Stratton Hill, MD***

2:27:47.2

Sure, sure.

***Tacey Ann Rosolowski, PhD***

2:27:48.1

Okay. I wanted to ask some observations about what you're doing now that you're retired, but first, maybe a little bit of reflection on what you did at MD Anderson. Of all of the roles that you served, what are you most pleased with as you look back?

***C. Stratton Hill, MD***

2:28:11.5

It would be really hard for me to choose because I've had just, to me, phenomenal things that have happened, and I've made connections and friends all over, everywhere. What I've done for different reasons has taken me all over the world, and so a lot of my patients have become friends, and we visit with them. My son lives in San Salvador, and I've had a whole lot of patients from down there, so that's helped him down there. We spent two weeks down there at Christmastime. I did a lot of work in the political arena getting these regulations and laws passed. I learned a lot about that. I made a lot of friends. I got appointed to the Texas Cancer Council. It

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seemed like I had about—I know I had two terms. It seemed like to me I was on that thing for about 16 years, and so that kept me in touch with a lot of things.

***Tacey Ann Rosolowski, PhD***

2:30:09.4

What was your role on the Texas Cancer Council?

***C. Stratton Hill, MD***

2:30:11.8

The Texas Cancer Council was organized to provide seed money for startup projects across the state in prevention and diagnosis. Not so much treatment, because you brought people into going institutions for treatment, but we were the granting agency for the money that we had. We started out with \$11 million for the first year, and then we got various amounts, but it was in the millions. Every time we'd have to give it away, people would write for grants, and we'd have to look at the grants and decide who got the money. That was what the Texas Cancer Council did.

***Tacey Ann Rosolowski, PhD***

2:31:24.0

How did you become involved with it? Was it an appointment?

***C. Stratton Hill, MD***

2:31:27.2

Yeah, Bill Hobby appointed me. He was a friend of mine. He called me up one time. I didn't even know—I knew that there was such a thing, but, I don't know, I guess he couldn't find anybody else, so he called me and asked me. He didn't run, so I thought, "Well, I'll just let this term go out," and Bob Bullock came along as the lieutenant governor. But then Jim Dannenbaum was president of the Texas Cancer Council, and he said, "No, I want you to stay on here." And I said, "Well, I've already said I'm going to quit. They've already given me a gavel." He said, "That doesn't matter. I'm going to put you up here, and I'm going to get some people to talk to Bob Bullock." He said, "You just write Bob Bullock a letter and tell him you're willing to do it." I did, and so Bob Bullock appointed me, too, to the Texas Cancer Council, and I got to meet a lot of people all over. Another thing that we did—and I don't know that I've mentioned this at all—is that I started the Texas Cancer Pain Initiative. Did I talk about that? That was—

***Tacey Ann Rosolowski, PhD***

2:33:10.7

I'm not sure I'm recognizing the name. No.

***C. Stratton Hill, MD***

2:33:14.7

I don't think I did talk about that, but I got that—

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***Tacey Ann Rosolowski, PhD***  
2:33:22.3  
I have the Texas Pain Society.

***C. Stratton Hill, MD***  
2:33:24.0  
No, that's different. The Texas Cancer Pain Initiative was the group at the University of Wisconsin. I think I did mention that.

***Tacey Ann Rosolowski, PhD***  
2:33:34.1  
Yeah, you mentioned Wisconsin.

***C. Stratton Hill, MD***  
2:33:35.1  
They started what they call the Wisconsin Cancer Pain Initiative, and I had written an editorial for the JAMA, and what was the name of that editorial? Oh, I wrote— They had a thing where you could write a little vignette, and I've forgotten the name of what they call that column. I wrote it about pain and the problem with pain treatment, and that's when they called me. That's how I got started on that, and then it kind of got momentum going. I guess that was probably in the '80s. And then everybody thought, well, we had a cancer pain initiative here, and actually, we just sort of did it and never did organize it formally, and so—

***Tacey Ann Rosolowski, PhD***  
2:35:15.6  
What were the goals?

***C. Stratton Hill, MD***  
2:35:17.6  
The goal was to improve the treatment of cancer pain. I went to the Hobby Foundation and asked them to fund a meeting to be held in Austin, and I got Kathy Foley to come down. By that time, I had made connections with the Narcotics Division of the Texas Department of Public Safety and had—what was his name?—Captain—I can't think of it right now. Anyway, I had all these people coming—we invited a lot of people to come—and we were able to pay from that grant from the Hobby Foundation to bring a lot of people from Anderson over to that meeting. We had an organizational meeting, and we started it up and formally got a charter from the state and incorporated, became a 501(c)3 corporation. And then we did a lot of things, and we had meetings.

I never will forget we had a yearly meeting of the Texas Cancer Pain Initiative, and I got Reginald Ho, who was the national president of the American Cancer Society, to come to the meeting here for the Texas Cancer Pain Initiative. We were putting on a meeting every year, and

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I would get speakers to come. We also lent our name to all the stuff that we were doing with the legislature, the Texas Cancer Pain Initiative, and so forth, and I got different people. There was a book called *The Culture of Pain* that was written by—his last name is Morris. Anyway, I had him come speak one time. He was a professor of literature, David Morris, and since then he's spoken at many, many pain meetings. He's become very— His father was a doctor, and he became a university professor at the University of Virginia. A university professor is almost like being God. I mean, you can do anything you want to. You've got tenure. You can teach in any department you want. I never knew that. And he was a writer; he quit teaching to be a writer. He's written a lot of different things. He was talking about— His big thing was the narrative of pain, and of course, being a writer, that's kind of normal. Are you familiar with the Rockefeller—? [Rockefeller Foundation] I don't know what it's called. It's an old monastery, I guess, in Bellagio, Italy, on Lake Como. Are you familiar with it?

***Tacey Ann Rosolowski, PhD***

2:39:49.9

Yeah, it's that residency program.

***C. Stratton Hill, MD***

2:39:51.9

Yeah, right, where you go and you can submit that you want to do a book, and then you go there. Well, he did that, and that was after I was out of things.

***Tacey Ann Rosolowski, PhD***

2:40:03.1

Yeah, that's very prestigious.

***C. Stratton Hill, MD***

2:40:04.8

Oh, yeah. He did that, and there's a book that came out from that, but that was after I had retired and everything. We did things like that. I got grants, and we got money to do a lot of research. That's the way I could pay these students to do things, research. We worked with the Sunset Commission, and I paid the law student out of that. I paid the law student here, and let's see, what else came out of that?

***Tacey Ann Rosolowski, PhD***

2:41:09.8

If I could interrupt you, I was wondering, from a slightly different perspective, what was the significance for Texas of having a pain initiative like Wisconsin had? Do you think it helped speed education?

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***C. Stratton Hill, MD***

2:41:24.2

I'll tell you what we did. The biggest project we took on with the Texas Pain Initiative—and this is where we found out a lot about the politics too—decided that we were going to get a doctor, a pharmacist, and a nurse in every major city in Texas. We got money to pay for them to come to a meeting in Austin, and I brought the people down from Wisconsin to teach. The purpose was that they were going to go back and teach this course, because we had money to give to them to pay locally. Well, for instance, in El Paso, when I talked to somebody there to get it set up, they said, “You're going to have to have two here because if you invite one group of doctors, the other group won't come and vice versa.”

***Tacey Ann Rosolowski, PhD***

2:42:38.9

Local politics.

***C. Stratton Hill, MD***

2:42:40.1

“You're going to have to have two groups, one from each one of those.” So we said, “Okay, we'll do that.” We did that and then—

***Tacey Ann Rosolowski, PhD***

2:42:49.0

What year was this that you—?

***C. Stratton Hill, MD***

2:42:50.3

This was—oh, it probably was in the late '80s. No, it probably was in the early '90s, because Nora Janjan took that over, and she was here at the time. I didn't know her, but there was an article about pain in Newsweek or Time or one of those magazines, and it had my picture in there and Nora's picture in there. That all occurred about the same time that we were having that. She was at Wisconsin then, and then she came here in radiation therapy. She's retired from MD Anderson now. But that unfortunately fizzled out. It didn't keep going. The concept was great, but it takes a lot of funding. Then we began to run into all the cultural barriers and all the legal stuff, and we're worse off now than we were before we started doing all this because the DEA came down on all of this. I convinced the powers that be in the DEA that we ought to look at this, and they even had me come to Annapolis, Maryland, to speak to all of their supervisors from all over the United States.

