

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

John R. Campbell, M.D.

Interview conducted June 21, 2005

by

Richard Mullins, M.D., and Matthew Simek

SUMMARY

In this interview, OHSU Professor Emeritus John R. Campbell, M.D., discusses his distinguished career as a pediatric surgeon. Campbell was the first pediatric surgeon in the state of Oregon when he came here in 1967. He describes the changes he has seen in pediatric surgery, health care, and medical education from the 1960s to the present.

The interview begins with Campbell describing his boyhood in Pratt, Kansas. The son of a general practitioner, Campbell often spent time with his father on rounds and in the office. That early experience led Campbell to pursue a medical career of his own. After receiving his degree from the University of Kansas Medical School, Campbell received further training in Kansas and in Philadelphia with Jonathan Rhoads and C. Everett Koop, among others. He shares anecdotes about the surgeons under whom he trained and discusses the medical advances to which they contributed.

Campbell came to Oregon looking for opportunity and found it as Chief of Pediatric Surgery at University of Oregon Medical School. He talks about the facilities available at Doernbecher Memorial Hospital for Children, about the types of cases he saw, and about the pediatric surgical service which included residents from both surgery and pediatrics. He explains how the hospital billing procedures and off-hill practices of his early days at the university were consolidated into a single financial management system through the University Medical Group in the 1970s and 1980s.

Campbell discusses the development and construction of the new Doernbecher Children's Hospital and notes that it has become the most recognized hospital in Oregon. He talks about the designation of OHSU Hospital as a trauma center in the 1980s and the impact of that change on pediatric trauma care. Looking back over his years as a pediatric surgeon, he touches on some of the advances he has seen in both the practice of pediatric surgery and in pediatric surgical training.

In closing, Campbell offers his thoughts on the future of OHSU and medicine in general, asserting that advanced technologies should never replace fundamental concepts and basic principles. He advises those in administration to "listen to the periphery" when trying to capitalize on strategic inflection points as OHSU moves forward into the new millennium.

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Interview with John R. Campbell, M.D.
Interviewed by Richard Mullins, M.D.
June 21, 2005
Site: Oregon Medical Association Headquarters
Begin Tape 1, Side 1

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Matt Simek, video producer, also contributed questions at the end of the interview.*

MULLINS: This is an interview with Dr. John R. (Jack) Campbell, which took place on June 21, 2005, at the Oregon Medical Association, Portland, Oregon. My name is Dr. Richard Mullins.

Good afternoon, Dr. Campbell. Can you tell me about where you were born?

CAMPBELL: I was born in Pratt, Kansas. They wrote a poem about that little town. It was called "Flat on my Pratt in Pratt, Kansas."

MULLINS: What about your parents? Were they in the medical profession?

CAMPBELL: My father was a family physician—we called them general practitioners in those days. I guess that's how I got interested in medicine. It was the kind of practice you'd like to have. He set hips, delivered babies, took out gallbladders, and performed gastrectomies. It was an interesting practice.

MULLINS: How big a town is Pratt?

CAMPBELL: It was about seven thousand, in those days.

MULLINS: And if you wanted to go from Pratt to Kansas City, how long would that take?

CAMPBELL: Well, in those days, it would probably take ten or twelve hours.

MULLINS: What year were you born?

CAMPBELL: Nineteen thirty-two.

MULLINS: So you could get on a train and take it into—is that the closest big city?

CAMPBELL: Well, Wichita is closer. Pratt's halfway between Wichita and Dodge City. It's out on the prairie, and it's flat, and the road between Wichita and Dodge City is straight; there's not a turn in the road.

MULLINS: Did your dad practice out of the home?

CAMPBELL: No. He had an office over the drugstore downtown.

MULLINS: Did you make rounds and go to the hospital with your dad?

CAMPBELL: Yes, I used to. He always tried to have Friday afternoon off, and by “off” he meant he would make country rounds. We would go down into Barber County, into the red dirt hills, and all over, to see homebound patients.

MULLINS: How old were you when you were doing this?

CAMPBELL: Oh, I suppose I was ten or twelve.

MULLINS: And where was he trained?

CAMPBELL: He was trained at the University of Kansas, and graduated in 1915.

