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The event that started my life-long approach to medicine was the result of a packed 3-month focus upon all aspects of a relatively new disease in 1948, Cystic fibrosis. Contrary to the medical school approach of massive information and regurgitation, I was allowed to spend a 3 month period of study of clinical data, autopsy study, and literature review that provided complete information about a single disease. This demonstrated for the first time the details from start to finish of the usual mechanism of death in this disease, pulmonary failure and infection. These findings were also in sharp contrast to the existing literature-(1). What fun! These experiences changed my life I understood that a similar approach should be used in other diseases encountered in subsequent clinical and pathologic experiences. Questions should be asked concerning what is going on, are the reported studies to date correct, and can new concepts enable improvements in the cures of children with serious diseases.

A change to a hematology fellowship made it possible to apply a similar attitude to the hematology activities of a busy academic center for children. Functioning as the Fellow that interacted as the first level contact with the pediatric staff. I studied every blood slide when the counts were abnormal, did and studied about 900 bone marrow studies, cared for over a hundred patients with hemophilia and sickle cell anemia, and made a detailed study a 10 year experience of about 100 cases of idiopathic thrombopenic purpura including follow-up visits' – A written report was accepted to by the New England Journal of Medicine. (2.) I understand that it became the "bible" for pediatrics for that disease. During the time in hematology I was given a box of anti-fols that Dr. Farber had sent to my mentor, Wilhelm Wolfgang Zuclzer to try in 1949. That gave me a whole year of learning about how to treat children with ALL with drugs

After a short period of residency at CHOP in 1950- I served in the Army for 21 months (Korean War). This provided my only training experience with adult pathology and clinical laboratory administration (for about 12 months as chief) in a 1600 bed hospital. - Back to pediatrics- as pathologist at Columbus Children's Hospital - were I still am involved. Yes I directed clinical and anatomic pathology there for 35 years and also became their hematologist since Bob Sylvester, one of the 3 pediatricians that did what Dr. Farber designed to show that drugs can change cancer, met me soon after my arrival, and gave me the clinical charts of about 20 cases of ALL. He just couldn't deal with dying children and their families.

I remained Chief of Hematology for 30 years that became predominately oncology. My 163 publications covered hematology, pathology, and oncology. Perhaps the outstanding hematology study demonstrated first that a chronic hemolytic anemia in a white child can be due to an enzyme deficiency, G6PD- not just a deficiency but total absence. The abstract that that was sent for presentation didn't contain the exciting part of G6PD- I found that out by phone that it was absent in 4 similar children only about a half hour before giving the paper at the annual meeting of the Society for Pediatric Research. (3.)

My roles in the advances of achieving cure rates of children with cancer are too extensive to do it in a limited time. Obviously I continued to grow from my becoming a member of Acute Leukemia Group A in 1957 until I actually left my microscope in 1993. What a wonderful life. It's all about cooperation, and who cares about credit. Group Study or Pediatric Cancer should have received a Nobel Prize- what other type of disease that is the most common cause of death due to disease in children whose cure rates went from almost nothing to 80% in a lifetime? My role started only as a PI when there were only a dozen members in the group- now it's about 3,000! As the workload increased I needed more help, with little money. A young nurse offered to help- and she became the first Pediatric Oncology nurse practitioner. Another became the first group study data manager in existence. When a suggestion was made that we should treat leukemia like an infection, I treated many with the only two highly effective drugs that we had together rather than singly. The patients responded notably faster, longer, and more completely. (4). I shared this with the Group B persons when I was deciding what group to join. Not too much later they showed that if you add two more, cures were produced! We first showed that Cytosar (5), and the first to treat CNS tumors with chemotherapy(6), and, along with others, that Actinomycin-D was a good anti cancer drug. About that time, Ruth Hein at Michigan and I created the first protocol for solid tumors in children for the new Children' s Oncology Study Group.

The next chapter is important- when I gave Actinomycin-D to Wilms' tumor patients whose primary was removed, and had no clinical spread after surgery and every 3 months for 2 years- Instead of the usual development of pulmonary metastases in half of the se patients, none developed (7). I urged Dr. John Hartman, the Chairman of Acute Leukemia Group A, to do a clinical trial, which he did- and that almost duplicated our significant experience(8). This led to the format ion of the first pediatric tumor-specific group, the National Wilms' s Tumor Study Group. Most importantly this "prophylactic" use of chemotherapy established one of the most important ways to cure any person with cancer, and is now universally done for similar stage of cancers. In retrospect this approach had been pioneered in Boston and Houston as well, but not known to me.

The rest of the story would be about my role in creating a national way to collect cancers for basic science studies, for the best way to classify tumors by the best reviewer for study evaluation, to review about 3000 cases of rhabdomyosarcma from all of the US over 30 years, leading to envelopment of a clinically significant prognostic classification system done with leaders in the US and Europe (9).

My last 16 years since leaving my role in cooperative groups in 1993 has been dominated by an attempt to provide the help that the leading Chinese pediatric oncologist/pediatrician Hu Ya Mei asked of me with this "Please help us"- CURE Childhood Cancer, of which I am its founding President, is now bringing clinical leaders from China to make possible the top cure rates in China, not only of pediatric cancer, but any serious disease China has 50,000 new cancers of children every year. Four of the US COG institutions have provided training of four specialties thus far. CURE is providing the funds for their educational experience costs in the United States. This will grow, as success is clear. China needs about 135 Centers of Excellence to care for all the cases.

This has to end with an important statement. I know that God selected me before my birth to help China this way and trained me for this responsibility. I would be pleased to describe my reasons why I am convinced this to be true.