***Tacey Ann Rosolowski, PhD***

2:45:02.7

You were going to educate them about the cultural issues.

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***C. Stratton Hill, MD***

2:45:05.6

About the need for it, because as far as they were concerned, narcotics had no useful purpose; it was all criminal. So I got the most egregious slides I could find of just terrible cases that we had, and I showed those to them. I remember after the talk and everything— And a lot of the guys had family members who had pain that wasn't unrelieved, so they kind of were saying "Yeah, there's something to this." But when I got the final comment, as I was talking to the guy in charge who was kind of the public relations officer for the DEA, I said, "What do you think they thought about the program?" He said, "Well, they think you're a nice guy, but you're full of shit."  
(laughs)

***Tacey Ann Rosolowski, PhD***

2:46:22.1

It's an uphill battle.

***C. Stratton Hill, MD***

2:46:27.8

Anyway, the Cancer Pain Initiative, then what I tried to do was— But this time, we said, "Look, we're making too narrow a focus on cancer pain. We now should just make it pain." I then reorganized the thing, and we called it the Confederation for the Relief of Pain or something like that. And one branch of it was going to be for cancer pain. The other would be non-cancer pain. In the meantime, the American Cancer Society Texas Division was interested in pain relief. By the way, I got the National American Cancer Society Humanitarian Award one year.

***Tacey Ann Rosolowski, PhD***

2:47:44.8

I was going to ask you about that. I have that— That's really quite an honor.

***C. Stratton Hill, MD***

2:47:49.9

Well, I was surprised about that.

***Tacey Ann Rosolowski, PhD***

2:47:55.3

That was in 1996, the year you retired, that you got that.

***C. Stratton Hill, MD***

2:47:58.9

Yeah, I had to go to Chicago to get that.

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***Tacey Ann Rosolowski, PhD***

2:48:04.7

When did you get the news? I mean, how did you get the news?

***C. Stratton Hill, MD***

2:48:09.4

My secretary— I didn't get the news until a lot later. I remember one time my secretary said, "Have you got anything going on in—?" whatever month it was. I said, "I don't know. Not that I know of." They told her to keep my calendar open, and so she did. Finally they— I remember because I had to go to Atlanta for that, and Dr. LeMaistre went over there because he was bucking for the presidency of the American Cancer Society at the time. He became president shortly after that. I don't know which time, but I know that— It seemed like to me there was somebody else that got an award from Anderson at the same time that I got that other one. No, wait a minute. I don't know. I went to get that in Chicago. I don't know what that was in Atlanta. I can't remember.

But the Cancer Pain Initiative—that was a very important step to get that going. We officially got that going, I think, in 1991. Everybody thought, "Well, you've had one going for a long time," and I said, "Well, not formally," but we got it done at that time. And then the American Cancer Society Texas Division kind of just— I don't know whether they're still running one that's called that or not, but because the pain is broader than it was to begin with, it's not as focused on cancer pain. The Texas Pain Society doesn't confine things to cancer pain.

***Tacey Ann Rosolowski, PhD***

2:51:04.8

And you found that was a politically savvy move to get by in?

***C. Stratton Hill, MD***

2:51:12.2

Yeah, because they then formed the Alliance for Cancer Pain Initiatives. June Dahl was the person behind that. She was a professor of chemistry at the University of Wisconsin, but she was on the Controlled Substance Board of Wisconsin, and they wanted to legalize heroin. She got interested in why. They were making the case that that was so much better for pain control than other drugs and so forth. She was a chemist, and she couldn't see that it was any better, and that's true. It's not better. It's more lipophilic. It's more soluble in fat, and nervous tissue is mostly fat, so it gets there quicker. It gives you the rush, and people like it better. Anyway, that's how she got into this—that book that I published—that we published.

***Tacey Ann Rosolowski, PhD***

2:52:41.0

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***C. Stratton Hill, MD***

2:52:42.0

Yeah, when we began. We brought the people from Wisconsin. We brought the people from all over, and that was the first attempt to really make this a meaningful multidisciplinary approach, including the social sciences. It wasn't just medical or the scientific part of it. It was getting the anthropologists in and psychologists and all the other people that had a role in this.

***Tacey Ann Rosolowski, PhD***

2:53:34.6

What's been the fate of that multidisciplinary approach? What's happening now with that?

***C. Stratton Hill, MD***

Well, that to me is a problem because one of the problems that you have in terms of getting pain treatment is who is going to pay for it? And who is going to pay for having—? If you're going to have a psychologist and say an orthopedic surgeon and a neurosurgeon and a neurologist and a psychiatrist and an anesthesiologist to get together and talk about a patient, who pays? And then if your patient doesn't have an orthopedic problem, why should you pay the orthopedic guy? But then if he's coming there and he's taking time away from his practice—so you have a hard time with the logistics of that, and so I know that was— And I'm not sure whether or not Medicare pays in their hospice mode for after care.

In other words, your expenses ought to stop when you die, but what about grieving? And I think that they do pay something for grieving after the person dies, so that means that expenses don't stop, but they don't just keep on paying. It's just a certain limit, so that's been a problem. My whole question is that all of these in this Institute of Medicine paper they're talking about, well, we need more of the multidisciplinary approaches to this problem. There's no question to what you do, but then how are you going to pay for it? And how do you decide what's effective, who gets what, and so forth?

There is an article also in the—I think it was in either the Houston paper or the Wall Street Journal, talking about this business of [President Barack] Obama dictating about contraceptive payment and so forth, that this is just the beginning because you're going to have committees that say these are the criteria for this resource, A, B, and C. You don't meet those criteria, you don't get the resource. You can get it, but you've got to pay for it, and it says it's going to be all over the place. I think that's true, particularly with the emphasis on evidence-based medicine, because evidence-based medicine is not a, shall we say, poured-in-the-concrete, scientific endeavor. There are too many variables that you can explain, like, say for instance, the placebo effect. Somebody might just do well on—I've had patients say, "I don't want this one here. I want that one over there." "Okay, that one over there is ibuprofen, and this over here is morphine. You'd rather have the ibuprofen than the morphine?" "Yes, that helps me better." So I give them what? I give them the ibuprofen. They say, "I'm not paying for that." When you make

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evidence-based such a rigid criteria you're going to get into deep trouble because of the nature of the pain problem itself.

It's just like the watermelon story I told you. You can't explain it. So that's what I see coming on board. It's like, for instance, before we had payment for medication, you could get a pump for a patient that would pump the morphine intrathecally. The pump costs \$10,000. The surgery to put it in there was maybe \$4,000 or \$5,000 and so forth. You could get that paid for by Medicare, but you couldn't get \$5 worth of morphine pills. There are all kinds of little things like that that are going to be a problem.

***Tacey Ann Rosolowski, PhD***

2:59:57.5

Can I ask you about your post-retirement activities?

***C. Stratton Hill, MD***

3:00:01.3

Yes. What I did, basically like I told you, I did a lot of testifying. I continued to do that because, by this time, I had a reputation. By the way, I forgot to call that guy. I've got to call him—the guy that called me from Wichita Falls about his daughter. By this time, I had a reputation, so I was doing a lot of testifying.

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**Chapter 18**  
**A: Post-Retirement Activities**  
**The Open Door Mission for Rehabilitation and Recovery; Awards**

Story Codes

- A: Contributions
- A: Activities Outside Institution
- A: Career and Accomplishments
- A: Post Retirement Activities
- A: Professional Values, Ethics, Purpose
- C: Patients

I just continued to do that, and about five years ago, a friend of mine who runs a mission for homeless men with alcohol and drug problems asked me if I would take a look at—they had a convalescent care center, and they had beds for people who were coming out of the hospital.

***Tacey Ann Rosolowski, PhD***

3:01:03.9

And this is the Open Door Mission.

***C. Stratton Hill, MD***

3:01:05.7

Yeah, right, and so there was a good guy who was head of Urology over at Baylor. Russell Scott was helping with them out there, but he got sick, and he couldn't do very much, and he finally died. After he died, my friend asked me if I would look at it. So I looked at it, and I could tell he needed some help, so I decided that I would help. I've been doing that.