MULLINS: Nineteen fifteen. Did he go to the war?

CAMPBELL: He did.

MULLINS: What did he do?

CAMPBELL: After he got out of medical school, he established a practice in Coates, Kansas, which was not far from Pratt, and then he was in the medical corps and was stationed down at Camp Beauregard in Louisiana, and the war ended before he got sent overseas.

MULLINS: And what about your mother? Where was she from?

CAMPBELL: Well, she was from Pratt, of pioneer stock. She also graduated from the University of Kansas.

MULLINS: In what?

CAMPBELL: In home economics.

MULLINS: Did she teach?

CAMPBELL: She did. She had a fairly large family, with three other siblings, and the first one to go off to college was sent by the family, and then that person got a job teaching school, or whatever, and sent the next one through, until everybody had gotten through school.

MULLINS: How many brothers and sisters in your family?

CAMPBELL: I have a sister.

MULLINS: So 1932 to 1941—the Second World War, do you have some memories that are medical of Pratt, or was it more that you think of yourself as just a Kansas boy?

CAMPBELL: Well, I was fairly young. We did have a B-29 base in Pratt, and the Enola Gay was there before it went over to drop the atomic bomb in Japan. The population of the city almost doubled during that time, and everybody opened their homes. We had families that stayed with us—lived in our home.

MULLINS: Your dad must have worked pretty hard in the war.

CAMPBELL: Yes, and he was only one of two physicians left in town, because all the others had gone to war.

MULLINS: My dad told me that when my older brother was born, the doctor was just exhausted. He was born in '45, and he said he felt so sorry for the doctor.

CAMPBELL: Well, it helps to love what you're doing. You can overcome a lot of fatigue, if you do.

MULLINS: Do you remember frequently going out at night or on the weekends with your dad?

CAMPBELL: Oh, sure. I used to go down to my dad's office. I told you his office was above the drugstore. That made it kind of hard for people with fractures to get up the stairs, but they got upstairs. And he had an old x-ray machine with two cathode-ray tubes with blue sparks in between that made the x-ray possible. I'd watch him set fractures, reduce dislocations, and put the plaster on, pull teeth and do all sorts of things.

MULLINS: So you decided to go to college where?

CAMPBELL: University of Kansas.

MULLINS: In Lawrence, Kansas?

CAMPBELL: Yes, in Lawrence, Kansas.

MULLINS: Did you have a good time at Lawrence?

CAMPBELL: Oh, sure. It was a lot of fun.

MULLINS: That would have been in the late forties?

CAMPBELL: I graduated from college in 1954.

MULLINS: And then you went to the University of...

CAMPBELL: University of Kansas Medical School, graduated in '58, and then went back to the Hospital of the University of Pennsylvania for my internship. I thought that I would do my residency in general surgery there, but that was the year that union insurance came in and the ward services evaporated, so I went back out to Kansas. The chief of surgery there was Frank F. Allbritten, Jr., who with John Gibbon did the first successful open-heart procedure at Jefferson. He was a family friend. My father was the Allbritten family physician.

MULLINS: As a medical student, were you influenced by surgeons in medical school?

CAMPBELL: Yes. Stanley R. Friesen probably had the greatest influence on me.

MULLINS: Tell me about Dr. Friesen.

CAMPBELL: Well, Dr. Friesen was a Kansan, just like Dr. Allbritten, and grew up on the outskirts of Wichita. He trained at the University of Minnesota in surgery with Owen Wangenstein, and then he came back to Kansas. His interest was GI and endocrine. He did the pediatric surgery at the University of Kansas. In those days, you weren't trained as a pediatric surgeon; general surgeons did the pediatric surgery. I suppose that's where I first got interested in pediatric surgery. He did some of the seminal work on trying to understand pyloric stenosis. He did some tinctorial studies on pyloric muscle biopsies in patients with congenital hypertrophic pyloric stenosis and showed that there were neuroendocrine problems that eventually pointed towards the nitric oxide influence.

MULLINS: As a medical student, what rotations did you take in surgery?

CAMPBELL: Well, I guess orthopedics, general surgery, neurosurgery, plastic surgery were the surgical rotations.