We have 35 beds, and I organized a social service department because they didn't have one. I was lecturing out there at the Graduate College of Social Work, University of Houston, and I knew the social workers out there. I asked them to help me write a job description. They did, and we got some grant money, and so I have three master-level social workers out there now that do most of the work. We don't actually do the medical care. We just facilitate it. I've taught them now, the social workers, the criteria of what to ask for about whom we can take care of and what they need to ask somebody when they call up. They were dumping people out there too. They'd put them in a taxi from the hospital and just send them out there with an IV going. We couldn't take care of people like that. When I first went out there, they were having a 911 call every day because nobody was keeping up with whether the guys took their medicine or not. It was just they let them keep the medicine at their bedside. So we instituted that, and that's been running now for several years. That's what I'm doing. It takes less of my time than it used to.

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***Tacey Ann Rosolowski, PhD***

3:03:49.9

Because it's up and running?

***C. Stratton Hill, MD***

3:03:52.1

Yeah, it's up and running and so—

***Tacey Ann Rosolowski, PhD***

3:03:59.4

Now, is this the activity that garnered you the Mayor's Volunteer Houston Award in 2010?

***C. Stratton Hill, MD***

3:04:09.3

Yeah, right.

***Tacey Ann Rosolowski, PhD***

3:04:11.0

That was nice. That was presented by Annise Parker, the mayor.

***C. Stratton Hill, MD***

3:04:17.6

Yeah, the grant writer turned my name in for that. Yeah, that was very nice.

***Tacey Ann Rosolowski, PhD***

3:04:30.2

What does it mean to be awarded something like that or the humanitarian award from the Cancer Society?

***C. Stratton Hill, MD***

3:04:38.4

Well, it's certainly some recognition that you've done something that somebody thinks is worth something. I don't know how much people pay attention to anything like that. It means more in the circles that— When I got appointed to the Cancer Council, I got calls from all kinds of politicians about how great this was and all that kind of stuff, and I thought, "Well, okay, that's fine." It doesn't pay anything, so you don't get any money, but then they do pay your expenses, and you do get recognition from different places for one reason or the other. But it doesn't— It's just personal satisfaction is the main thing as I see it. I'm glad that it's recognized, and hopefully it will lead to further things, that you're able to do more for the people that you're doing things for.

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I had a pretty good example of that with a woman that was very much interested in the pain part of things. She's a great philanthropist. She owns Exxon, among other things. The Blaffer's—you may have heard of the Blaffer Gallery. Jane Blaffer Owen, she restored New Harmony, Indiana. I don't know if you're familiar with that or not. That was one of the early commune communities in the US, and she was married to an Owens. We actually visited up there with her. It's nice to fly up there on her plane, too. The Owenses were a very, very interesting family. One of the Owenses was the first president of Purdue University, and they did the first geological survey of the United States. They were all geologists.

Well, I took her out to the mission one time, and she said, "You know, these guys need a garden to work in." And I said, "Yeah, that'd be a good idea, but we don't have any land." And I said, "That would be a problem." She said, "I'm going to give you some money, and you getting the land is going to be your problem." She wrote us a check to get some land, and just out of the blue, and so long story, politicians were involved. They're building a light rail out in Harrisburg where this mission is, and the politicians knew that that raised the land value. Nobody wants a mission in their backyard, so they were trying to get rid of us. So the city had a program where if they tore down a house, you could rent that lot for a garden, but you had to have the permission of the representative from that area. They wouldn't give us permission to use any of their land because they wanted us out. They weren't going to let us sink down any more roots anywhere. We finally found a place and got the thing built, but then we had a shakeup in the mission hierarchy, and that thing is just sitting there. The best laid plans can go awry. I'm hoping that when we straighten out about the—get a new executive director, that we can start up. Jane was 93 years old when she died, and she was just as spry as she could be. She spent her summers up in New Harmony, and we went up there several times with her.

The Harmonites was the group that came in there first. It was around 1815 or something like that. They were German, and they settled in that area. They stayed there about 20 years. And then her husband's family, the Owenses, bought it, but that didn't last but a couple of years. It was going to be another commune, and a lot of the buildings had fallen down. I mean, the roof had fallen and dilapidated. She built it all back, just like it was, and then she also built what she called a roofless church. She had Philip Johnson as the architect, and she fired him. But the roofless church, it's a church building without a roof. It's got an altar, and there's just grass in there. While we were there, some girl had a wedding in there. And she had a pieta there and sculptures and several other famous sculptures. A big theologian that was a friend of hers is buried there. The name is right on the tip of my tongue. It was Paul Tillich. She had a garden designed for him, and there's a big bust, and he's buried there. It was all pine trees. Now the pine trees are real high, so it's a very nice garden.

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[REDACTED]

***Tacey Ann Rosolowski, PhD***

3:14:00.0

I don't think so.

***C. Stratton Hill, MD***

3:14:00.8

Sam was a neurosurgeon that we recruited here because of his interest in pain. He was a prince of a guy. I worked a lot with him. We did patients together, and we were doing studies on different things like a drug called Klonopin. We had one patient that was a very big success. We put a pump in her and treated her for about a year, maybe two years, three years. And we wore out a pump. We had to put another pump in there.

***Tacey Ann Rosolowski, PhD***

3:14:59.8

The patient did okay?

***C. Stratton Hill, MD***

3:15:01.5

The patient did great.

[REDACTED]

He told me, and I called him up. I said, "Hey, this lady said that she doesn't have any more appointments with you, and she's got all these problems and so forth." He started giving her some medication, but there were too many side effects and everything. So he comes over one day, and he says, "You've got to take her." I said, "Look, I think maybe she might fit one of our protocols with Sam Hassenbusch, but she'll have to come over to Anderson." He said, "That's okay." We got her over there, and I got Sam to see her, and sure enough, she fit that protocol. They were about to operate on her over there at Methodist on something, and I thought, "Man, you're stretching it if you think that's causing her pain." And so he decided— That neurosurgeon got cold feet and said, "No, I'm not going to operate." Anyway, we brought her over and put that pump in there. She did fine. She told everybody in town that we were great.

***Tacey Ann Rosolowski, PhD***

3:17:03.9

I just had one more question I wanted to ask you, and it's kind of linked to the fact that you've received this humanitarian award from the American Cancer Society. I got the impression that when you started working with pain you didn't necessarily think of it as a humanitarian activity. You just kind of dove in and did it because it was necessary. I'm wondering now that you can step back and sort of reflect on things, what is the humanitarian dimension to that?

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***C. Stratton Hill, MD***

3:17:36.0

I think that kind of becomes— I think that probably reflects my upbringing that my parents instilled a value system that— I don't know whether you could say it's innate, but you just think that this is the way it ought to be. You ought to have relief of your pain. That reminds me of the time that I had a debate with Ivan Illich. You've probably heard of The Death of Ivan Ilyich. Well, this is another Ivan Illich that was a real character. He was a Catholic priest.

3:18:41.0 (end of audio session 3)

## **C. Stratton Hill, MD**

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### **Chapter 00D** Interview Identifier

*C. Stratton Hill, MD*

0:00:00.2

Excuse me. Where did we leave off?

*Tacey Ann Rosolowski, PhD*

0:00:03.3

Let me just quickly put an identifier on. I'm Tacey Ann Rosolowski, and today I'm talking, during the fourth session, with Dr. Stratton Hill, the interview taking place at his home. Today is February 28th, and the time is about 2:00.

Interview Session: 04  
Interview Date: February 28, 2012

**Chapter 19**  
**A: Personal Background**  
**A Southern Baptist Background Inspires a Life of Service**

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

***Tacey Ann Rosolowski, PhD***

0:00:03.3+

Last time we were together, the recorder shut off very unceremoniously, so we're back to ask a few followup questions. I had asked you about the humanitarian dimensions of your work on pain control, and you were talking about how there were values that had been instilled in you when you were very young, then it kind of cut off. So I'm wondering if you can talk a little bit more about those childhood experiences. I was wondering, too, about any spiritual dimensions of that, if religion plays a role in that for you, and if that was part of your childhood experience as well.

***C. Stratton Hill, MD***

0:01:11.6

Well, I think probably— I don't know whether yes is the answer to both of those. But anyway, my parents were— And I don't know how you grade religion as highly religious. They were highly participatory in organized religion. Let's put it that way.

***Tacey Ann Rosolowski, PhD***

0:01:42.1

What denomination?

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***C. Stratton Hill, MD***

0:01:43.1

They were Southern Baptist, and basically I think where I grew up, the doctrine of Christianity is whether or not you were a Wesleyan Methodist or a Southern Baptist or a Presbyterian USA or a so-called Christian church, which were the Disciples of Christ. It was all just Christian, basically. It was interesting that the Presbyterian Church was— At that time, the way that the churches were divided was the Presbyterian Church USA, and that was the northern Presbyterian church, which is interesting because the Presbyterian Church US was the southern Presbyterian church, and here we were in the deep south. I'm not sure how that all came about. I was not a Presbyterian at that time. I started going to the Presbyterian Church after I went to college because I went to a college that was affiliated with the Presbyterian Church. It seemed to be better suited to me just from a comfort point of view. I was not aware of major doctrines, although my father was sort of well-schooled in, you might say, the platitudes that go along with if you're Presbyterian you believe in predestination, or if you belong to the Christian church, you belong to the Carmelite church. Those things didn't mean anything to me. And then they had a branch of the church of the Disciples of Christ that didn't believe in music, and they were called the non-fiddling Carmelites.

***Tacey Ann Rosolowski, PhD***

0:04:23.9

I was just curious because it's a question that I usually ask the interview subjects who are participating in this oral history project, and for some of them, they say yeah. I mean, it may not be a doctrinal thing, but it may be that their sense of spiritual practice includes the work that they've done.

***C. Stratton Hill, MD***

0:04:45.6

Well, this is what I think— That was what I'm trying to get at, that it was the Christian beliefs in terms of Christianity being a religion of love and of service to others, and to me it didn't make too much difference whether you went to the Presbyterian church, the Methodist church, or the Baptist church. There were very few Catholics, very few Catholics, and they were just considered the oddballs. No Episcopal, no Episcopalians in that particular town, but as I say, it was the belief of doing for others that was the predominant theme in all the churches, and nobody separated anybody and said, "Oh, yeah, they go to the Methodist church." Or if somebody went to the Methodist church and they married somebody in the Baptist church, whichever one, they discussed it between themselves. They decided that person switched over and things of this sort, which to me made sense. It was nothing other than the basic tenets of Christianity that made a difference. Very few Jews. The Jews, they had to congregate in the larger city, so if they wanted to participate, they had to drive to another town and so forth, and it was a great emphasis.

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My parents made me go to church. I remember the only time that they ever said you couldn't go to Sunday school or church was during the summertime when the fear of polio was around. You didn't congregate anywhere, and I thought that was pretty cool that you didn't have to go to Sunday school and church. I was brought up in a very devout family, and they were devout Christians. Their parents were devout Christians and so forth.

Since I've gotten older, and in particular, since I've started working out at this mission, I've gotten a lot into the differences in religions and really have gotten into a lot of tenets, a lot of history, and discussions about all types of religions—Hindu, Buddhism, Islam and so forth. But before that, I've never really—it's all been pretty much from an academic point of view. I'm not looking at—I've come to learn that Christianity is one of the—about the only religion that actually emphasizes a belief. Judaism, it's not what you believe that makes a difference; it's what you do, whether you follow the laws of Moses and the prophets and so forth. And the same way with Islam—Islam is the same way. It's not what you believe. You can't believe but one thing if you're Muslim. So anyway, that had really nothing to do with what I've been doing except from an academic standpoint. That may be more than you ever wanted to know.

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**Chapter 20**  
**A: The Clinician**  
**Hospice and MD Anderson**

Story Codes

B: MD Anderson History

C: Portraits

C: Patients

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

D: The History of Health Care, Patient Care

D: Cultural/Social Influences

A: Overview

A: Professional Values, Ethics, Purpose;

***Tacey Ann Rosolowski, PhD***

0:09:36.5

Well, one thing we haven't talked at all about is your work with hospice. Did you want to comment a bit on that, because that's something you've gotten involved with?

***C. Stratton Hill, MD***

0:09:45.3

That might have been the thing that I was thinking about because when the hospice movement started, of course, Dr. Clark was no big fan of hospice at first.

***Tacey Ann Rosolowski, PhD***

0:10:12.1

Really? Why?

***C. Stratton Hill, MD***

0:10:15.3

He didn't like it, to think of Anderson as a place to die. He did not want Anderson to have that reputation, so that was the reason why the requirement for people to come to Anderson was that we had something to offer. We were not to preside over people's death, and we took a lot of flak for that. I know another thing that I may have mentioned. I don't know whether I did or not, but when Anderson started up and the doctors in Texas realized this was going to be a serious effort, they were very much opposed to MD Anderson. We can talk a little bit about that later, but when the hospice movement started, since I was running the clinic at that time, that was mine.

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***Tacey Ann Rosolowski, PhD***

0:11:39.1

This was the Ambulatory Clinic?

***C. Stratton Hill, MD***

0:11:40.8

Ambulatory period. I was pretty much involved with everything that was going on in delivery of care, so I attended the very first meeting of the National Hospice Organization. That was during the Carter administration, and the Secretary of Health and Human Services was—his name was Califano, Joseph Califano. He was the keynote speaker there, because one of the things that the hospice people were pushing as a plus for hospice care was that it was cheaper. When care became futile, then you should—well, when treatment became futile, let's put it that way, then you should look at comfort care. Dr. Clark didn't like that. He didn't want us to be associated with anything like that. "Okay, you come here, we don't have anything for you, but we'll make your life worthwhile for whatever time is left." That was a no-no. You did not say that to anybody. Actually, when we got more into data collection and evidence-based stuff and we started quoting percentages, he wasn't too thrilled about that either because he really wanted to hold out hope. He thought, well, you've got a 10 percent chance of survival of this particular type of tumor. He didn't want to dwell on that. We're going to do the best we can. We're going to give you the most that you can get and let it go at that.

***Tacey Ann Rosolowski, PhD***

0:14:26.5

Let me ask you a question. When you attended this meeting of the National Hospice Organization—did I get the name correct?—when you attended, this was that something you were doing on your own time because Dr. Clark didn't approve of that, or what was that about?

***C. Stratton Hill, MD***

0:14:43.2 No, I did that representing MD Anderson. He wasn't that much against it. He just didn't want it to be—he wanted me to know about it. But if I'd have come on and written an article for the newspaper, he might have not liked that. But he wanted us aware of what was going on. The whole hospice movement, as it started in this country, was that the hospice people did not want the doctors involved. They wanted to just make the patient as comfortable as possible, but failing to understand the nature of the disease it was not a choice of the disease leaving the patient alone to die.

In other words, the disease did things to the patient, and they had the concept— As a matter of fact, the first group that I worked with was a group dominated by psychologists, and they were of the opinion that changes in contemplation of death—and this is my speculation. I mean, I don't know what they thought. But from the outward manifestation of their behavior, I concluded that

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they thought that the contemplation, whether it was intellectual exercise or whether or not there were changes that came over the psyche, that you began to get apparently revelations of deep insights into who are we, what are we here for, what's the purpose of life, and all that kind of stuff, and they were going to be the scribes. They were going to sit down, these people were going to tell them all these different things, and they were going to write it down. Now, that may be an oversimplification. I'm sure it's an oversimplification, but they did invite me to participate in some of the early meetings of people who were interested in starting hospice here. It was a nurse, a male nurse, who was rather obese, who was behind the whole movement, along with the psychologists.

***Tacey Ann Rosolowski, PhD***

0:17:50.0

Was that connected up in any way with the work of Elizabeth Kubler-Ross?

***C. Stratton Hill, MD***

0:17:54.4

Oh, yeah. No, no, no. Elizabeth Kubler-Ross was parallel. She was coming along at that same time, but she never published anything.

***Tacey Ann Rosolowski, PhD***

0:18:05.9

I was just curious because some of the things that you were saying about the insights that the psychologists felt a dying individual might come to kind of reminded me of those later stages in Elizabeth Kubler-Ross's notions of the phases of coping with it and that kind of thing. I was just curious about the connection.

***C. Stratton Hill, MD***

0:18:27.4

No, that was all developing at that time. This was— Dame Cicely Saunders was the world leader, instigator, of the hospice movement at St. Christopher's Hospice in London, and she had a background of a nurse, social worker, and then a physician.

***Tacey Ann Rosolowski, PhD***

0:18:58.9

Just to kind of dot the I on this, the individuals involved in the hospice movement did not want physicians involved because they felt the physicians might try to save the patient or prolong—is that—?

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***C. Stratton Hill, MD***

0:19:13.1

Exactly, exactly. In other words, what they would do to the patient would diminish the quality of life, that they'd give them chemotherapy. They'd want to keep on doing this. Anyway, that effort didn't do much. Then there was a lady by the name of Marion Wilson who came along, and she was a behind-the-scenes instigator and really got the hospice movement going and was able to convince people here to actually do a hospice. I forgot now— The nurse, the big nurse, wanted to call that hospice Helping Hands, which I thought was a pretty good name. I'm not sure if they had a name at that time, they were able to hold this together, and I met with them periodically.