MULLINS: What hospital did you work at?

CAMPBELL: At the University of Kansas Medical Center hospital and at the Kansas City Veterans Hospital.

CAMPBELL: And, then, when you got to Philadelphia, was that a much different kind of hospital?

CAMPBELL: Well, just older. But it was a very similar hospital.

MULLINS: And who was the professor at Philadelphia?

CAMPBELL: Well, Isidore Ravdin was the chairman; Jonathan Rhoads succeeded him, and I became good friends with Dr. Rhoads.

MULLINS: Now, Dr. Ravdin operated on President Dwight D. Eisenhower, didn't he?

CAMPBELL: That's right, he and General Michael G. Healy operated on him for Crohn's disease.

MULLINS: Do you remember when that happened?

CAMPBELL: Well, it would have been in the—when Eisenhower was president. It would have been in the late fifties, July 1956, I think, if I remember correctly.

MULLINS: You weren't there at the time?

CAMPBELL: No.

MULLINS: I'm sorry.

What kind of guy was Dr. Ravdin? Was he an inspirational chairman?

CAMPBELL: Well, he was a hard taskmaster. He was president of everything at the time and was gone a lot. He was a surgical politician; his judgment was excellent, and he had good results because of his good judgment.

MULLINS: So as a surgical politician, meaning he was a leader of—

CAMPBELL: Well, he was president of the American College of Surgeons, American Surgical—I mean, you name them, and he was involved in a leadership role.

MULLINS: Okay. So he was active in that sense.

CAMPBELL: Yes.

MULLINS: Was he active in—could you tell, locally? Was he a personality?

CAMPBELL: Well, he was definitely a personality, but he was not involved locally, like Jonathan Rhoads was. Jonathan Rhoads was president of the Philadelphia School Board, he was on the board of Haverford College, and he was president of Penn Salt. I mean, he was really involved.

MULLINS: He was a very big man.

CAMPBELL: Yes.

MULLINS: He and—

CAMPBELL: The surgical textbook of the time was by Allen, Harkin, Moyer and Rhoads.

MULLINS: Did he inspire you, as you were an intern interested in surgery?

CAMPBELL: Yes, he did. When I was in the Navy, I invited him down to Portsmouth, Virginia, to the naval hospital as a visiting professor, and we were good friends.

MULLINS: When did Dr. Rhoads become chairman?

CAMPBELL: Well, it would have been just prior to 1958—he was Provost of the University of Pennsylvania at the same time that he was chairman.

MULLINS: As you look back, did you—was that a valuable year you spent?

CAMPBELL: Oh, certainly, certainly. I would encourage every surgical trainee to not take all of his or her training in one institution.

MULLINS: So you returned to Kansas and you did the residency there.

CAMPBELL: Right.

MULLINS: What do you remember about that?

CAMPBELL: Well, I remember that was when Kansas was starting its open-heart surgery program. The first nine open-hearts didn't survive, the tenth one did, and they were off and running and developed a good program.

I thought I was going to be a heart surgeon. I was deferred through the Berry Plan for my general surgery residency, and then I got a deferment for cardiac surgery. When the time came, I decided that I really didn't want to be a cardiac surgeon, so the Navy took me for two years. That's where I decided I wanted to be a pediatric surgeon.

MULLINS: During your surgical training was there a lot of involvement of the faculty in the care of the patients?

CAMPBELL: Not like there is today. You would be involved with your faculty on their rotations, and then, when you became the chief, you had your own service. It was called the ward service and you would be responsible for those patients. You would call consultants when you needed them. You did have a faculty surgeon to oversee you; he made rounds with you once a week. The paradigm has changed considerably. Now faculty staff every patient in a teaching hospital, and it has resulted in better education, and it has certainly resulted in better outcomes for patients.

MULLINS: What about the morbidity and mortality conferences or case reviews? Do you remember that at Kansas?

CAMPBELL: Oh, yes.

MULLINS: How did that go?