[REDACTED]

Then there was a young man here who was just finishing medical school. His name was Porter Storey. In the meantime, the people who had started this hospice— Now, hospice was basically in homes. They had no place, and I discouraged that. People were “Oh, we've got to get money to build this.” I said, “Look, you can die anywhere. You don't have to go to a place to die. People die on airplanes. They die on trains. They die in homes. They die in the theater. They die everywhere, so don't build a place for them to die. You may want some beds to use to do this because the family can't take care of them, but forget that for the time being.” And they did. They forgot that, and they got organized. They decided to go to the mother lode, and where would you go to the mother lode to get a medical director for a hospice? London, England. They brought a guy over that I had read some of the stuff that he'd written, and he was a typical irascible, inflammatory Brit. He totally didn't understand the American medical system. He was a disaster. He was a disaster, so they fired him and sent him back.

***Tacey Ann Rosolowski, PhD***

0:23:22.9

Do you remember the man's name? I was just curious.

***C. Stratton Hill, MD***

0:23:33.8

I want to say it was— It seemed like it began with an H, but I—

***Tacey Ann Rosolowski, PhD***

0:23:43.9

That's okay. We can add it later if we need it.

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***C. Stratton Hill, MD***

0:23:46.0

If I can come up with it. Anyway, so then this guy, Porter Storey, did a residency in internal medicine, and this was before they had actual programs in geriatrics. They were just getting one going in Baylor, and he took that program, and then he became the medical director for the hospice. He was excellent.

***Tacey Ann Rosolowski, PhD***

0:24:18.3

And he must have been pretty young when he took that on.

***C. Stratton Hill, MD***

0:24:20.2

He was. Yeah, he was. He was very much interested in that, and then that particular hospice did well, I would say, in spite of itself. It had conflicts. It had poor— It had some mismanagement or something, but it ended up building a wonderful inpatient unit. It's over there on Holcombe. I don't know if you know where that is. That's the Houston Hospice, and it's a beautiful building, beautiful facility. It was the home of Oscar Holcombe, who was one of the outstanding—or maybe notorious might be a better term—mayors of Houston. Holcombe Boulevard is named after him, and this house is on Holcombe Boulevard. They were able to do that, but right now, we're considering finishing out the third floor. It was just finished out, the first two floors. I worked with Porter a lot during that time. We brought people over in palliative care in Britain and places like that, and basically the current medical director, I trained her, Betsy Strauch, S-T-R-E-C-K, I think it is.

***Tacey Ann Rosolowski, PhD***

0:26:12.4

S-T-R-E—

***C. Stratton Hill, MD***

0:26:13.5

S-T-R-A, Strauch, A-U-C-K, I believe, Elizabeth Strauch. It's doing very well now. I'm just on the board. I'm on the oversight committee for quality, Quality Oversight Committee, and the guy who is now the chairman of the board is Tom Burke. He's the physician-in-chief at MD Anderson. I have just had peripheral involvement with the hospice in providing speakers here, usually when Porter Storey was there or Betsy wanted somebody. Or if I was bringing somebody for a program in palliative care, I'd call her up and say, "Hey, you want to use this guy or this girl here while he or she is here for a program over there?" And we'd do things like that.

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***Tacey Ann Rosolowski, PhD***

0:27:46.8

How did MD Anderson's relationship with hospice change? Or Lee Clark was—didn't want to deal with it.

***C. Stratton Hill, MD***

0:27:56.4

He was fading away, and we just kind of did it. His health failed, and he was just not in the loop very much, so as we improved into treatment and could offer more, he went along with adding that to the mix of what people were— But he was even against—well, that goes back to the culture at the time. He didn't like it for this Reach to Recovery. Are you familiar with that? Well, that's with the American Cancer Society. In the days of the radical mastectomy, when women were being mutilated, a radical mastectomy removed all the pectoral muscles. You could hardly lift your arm, so they were given exercises to reach recovery. You don't need a professional to do that, and the American Cancer Society promoted that. Well, he didn't like that, but he got over that. He became president of the American Cancer Society, the national American Cancer Society, so he got over that.

That was in the days when fee-for-service ruled, and that gets into the reason why MD Anderson was considered a persona non grata in the medical profession. It was socialized medicine, and therefore the Texas Medical Association passed a resolution saying it was unethical to refer patients to MD Anderson because it was strictly a fee-for-service. If it wasn't fee -for -service, it was nothing, and so having a closed staff made it socialized medicine. They lost their patients when they referred because nobody but Anderson doctors could take care of the people, the patients at Anderson.

I had a patient one time that was so taken with the care that he'd gotten he wanted to start a branch of MD Anderson in Fort Worth, and that was the hotbed of the anti-Anderson movement. I think that's called— I can't remember what county Fort Worth is in right now, but that was the seat of the opposition to any type of care that was not fee-for-service, private practice and so forth. And until HMOs came along, you had to have a— The Texas Medical Association got that in the Enabling Act that only patients that were referred by a doctor could come to MD Anderson. They figured that they could dry MD Anderson up, and then when Dr. Clark said— So then some of the doctors thought, "Well, we'll just send all of our patients who are dying to MD Anderson, and it'll become a death house, and nobody will want to go there." So Dr. Clark stopped that. He never let it get started. So that was some of the politics.

***Tacey Ann Rosolowski, PhD***

0:32:30.2

Right, so that really fed his attitude towards hospice at the beginning.

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***C. Stratton Hill, MD***

0:32:33.2

Oh, yes. He just didn't want— It would be so easy for people to say, "Oh, you can't do anything with cancer anyway. Go over there and die." And I can remember when I was running the clinic and getting calls from doctors and referrals, and I'm the one that set up these referral secretaries. I've forgotten what we called them, referral specialists or something, and they would ask the doctors the questions. The doctor would say, "Yeah, this patient is jaundiced. He can't get out of bed. We've got intravenous feedings and so forth." And they'd say, "Well, I'm sorry. We don't take patients like that." Well, they'd get mad because they had to take care of a patient dying, and they didn't want to do that. Sometimes they would refer that into me, and they'd say, "Doctor, you don't realize it. This patient is dying." I said, "That's exactly what I realize, and that's the reason why we don't take patients like that." We're not here to preside over any individual's death. That is the time that they need to be with their family and their loved ones and the support of their friends and relatives in a setting that the patient is familiar with. And sometimes the doctor would hang up, and he'd say, "Thank you. Bye." That was—

***Tacey Ann Rosolowski, PhD***

0:34:30.8

Interesting, but that's exactly where hospice steps in, obviously.

***C. Stratton Hill, MD***

0:34:34.7

Yeah, that's what hospice is all about.

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**Chapter 21**  
**B: Building the Institution**  
**Expanding MD Anderson's Reputation**

Story Codes  
B: MD Anderson History  
C: Portraits  
C: Patients  
B: The Business of MD Anderson  
B: The MD Anderson Brand, Reputation  
A: The Researcher  
A: The Clinician

***Tacey Ann Rosolowski, PhD***

0:34:39.0

You had mentioned something a little earlier I just wanted to go back to because you were saying at the beginning, the hospice movement didn't want to have doctors involved, and then you started to talk about how there were certain things they didn't understand about the progress of the disease. I was wondering if you could elaborate.

***C. Stratton Hill, MD***

0:34:56.2

Oh, yeah. See, one of the areas where we got a lot of referrals because nobody knew how to take care of them would be cancers of the head and neck. The last thing that an ENT doctor wanted was to take care of a patient who had cancer of the tonsil or the tongue or any part of the head or neck outside of the brain.

***Tacey Ann Rosolowski, PhD***

0:35:31.1

Why was that?

***C. Stratton Hill, MD***

0:35:33.1

Well, you've got a bunch of kids in your office with tonsillitis, and you get a guy coming in with a big tumor on their face or something like that and sitting there in the waiting room waiting to be seen, and these kids and all the mothers and everybody there looking at this guy with all his horrible tumors, that was not too good for business. Then you get into— See, we brought Dr. Bill—what is his name? The head and neck guy. I mentioned him before. He came from Memorial, and nobody did head and neck here. Dr. Clark had to send a guy to Memorial to get him to learn how to do head and neck surgery. He came here and worked at Anderson, and he

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realized what a lucrative practice he could have. He left and set up his own practice. I don't think Dr. Clark ever spoke to that guy again.

Bill McComb. He was the first guy here. At that time, he did radical surgery. Then to do repairs, do plastic surgery, at that time, you had to walk a flap. If you wanted some tissue, you had to walk a flap maybe from the abdomen, and what that means is that they would prepare like a roll of skin. They'd make an incision, say, that long, maybe almost a foot long, and they would take the skin off, separate it from the abdomen, and then they would cut it off here but leave this on down here, and that gave us blood supply to this flap that you separated. They'd just tack that on to hold that flap in place, otherwise it would just be flapping around. Then they would sew that skin together underneath. They could pull that skin together. Then they'd wait about— Well, actually, they would sew both ends together, so you'd have a flap that was like a tube. You wanted to move that from here to here, so you had it hooked here, and it hooked there. Then after about two or three weeks, you'd cut this loose here and pull it over here and then you would let this blood supply—

***Tacey Ann Rosolowski, PhD***

0:39:02.1

So you attach it on the chest.

***C. Stratton Hill, MD***

0:39:04.1

The chest and let that grow for two or three weeks, and the blood supply would be from both sides. But then you cut this off, and then you flap it up here. It may take six months to walk that flap up there. If you've got somebody in your office that is sitting there with a big roll of skin hanging down, they don't want that either. I mean, the doctors don't want that in their office, and we had a problem. At Anderson, when I was running the clinic our clinics looked like—I think I told you—looked like feed lots. I mean, it was just packed with people. Well, a guy would be here from Aberdeen, and he's getting this defect in his face—half of his face might be gone. He's getting that repaired. Well, he has to stay in a hotel or motel, and if you're going to go in the dining room of a hotel with a flap of skin right there, you looked like you were from outer space. People, they could either sit in their room at the hotel/motel, or they could come to Anderson and sit in the waiting room and visit with people, so we had a whole bunch of people just sitting around just visiting and so forth. Your waiting room had a lot of people.

***Tacey Ann Rosolowski, PhD***

0:40:54.3

And just to clarify, you knew this was going on. You knew people were basically using it as a place to socialize, and that was okay with you, and you didn't monitor that or throw people out.

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***C. Stratton Hill, MD***

0:41:05.8

Nothing. This was great, as far as we were concerned. That gave them support. It's like AA. Nobody in this town did anything like that. Now you don't have to do that anymore. They've got different ways of doing things, so you don't have to worry about those flaps. Or you might see that occasionally, but not much. That was one of the first things that we did, that Anderson did, and then people got to see the results. They'd say, "Wait a minute. Hey, those people are supposed to be dead."

Then we got Gilbert Fletcher. We talked about him, I think, the radiation guy, and of course, his work began to be noted. He was getting comparable results to the radical surgery that Memorial was doing. And John Stehlin was getting comparable results with the perfusions, and that was salvaging the lower extremities so people could walk. So that got around. Then John Stehlin realized that he was doing more of that than anything and he could make a lot more money, so he left Anderson and set up shop. He set up in all the hospitals, but he couldn't manage that, and he ended up in St. Joseph. He must be 90. He's out of it. There's no Stehlin Clinic anymore, I don't think.

Gilbert Fletcher, it's interesting. Bill McComb was a radiotherapist before he was a surgeon, so he and McComb got along real well, whereas Hayes Martin, up in New York, was a surgeon, so anybody that had a head and neck surgery was surgerized in Memorial. Bill McComb and Gilbert Fletcher treated a lot of these internal tumors of the sinuses and so forth with radiation therapy, and Gilbert Fletcher was the leading radiotherapist in the world. They got tremendous results and less disfiguring, and they began to radiate carcinoma of the larynx. At Memorial you got your larynx out, and you were no longer able to speak or had one of those mechanical voices with a synthesizer. You'd sound like a foghorn. So that began to bring people to MD Anderson. We had that, and we had the—the head and neck people, the gynecologist, and both of those were reinforced with radiotherapy, so Anderson made a big reputation on those two things. Then you brought in the chemotherapist, and that pretty much put Anderson in the forefront. And about that time, that's when the Rockefellers got interested in what was going on down at MD Anderson. I remember being in meetings with Laurence Rockefeller because I was running the clinic. He was down here studying what Dr. Clark had set up.

We were a close-staffed hospital. We didn't practice anywhere else but at MD Anderson, and nobody but us could practice at MD Anderson. And at Memorial, the goal for the doctors up there was to get in with somebody who was— The doctors at Memorial, the way that medicine was practiced in those days was that it was strictly a private practice. But then you had guys like Hayes Martin and George Pack. And what was that breast surgeon's name? I've forgotten, but that was only a categorical hospital to practically run. You had all of those TB hospitals, but that was a public health situation. Those guys had their offices on Park Avenue, and they used

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Memorial Hospital. Not many hospitals want cancer doctors to use their hospital because they use an inordinate amount of resources.

For instance, we had this **Dr. (???) Brunswick** who was at Memorial, and he was German, obviously, with that name. He fit the category of the image of oppression, that I'm-going-to-cut-you-in-two. We used to say that he did hemi-humanectomies. (laughs) And some of those residents— He thought potassium was a poison, and of course, it is if it's used in a certain way. But he wouldn't let his residents give patients potassium. That's crazy. They'd have to come back after making rounds with him and give the potassium to the patients, and they would tell me— I knew all the surgeons up there, and they would say he had a butcher-knife-type of thing that had a cautery on it. He'd cut half the liver in two and let it bleed, and he would use 20 and 30 units of blood. You're not going to get a little community hospital to let one doctor use up all the blood. No way. So they get out there, and they can't practice that way. They shouldn't be practicing that way anyway. Of course, that never caught on.

***Tacey Ann Rosolowski, PhD***

0:49:02.5

But it gives cancer physicians a real reputation.

***C. Stratton Hill, MD***

0:49:05.6

Oh, yeah, but I think Dr. Clark was smart enough to realize that people wanted to get rid of their cancer but not at all costs, in term of the quality of life that they had. He wanted it to go as far as possible, but if there was another way, like a limb-salvage-type of operation or something like that, he was all for exploring that and other means of therapy. He was not— They were not ideologues like the surgeons at Memorial Hospital, a strictly surgical hospital. So that was the thing that gave— That was a window of opportunity for Anderson to step into that, and Clark was pretty persuasive.

They used to publish— I don't know whether they still do or not. I don't think— They might have. They called it the yearbook of so and so, the Yearbook of Cancer, the Yearbook of Urology, and it was a company that did that. Clark pulled off the coup of having the Yearbook of Cancer written by the people at MD Anderson. That was a good move. He had insights like that, and I guess you could say that's somewhat of a political moxie that he had that doctors in general don't have. We can step in at this point, and this is a good place to get attention, and so that's what he did. And then because he brought this guy that was the radiation person in there— And they developed the cobalt machine here, then he focused on isotopes, so that's the reason we were the earliest people that had radioactive iodine in the whole Southwest. It's the reason we got the reputation in thyroid diseases. We could do scans and stuff like that that nobody else could do. And then of course, people gradually got trained in that and came and did it and we did

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all kinds of things with— Memorial was called Memorial Hospital for Cancer and Allied Diseases, and boy, that term allied was broadly interpreted. We had everything you could think of, practically, at Memorial in New York that was kind of a low incidence of rare disease. We had a bunch of them, so that's what I found so fascinating about being in a cancer hospital, and that's the same way with us. Then we got down here and we get into hereditary diseases, and people began to write about the association of one tumor to the next. Then we were doing all this followup. Then we found, well, wait a minute. We've got this person that had that tumor that's got this one, and so we made the association. We were one of the first to really write with extensive experience in those different areas, particularly medullary carcinoma of the thyroid.

***Tacey Ann Rosolowski, PhD***

0:54:07.3

And what was an associated cancer with that?

***C. Stratton Hill, MD***

0:54:10.5

There were two of them, the pheochromocytoma, and that's a tumor of the adrenal medulla, and then the parathyroid carcinoma.

***Tacey Ann Rosolowski, PhD***

0:54:25.7

Yeah, I think you mentioned that in one of our sessions. Yeah, I do remember that.