CAMPBELL: Well, that was one tough act. You had to have a letter signed by your mother not to appear at M&M conference. In those days, every case you operated on was listed: preoperative diagnosis, postoperative diagnosis, operation performed, morbidity, mortality, reason for morbidity, and reason for mortality. Then it was all critiqued right there on the spot. It was similar to the conferences that we have here at Oregon, but they were a lot tougher because they were your patients as the surgeon in charge of the ward service; it was on the Philadelphia paradigm. For example, the chief resident, when he was on call—and he was on call every other night—had to call Dr. Allbritten at 9:00 p.m. and report on every surgical patient in the hospital whether they were on his service or not. You were expected to know everything about them including all of the lab results. Again, that was the Philadelphia-paradigm.

MULLINS: You then went in the Navy for two years.

CAMPBELL: I did.

MULLINS: What did you do in the Navy?

CAMPBELL: Well, I was very fortunate. I was chief of the dependent surgical service. I'm the only person that I ever knew who got the assignment he asked for. I asked for a large teaching hospital on the East Coast, and they sent me to the largest naval teaching hospital on the East Coast in Portsmouth, Virginia.

For the first three months, I was the rear admiral on the proctology ward. I never saw so many pilonidal cysts and sinuses. After that, I had the dependent surgical service, which means I took care of the kids. I suppose that helped cement my interest in pediatric surgery. But I also took care of dependent wives. It was breast cancer surgery and adrenalectomies and, you know, all of those things.

MULLINS: So you felt pretty comfortable after your training in Kansas to do that.

CAMPBELL: Yes. I felt well trained.

MULLINS: Did you go to the Caribbean for a while on a navy ship?

CAMPBELL: [Laughs] I went down to the Dominican Republic for Lyndon Johnson, when there was an insurrection down there.

MULLINS: And tell us about that.

CAMPBELL: Well, I was taking out a gallbladder one morning at the naval hospital, and a corpsman came in the room, and he said, “Dr. Campbell, you’re relieved. Go home and get your gear; be back here in an hour.”

And we had, of course, previously been set up on surgical teams and trained at the Marine base, Camp Lejeune, North Carolina. I was on Surgical Team 13. It turned out okay anyway. I was the surgeon, there was an orthopedic surgeon, an anesthesiologist, and we had ten corpsmen, ten thousand pounds of surgical gear, and we could go anywhere and set up a mobile hospital if somebody could provide us with electricity and could feed and house us.

They cut us some orders that said we were to proceed to the Norfolk, Virginia, naval base, which is just across the Elizabeth River from the naval hospital, for further orders. Well, we got over there, and we never got further orders, but we got sent to the Dominican Republic and came back on that same set of orders.

It was a little difficult without a set of orders. We landed at San Ysidro, and there were cracked up airplanes all along the side of the runway. Somehow, one of the regular navy people, our orthopedic surgeon, managed to get us transported out to the El Ambassador Hotel, where a mobile hospital had been set up by the Dominicans on the polo field. We were still in our dress uniforms, and they were bringing in the casualties, mostly “willie peter” (white phosphorous) grenade injuries and we spent the night standing around on the polo grounds. The next day we were transported out to an LST (Landing Ship Tank) in the harbor, where we set up our mobile hospital.

MULLINS: How is it that you ended up being a pediatric surgeon?

CAMPBELL: Well, I had always been interested in embryology. One of the things I had done in college is that I had serially sectioned chick embryos at their various stages of development and made slides and studied them in a very good comparative anatomy course. And also I wanted to do the most general of surgery that I could do, be in all the body cavities, and since pediatric surgery is a specialty of an age group and not an organ system, that met my bill.

I had a very good friend who was in the residency in Philadelphia at the Children’s Hospital with Dr. Koop, and so I wrote Dr. Koop and told him I’d like to come for an interview. In those days, you didn’t enter a match; if he liked the cut of your jib he would offer you a job. So I was in Philadelphia for two years at the Children’s Hospital.

MULLINS: Do you remember some of the questions Dr. Koop asked you? Did he have that big beard when you interviewed him?

CAMPBELL: He didn’t have that big beard in those days, no.

The questions were not medical questions. We tell our residents now, you know, after you’ve finished general surgery and you’re applying for a residency beyond that, you’ve already proven that you know the facts. The American Pediatric Surgical Association did a

survey of pediatric surgical training directors. It has shown that people are chosen on their personalities and on their commitment and on the human factors. That's the way that "Chick", as we learned to call him, did it.