***C. Stratton Hill, MD***

0:54:29.6

As a matter of fact, I used Andy von Eschenbach, who was head of the FDA, and he's an Anderson graduate, so to speak. He was the one I would refer the pheochromocytomas to because that was in the area of the kidney, so I thought he was the best surgeon for something like that. We began to study those things from an epidemiological point of view. And one time there was another surgeon in Houston that fancied himself as a thyroid surgeon, and he was. His name was Henry Glass, and he was a little bitty guy. He had to stand on a stool in the operating room. In our studying, we made contact—or I had these two girls that were working for me, and they made contact, and they said, “Dr. Hill, they tell me that they're operating on their cousin over in the diagnostic hospital right now.” And I said, “Are you sure?” And she said, “Yes.” “Find out who it is.” It was Henry Glass, and he was operating on the thyroid. So I knew him, and I called over, and I said, “Do you mind if we come over?” He said, “No, come on.” We went over there, and I said, “The first thing I want to do is look at the anesthesia chart. I want to see what the blood pressure is doing.” (phone ringing)

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***Tacey Ann Rosolowski, PhD***

0:56:28.6

Oh, dear. I forgot to turn off my phone. Pardon me. Oh, dear. I will turn it off now. There we go.

***C. Stratton Hill, MD***

0:56:49.3

We went over there, and I said, "Let me see the anesthesia record." The anesthesiologist was there. Wide swings and that was the blood pressure. I said, "This patient has got pheochromocytoma." He said, "Oh, in these surgeries we have wide swings," and I said, "You don't have wide swings like that." Anyway, he was about finished with the operation, and I never convinced the guy, the anesthesiologist, this was a patient with pheochromocytoma. The patient recovered and went home. I called him, and I said, "That woman had pheochromocytoma. She's got it." "Oh, I think that was just stress of the operation and everything." I said, "Well, do you mind if we follow up on it?" He said, "No, go ahead." I think he didn't want to operate on it. I don't know whether he thought that was beyond him or whatever, so we brought her in, did the studies, and she had a pheochromocytoma.

***Tacey Ann Rosolowski, PhD***

0:58:20.1

She did.

***C. Stratton Hill, MD***

0:58:21.1

And we operated on her. We learned the hard way that we could better demonstrate those by doing a venogram rather than an arteriogram to demonstrate the pheochromocytoma. Because right after I got there to MD Anderson, before we really knew all of this, we had a case in which this woman had an operation on her thyroid, had the same thing, and then for some reason we did an arteriogram on her. She had bilateral pheochromocytomas, and the guy on call that night, he thought, since she'd recently had a thyroid operation, that she had a thyroid crisis and treated her for that, and she died. At autopsy, we showed these huge bilateral pheochromocytomas.

***Tacey Ann Rosolowski, PhD***

0:59:59.8

What happened as a result of those findings? Did it become kind of standard to look for these other cancers?

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***C. Stratton Hill, MD***

1:00:07.3

Oh, yeah. Then we got the calcitonin marker. So you got the calcitonin marker, and you can look at that. Then of course, I'm pretty sure they're still studying those families, the Falticzek family, because they produce them. It's autosomal dominance, so somebody is going to have it in every generation. Now they can pick them up early. But that was the story of sort of how we got into the familial studies, and we brought people from all over the country. We had a grant. I remember one time we had one patient who was a relative from California, and we said, "Hey, you might have this problem. We can put you in the hospital, and it won't cost you anything." The guy was saving money for the thyroid operation. Well, he decided that he would come to Houston. On his way, he stopped by Las Vegas, and he won a pot of money. Then he comes to Houston, and all of his treatment didn't cost him a penny because he was on our grant. But he stopped there and won—I've forgotten how much it was. It was a pot of money. He used the money he was going to spend on having his operation for his time in Las Vegas.

And the other side of that was a family we had from Arkansas who had a brother who was in the army, a career army guy, and we said, "Tell your brother that they can work him up in the service and so forth. He might have a medical discharge." But anyway, he could get treated. Well, I think he was afraid. He didn't want to be discharged from the army, and he was afraid that if they found something they'd discharge him, so he did not do that. He retired from the army, and he did have it. He came to Anderson. This was after I was no longer doing the thyroid and had he come to Anderson—I mean—had he been treated, and if they'd kept him in the service, he would have been retired, and under those circumstances, you pay no taxes on your income from when you're medically discharged from the army, so he would have had all that without having to pay any taxes. Now, whether or not he— He was a non-commissioned officer. If he was already a master sergeant, the only thing that he could have done would have been to accumulate time to increase his pension. But anyway, he didn't do it. There were consequences like that.

I remember one time I had this family from Arkansas, the same family. A little woman who was—you'd be a giant compared to her. I mean, she wasn't real short, but she was small-boned. She was in the cafeteria one time, and at that time, everybody ate together. I was going through the line coming out, and she comes up to me, and she was choking. I put my tray down and did the Heimlich maneuver and popped out the food but broke every rib in her body. We had to put her in the hospital with broken ribs.

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## **Chapter 22**

### **A: Post-Retirement Activities**

#### **An Endowment for Education, More Research, and a Think Tank**

##### Story Codes

- A: Contributions
- A: Activities Outside Institution
- A: Career and Accomplishments
- A: Post Retirement Activities
- A: Professional Values, Ethics, Purpose
- A: Character, Values, Beliefs, Talents
- B: Philanthropy, Fundraising, Donations, Volunteers
- C: Donations, Gifts, Contributions;

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

1:05:01.6

Dr. Hill, I wanted to ask you about the endowment that you made for the lectures, the educational pain management, because that's kind of one of the big legacies that you've left, among other things, is this endowment. I was wondering if you could talk a bit about that. That was in 1998, the endowment to MD Anderson for education on pain management.

#### ***C. Stratton Hill, MD***

1:05:30.9

Just recently, this guy named [Richard] Holz, who is in the development department for planned giving at Anderson, I'm sure he was wanting to see if I had any more money to give to that endowment. When he called me I said, "I'm absolutely thrilled that you have called because I've been wondering about what to do about this endowment because I'm just a little bit concerned about what might happen to this because of the uncertainty or the fluidity of pain at the moment." And when I was there, although I was working mostly in pain, I realized that there were other distressing symptoms that needed to be looked at. We actually changed the name of the service to the pain and symptom management.

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

1:06:47.0

What were some of the other symptoms?

#### ***C. Stratton Hill, MD***

1:06:49.9

Shortness of breath, fatigue. We didn't do too much with the diarrhea because that's generally the bailiwick of the gastroenterologist, but we did have a significant number of people that had

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radiation-induced urgency, which is a terrible, distressing symptom. It makes you feel like you are about to have a bowel movement all the time. It's sort of a pushing-down feeling. What it amounts to is, with the old type of radiation, you had a lot of damage to surrounding tissue. So if you had, say, carcinoma of the prostate, you might have radiation and end up with this feeling that you had to go to the bathroom all the time, that you had to have a bowel movement. Well, that doesn't get relieved with morphine or pain medication. At that time what we did was we started treating that with steroid enemas, and I believe that there was a company that finally made enemas with steroids in them. They had to be dispensed on a prescription, but that would cut down on the inflammatory reaction.

So I realized that there are far more symptoms than just pain that were distressing that had to do with either the tumor or its treatment. I realized that we needed to look at those things from a purely scientific point of view. It's just "Oh, you've got cancer. You had radiation. What do you expect? You're tired all the time. That's what it does to you." Well, if that's the case, what caused it? When we started out, we thought we were really going to make a push to get a significant amount of money, but not to just give a lecture in pain because there are too many variables. There are too many people who are advocates for a certain type of treatment or something like that, who are advocates against a certain type of treatment and so forth, so let's set up a colloquium, if you want to call it that, so that you'd have opposing views for a couple of days, and then you'd have that published.

We tried that, and we realized that it took an awful lot of money for that. It would take millions of dollars. We'd have to pay for people to come, to stay here for two or three days, to get them to do a manuscript, and to print it and so forth, so it ended up then that we'll start with a lecture, and of course, we wanted to get leading people. Kathy Foley was the first one. I'm pretty sure she was the first one. Everybody knew her, all over the world, so she gave the first lecture. I think Russ Portenoy was next, and then Dan Carr. He was one, and I'm not sure that we— And then after that, things began to change in terms of the pendulum swinging over to the regulatory and law enforcement agencies clamping down on doctors. I don't think we had anybody that got into that. Those three people were in the science of pain. I kept doing programs for the Texas Pain Society, and we kept bringing people in because that was the thing that was spooking the doctors, sanctions by regulatory agencies and so forth. Since it has swung way over to most of us all being anesthesiologists and they're interested in interventions and procedures because that's where the money is, it's become almost an exclusive bailiwick of anesthesiology. You've got anesthesiologists that will treat— Would you like another Coke?

***Tacey Ann Rosolowski, PhD***

1:14:20.3

No, I'm good. Thanks.

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***C. Stratton Hill, MD***

1:14:24.0

That will use drugs and so forth, but most of them can't do anything more for you. When the procedure is not working, and especially when the procedure is not working and payment for the procedure has stopped, then they really can't do anything for you. That's been the problem, and then you've gotten into the problem with the pill mills, where it's taken on a sinister image, and so Charlie and I have been thinking, what should we do?

***Tacey Ann Rosolowski, PhD***

1:15:10.7

Is this Charles Holtz?

***C. Stratton Hill, MD***

1:15:13.2

No, Charles Cleeland. He spells that with a C. And so we're going to have— Last year we had one on—and I've forgotten the name of it, but it had to do with encouraging research for other distressing symptoms. This year it's going to be on toxicities from cancer treatment, which is sort of the back door of treating symptoms of cancer treatment. That's coming up in April, and I don't think he's gotten the faculty for that firmed up yet. I think he's got some people on it, but that'll be a couple of days, I think, at the ZaZa Hotel. That's what it's evolved into.

Now, what I have— When Mr.—I forget what his first name is—Mr. Holtz came, I indicated how this had developed. When we're all gone, what's going to happen to that money, and where is it located? Administratively, does Anderson have its hands on it, or is this part of the general university fund, and it's just put in there, and you get your percentage of whatever interest it is depending on your percentage of the thing or what-not? We had a hiatus in there where we didn't do anything, and I think that the university from Austin got on us and said, "Hey, if you don't want this money, other people do. We can use this money." That's when we had the thing last year. Mr. Holtz did send me something back that they had in their file, which even makes it more problematic because it wasn't signed by me. It was signed by Mike Best, who was the business manager at that time, and it was not the final product. Then the lady that works for me came yesterday, and I said, "I need to find that stuff that relates to that endowment," and she came up with a signed document that's got my signature and somebody from Anderson's signature. I really haven't had the chance to look at it to see where it says the money is— If we can't do it in the university, then it goes to another place. I know that other place is not viable anymore either. This may just kind of bounce around and nobody knows about it until somebody up there in Austin says, "Hey, there's some money over there that's not being used," and they call up somebody down here and say, "You've got some money. Who should get it?" and the guy or whoever is in charge thinks, "Oh, that'd be nice for so and so."

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***Tacey Ann Rosolowski, PhD***

1:19:29.7

In the ideal world, what would you like to see that money used for?

***C. Stratton Hill, MD***

1:19:33.7

I would like to see it used as a think tank, support for innovative symptom relief. You've got the tailored therapy money, which Dr. Mendelsohn is going to be using, and the sheik gave the money for the building. The Bush family has been supporting that for years. Every time they would sponsor somebody being here, there would be at least \$10 million raised, so there are millions of dollars in that that has to do with focused therapy. I'd like to see think tanks for how to deal with things like this. The Baker Institute over there at Rice is sort of the—or let's say the Hoover Institute or the Cato Institute. Those are all political. I don't know about the Hoover. The Heritage Society—no, not Heritage. But those are all national, and they are funds that are used for think tanks for different things. That's what I would like to see, because I don't know that you're going to— Almost everybody likes the biomedical model, the Cartesian, and of course, there's a lot to that. But I think until we can get our hands and arms around some of these concepts that we need to know where to focus things.

There was a neurophysiologist at the University of London named Pat—oh, let's see; I'll think of it in a minute—Pat Wall, and he says the body has an amazing capacity to create pathological pain pathways. See, you can do things like— And Ronald Melzack at McGill in Montreal, he and I are good buddies, and we've talked about phantom pain a lot. He's looked up people who have had phantom pain who have been in automobile accidents and had back injuries and investigated whether or not there was any connection from a severed spinal cord, some places where they had to take sections of the spinal cord out, and that means they take the sympathetic chain. There are just no connections whatsoever, and yet people still have phantom pain. And of course, he talks about these images that are created and mechanisms in the brain that are set up and that they don't need a stimulus. They just occur. So things like that. We haven't arrived there yet, so have people think things like that. Basically, what you'd have to do, I think, is have somebody to come up with some thought that you think is absolutely stupid and crazy and that they've done some work and say, "Gee, let's give that a shot." And it may turn out that that's the way it's going to happen somehow. You've got to do that.

***Tacey Ann Rosolowski, PhD***

1:25:35.6

That would be a great legacy. Well, I don't have any other questions. Is there anything else you would like to add at this point?

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***C. Stratton Hill, MD***

1:25:43.6

Let's see if I can think of anything. I'm trying to think of unusual things that have happened. Well, there was a murder at Anderson.

***Tacey Ann Rosolowski, PhD***

1:26:12.1

I think James Olson wrote about that in his book.

***C. Stratton Hill, MD***

1:26:16.6

I don't think we want to go there again, and there's nothing to go there for. I mean, nobody knows what happened. And I told you about Eleanor MacDonald, that her adopted daughter just vanished.

***Tacey Ann Rosolowski, PhD***

1:26:33.5

Yeah, pretty amazing stories, and the Marshall Islands.

***C. Stratton Hill, MD***

1:26:37.8

Oh, the Marshall Islands, yeah.

***Tacey Ann Rosolowski, PhD***

1:26:44.5

Well, it's always possible, if you think of something down the line that's really significant, you can give me a call.

***C. Stratton Hill, MD***

1:26:49.9

There have been characters at Anderson that are just—stories that are really—unusual people that have nothing to do with Anderson, but I think Anderson is a place that attracts minds that cause the individual to have different behavior, you might say.

***Tacey Ann Rosolowski, PhD***

1:27:35.3

Eccentric, perhaps.

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***C. Stratton Hill, MD***

1:27:36.6

Yeah. I mean, we had one guy that I knew real well, and I don't know where his money came from, but he was a pathologist. He quit and went to live in California. I had an exhibit at the American Medical Association that was meeting in San Francisco. He lived there, so he came by. I recognized him at the exhibit, so we visited, and he said, "Let's have dinner," or something. We had dinner, and he took us to his house, and his house was just strewn through with all kinds of things. He had mail all over the floor and all over everything. And I noticed that some of them, they were obviously checks that he hadn't even opened, and he told me that— I don't know how we got to talking about it. He was talking about one of his children going to Reed College. I think it's in Oregon. He said that Sunday he'd go up and visit his son, and he knew that he lived off campus at a house. He said he went there, and his son said, "Dad, we don't have another bed here. We've got a bed, but all it's got is just springs. They're not box springs. They're just springs." And he said, "That's the only bed we've got." This guy said, "That's okay. I'll sleep on that." He went to bed, and I guess he went to sleep, but he woke up, and he was freezing. His son had a bunch of cats, so he goes and rounds up all those cats and puts the cats on him to keep him warm.

***Tacey Ann Rosolowski, PhD***

1:29:40.7

That's quite a character.

***C. Stratton Hill, MD***

1:29:42.5

He said that he would take us to the airport. Well, when he arrived at the hotel I thought my wife was going to go out the back door because he had on a black French cap, a purple suit with a big red tie, and some weird colored shoes. He drove a Citroen of the vintage when the Citroen looked the weirdest it's ever looked, and we went to the airport in that car. I hope nobody saw us that knew us.

***Tacey Ann Rosolowski, PhD***

1:30:27.2

Well, I think MD Anderson is a place—well, great minds have sometimes interesting characters.

***C. Stratton Hill, MD***

1:30:31.9

He was a smart guy.

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***Tacey Ann Rosolowski, PhD***

1:30:39.7

Well, thank you so much.

***C. Stratton Hill, MD***

1:30:41.5

Thank you.

***Tacey Ann Rosolowski, PhD***

1:30:42.4

I really enjoyed talking to you.

***C. Stratton Hill, MD***

1:30:43.6

I hope that this all comes out. Do you want me to just kind of either fill in the names or correct spelling? Do you want me to add any text to anything?

***Tacey Ann Rosolowski, PhD***

1:31:02.3

Since we're talking business, why don't I just turn off the recorder? It's 3:30, and I'm terminating the interview now.

1:31:09.2 (end of audio session 4)