MULLINS: Did your dad want you to go back to Pratt and work with him?

CAMPBELL: Well, my father was deceased by then so didn't have that influence. But I'm sure he would have said, "Go for it." I asked him once—he grew up on a farm, and there was no high school in his hometown of Meade, Kansas, so he got on the train and went to Topeka for his last two years of high school and lived in a boarding house. I asked him once why he went into medicine. He said, "To get off the farm". I mean, that was facetious, but there was a lot more to it than that.

MULLINS: Yes. But, still, he's a man who got out and did what he wanted.

CAMPBELL: Yes.

MULLINS: And saw a need and fulfilled it. He must have had a very satisfying career in Pratt.

CAMPBELL: He did. It was estimated that he probably delivered four thousand babies.

MULLINS: Just an aside, you've practiced in a big city where, you know, you probably don't see your patients very often, and in Pratt he had to kind of live in the city with his patients. Have you ever thought or have any comment about the difference between those two circumstances?

CAMPBELL: Well, that's true. I mean, when I was a kid, I could walk down Main Street and know everybody on the street. Maybe I couldn't speak to them, but I'd know their names and I knew who they were. I'd know who the bootlegger was. I knew everybody. It was a good life. I mean it really was. But it limited you in what you could do professionally. I think Portland is an example—or, an opportunity to have an advanced practice but still live in a community where you're part of the community and you know people.

MULLINS: So what do you remember about your training as a pediatric surgeon? Was it fun, hard work, challenging?

CAMPBELL: It was all three. There were two of us residents who were staggered by a year, and we were on call every other night, and on our night off we didn't leave—well, you know the story. We didn't leave until the work was done, and we might come back if something came up.

But Dr. Koop was a wonderful mentor, and he was inspirational. He, too, was in a lot of things. He did a lot of overseas travel; was a member of the British Association of Pediatric Surgeons; trained a lot of the overseas people, trying to spread pediatric surgery

around the world; he went down to the Dominican Republic, and set up diarrhea stations; you know, the things that would improve health for the greatest number of people.

MULLINS: So was he a talented surgeon?

CAMPBELL: Oh, yes, he was very talented, technically very adept. As good as any I've ever worked with.

MULLINS: You saw decades of pediatric surgery in your profession. How did it change?

CAMPBELL: Well, when I started at Oregon, Wilms' tumor (nephroblastoma), the common abdominal tumor of the kidney in children, if you had metastatic disease, you were sure to die. Now, with our surgical techniques and safe blood transfusions, a choice of antibiotics, and good laboratories, good imaging, and with the chemotherapeutics available to us, the mortality for all children with Wilms' tumor is only five percent, and that includes all the ones with metastatic disease. So, of all the tumors that humans have, it really is the one with the highest success rate. Childhood leukemia is right behind it.

MULLINS: So you remember TE fistulas [tracheoesophageal fistulas] and these things?

CAMPBELL: Oh, sure.

MULLINS: Did you have a good operation for that back in the 1960s?

CAMPBELL: Cameron Haight did the first successful repair in 1949, and the repair is still the same: two layers or one layer. His was a two-layer. One layer has a lower stricture rate, and, if done properly, without tension, has a very low leak rate.

When I was a resident, we had four or five TEFs in the neonatal unit at any one time. Our third child was about to be born in Philadelphia, and I was sure he was going to have a TEF (esophageal atresia) [laughs], because that's all I saw, just about.

MULLINS: That's a problem when you're—

CAMPBELL: And, then, one afternoon, Betty Thompson, one of our anesthesiologists, and I were operating on a patient with esophageal atresia about two o'clock in the afternoon, and just as we finished the first one, we got a phone call that there was another baby with TEF coming in, and we finished that one, and we got a phone call there was another one coming in, and another, and on one Friday afternoon and evening we repaired four esophageal atresias. Now, that was at the time when the Doernbecher Children's Hospital was the only referral center in the state.

MULLINS: So you came to Portland in what year?

CAMPBELL: Sixty-seven.

MULLINS: And what brought you to Portland?

CAMPBELL: Well, I was looking for an opportunity. As I finished my residency in Philadelphia, I got out a map, I looked at what universities didn't have a pediatric surgeon, and Oregon didn't. The American College of Surgeons was meeting in San Francisco, and so I wrote Dr. Krippaehne and told him I'd like to stop by for a visit. I also went to Seattle and visited Sandy Bill; and I stopped in Salt Lake City and visited Keith Reemtsma, who was chief of surgery at the time; I stopped in Kansas City, where Tom Holder was the chief. On one trip I visited all those, and then I visited Minneapolis. I had a job offer there, and I had a job offer at Vanderbilt, and I had one here. I liked it out here. I'd been here as a child, visiting family. I also wanted to be a chief-of-service, not second in line. So here I am.

MULLINS: Did you talk to Dr. Koop about this?

CAMPBELL: Oh, sure. Dr. Koop was very supportive, and after I came, about three months after I'd been here, he came out and gave a talk and met all the surgeons and pediatricians in town and really helped put me on the map. And he's visited here many times since; two or three times after that, and then, since he became Surgeon General, he's been at the University three times.

MULLINS: Dr. Koop trained a fair number of pediatric surgeons, didn't he?

CAMPBELL: Yes, he did.

MULLINS: What do you think was part of the key to his success? Not just training surgeons, but training people who have academic careers?

CAMPBELL: Well, first of all, he is an excellent surgeon, number one. Number two, he was doing research in pediatric surgery at a time when very little research was being done. Now, granted, it was clinical research, although he had been working on intravenous hyperalimentation himself before it took off in Philadelphia in 1965 and '66. I asked him what he used for intravenous catheters, and he said, well, the best he could do was to get radio wire, which was the copper wire that had a shellac cover on it, and he'd pull the wire out and use the shellac cover for his intravenous tubes. They didn't work very well, but he was looking for things to do the job.

Then, of course, the story of intravenous hyperalimentation started in Philadelphia with a little baby called Colleen Burgess. Stan Dudrick and Doug Wilmore, at the Harrison Department of Surgical Research at the University of Pennsylvania, under the leadership of Jonathan Rhoads built on what Dr. Rhoads and Dr. Koop had been working on.

MULLINS: There was a pediatric surgeon involved as well, wasn't there?

CAMPBELL: Yes, Harry Bishop was the staff surgeon.

MULLINS: And I saw a paper, Dr. Rhoads' name was on it too.

CAMPBELL: Well, Dr. Rhoads, of course, was in charge of the Harrison Department of Surgical Research and was Dr. Dudrick's mentor and was the one that was pushing Stan, and so his name appeared on it too, sure. By the way, Dr. Rhoads did the first abdomino-perineal pull-through for imperforate anus, too, which he published in the *Annals of Surgery*.

MULLINS: The first?

CAMPBELL: The first.

MULLINS: What year would he have..?

CAMPBELL: 1948.

MULLINS: So he actually developed that operation?

CAMPBELL: He didn't know exactly what he was doing—he didn't understand the importance of the smooth muscle complex and the muscles of continence, and in order to avoid injury to the nervi erigentes, he hugged the hollow of the sacrum. So he missed all the important muscles of continence, but, you know, it was a start.

MULLINS: Yes, yes.

Can you tell me a little bit about your impressions of Dr. Krippaehne's Department of Surgery when you joined it in 1967?

CAMPBELL: Well, the Children's Hospital in Philadelphia was down at Eighteenth and Bainbridge Street, and it was an old, old hospital. When I came out and visited Dr. Krippaehne, the University Hospital was new, it was clean, it had a record room where you could find records, it was green for Oregon [laughs], and I thought I'd died and come to heaven. So, yes, the institution here, compared to the Philadelphia Children's Hospital, was a real contrast.

Yes, and Dr. Krippaehne was a real supporter. He did everything anybody could do to make pediatric surgery and my career a success in our community and state.

MULLINS: Were you the first pediatric surgeon?

CAMPBELL: I was.

MULLINS: So prior to that, who would do the TE fistulas?

CAMPBELL: Well, they would be done by—Dr. Peterson. Clare Peterson, was in charge of children's surgery, and he had a cadre of community physicians who were interested in pediatric surgery—Bud Zeller, Russ Gustavson, Ed Wayson, Millard Rosenblatt, William Garnjobst, Joe Nadal, and Matthew McKirdie, and they would volunteer and take their turns doing it. Plastic surgery, and the skin grafting of burn patients, would be supervised by Verner Lindgren and other volunteer plastic surgeons. More complex reconstructive surgery was overseen by a volunteer Dr. Dan Steffanoff, who interestingly was a violin maker.

Before that, C.W. Brunkow, who was a community physician, did cleft lips and cleft palates, and that's what really got the Doernbecher established as a pediatric surgical center, because he would come up and do cleft lips and cleft palates—the first in Oregon and the only hospital doing this surgery. Another community volunteer in the early days was Winfred Bueerman.

MULLINS: Now, Dr. Campbell, when you came, was the Doernbecher on the top floor of the—

CAMPBELL: It was on the top two-and-a-half floors of University Hospital.

[End of Tape 1, Side 1/Begin Tape 1, Side 2]

MULLINS: And was there an ICU?

CAMPBELL: No, there was not a PICU. There was a neonatal center that Dr. Gorham Babson had started, and it was patterned after the first pediatric surgical neonatal center that Dr. Koop started in Philadelphia.

MULLINS: In 1964, I think it was, or '63, the president of the United States' son died as a newborn. You probably remember that.

CAMPBELL: Yes.

MULLINS: I guess he died of respiratory failure.

CAMPBELL: Yes—Patrick Kennedy died of respiratory distress syndrome (RDS) at Boston Children's Hospital.

MULLINS: Nothing could have been done for even as important a child as that?

CAMPBELL: Well, they didn't have surfactant, they didn't know about the use of steroids, they didn't have ECMO, they didn't have any of the things that—

MULLINS: Mechanical ventilation?

CAMPBELL: Yes. Well, mechanical ventilation, but to put a kid on a mechanical ventilator in those days was a death warrant.

MULLINS: So you would do major surgery on a TE fistula and the child would be extubated?

CAMPBELL: Yes. And if they needed to remain on a respirator, we had respirators, but they were not safe. I mean, they helped; they were a beginning. The Bird respirator was probably the best at the time. And, of course, the Drinker had been around for a longer time, but Drinker's doesn't work for infants.

MULLINS: So when would you say that a pediatric ICU was established at the Doernbecher?

CAMPBELL: Well, it was probably established about three or four or five years after I got here, probably in the early seventies.

MULLINS: You had a set of Siamese twins case, is that correct?

CAMPBELL: Dr. Peterson had a set of Siamese (conjoined) twins in 1959.

MULLINS: Would you want to talk about that?

CAMPBELL: Sure. These were omphalopagus, which means they were joined at the abdomen, and he successfully separated them. At the time, that was the most extensive joining that had been separated successfully.

MULLINS: And that was here at OHSU?

CAMPBELL: Yes, '59.

MULLINS: Do you remember hearing about that?

CAMPBELL: Oh, sure. And I've seen the children when they came back for their follow-up visits. Clare called me over, and we looked at them together.

MULLINS: How did they do?

CAMPBELL: They did very well.

MULLINS: Did you ever have a case of your own?

CAMPBELL: I had about six or seven different infants or pairs of infants that were born that were conjoined or were monsters, like mermaids where the legs are fused together, and things like that. Fortunately, they all had lethal heart disease and they never presented

themselves for—were never seriously considered for separation and died quickly. We also had a *fetus-in-fetu*, a child with an intra-abdominal teratoma that was almost a fully formed fetus.

MULLINS: I guess I'd just like—

CAMPBELL: Now, one more pair of conjoined twins has been born since then, over at Emanuel, that Tom Curran, who was in our group, successfully separated.

MULLINS: I guess I'd just like to talk a little bit about this concept: you have a high-profile case with a lot of publicity and exposure. Do you want to just talk about that through the years? For instance, Dr. Koop was a very high-profile surgeon general and had convictions that he clearly expressed. Can you comment a little bit about publicity and dealing with the public and going on the nightly news?

CAMPBELL: Well, I always felt like my first obligation was to the family, and most families don't want a lot of publicity. If they did, they made their own. So I really didn't get involved in the evening news and that sort of thing. Now, I gave interviews, you know, at the termination of a successful case, or something like that, because I thought it was good for the hospital and to let the public know what can be done. So that really wasn't a problem for me.

MULLINS: Did you—I don't want you to violate any confidence here. Did you ever talk to Dr. Koop about his controversial...

CAMPBELL: Oh, sure. He was—I forget—down in Eugene, I think it was, giving a talk when he was Surgeon General, and a child who was anencephalic was born down in Newport and was transferred up to the Doernbecher while he was down there, and he called me from Eugene and wanted to know about it. That was at a time when, you know, everybody was supposed to squeal on everybody and report all these things to a toll-free number and make sure they were done right, so he said, "I'd like to come up and see this patient." Well, he came up and he thought we'd made the right decisions, and that was it. But, yes, I talked to him about it.

MULLINS: How about his tenure as the Surgeon General? What does he say about that?

CAMPBELL: Well, Ronald Reagan first appointed him, and you will remember that his confirmation was delayed because he was too old to be Surgeon General. They had to change the law. I think the law at that time said that you couldn't be Surgeon General if you were over seventy, and he was over seventy. So it took about nine months to get the law changed, and when they got the law changed, why, then he became Surgeon General. Because his confirmation was delayed, he served into the term of George, the first, Bush's term. He spoke out against smoking, encouraged the public to exercise, explained AIDS to the American public, urged the use of condoms to prevent AIDS, and made very sensible pronouncements based on public health principles, regardless of ideological beliefs.

I think he surprised a lot of people. Chick, as we all called him, has very fundamental beliefs, and his attitude was always, “keep the most men at the most guns as long as possible.” He had strict standards, and he expected everyone to follow them.

I’m not sure if I’ve answered that question.

MULLINS: Well, I’m trying to set the stage about an era that you kind of grew up in when there were very powerful, vocal leaders in American surgery, and the question is, do they still exist today or are things changing in the way American surgery is being practiced—academic surgery, anyway?

CAMPBELL: Well, I think they have changed. I think there are still people with strong opinions and there are still pioneers and there are still people out pushing the envelope—I mean, I know there are—but there is a lot more regulatory activity. Just the human subject investigation committee: I mean, to do a retrospective case review you have to have permission or you have to have the approval of your institutional review board now.

MULLINS: Well, during your tenure here from ‘67 to—when did you retire?

CAMPBELL: I retired about five years ago.

MULLINS: You saw a lot of changes at OHSU.

CAMPBELL: Yes.

MULLINS: I’d like to kind of go over those, if we could.

CAMPBELL: Okay.

MULLINS: The era, say, ‘67 to the mid seventies there was a—one thing that happened is that Medicare came in and the number of patients at OHSU declined. Did you see that influence your practice?

CAMPBELL: No.

MULLINS: Medicare doesn’t—that’s a bad question. Did you see a change in your practice from ‘67 to ‘75 in terms of what was coming to the Doernbecher hospital?

CAMPBELL: No. During that period of time, Doernbecher was the only children’s hospital and, as I previously recounted, we operated upon four esophageal atresias one Friday afternoon—

MULLINS: And you were the only—were you working all the time?

CAMPBELL: Yes, for the first ten years I was the only pediatric surgeon.

MULLINS: No one else took backup call?

CAMPBELL: No, no one else.

MULLINS: That must have been a long, hard ten years.

CAMPBELL: Well, I got to know my kids better afterwards.

MULLINS: Was there a particular part of pediatric surgery that interested you the most?

CAMPBELL: Well, I think childhood neoplasms were my special interest.

MULLINS: You started an oncology clinic, didn't you?

CAMPBELL: I started a pediatric tumor board. In those days, we didn't have any pediatric hematologists or oncologists, so I recruited Bob Goldman, who was an internist/hematologist, to come to the clinic that I set up on Wednesday mornings and to be our resource and adviser on the use of chemotherapy. I bootlegged some protocols from the NIH-sponsored Children's Oncology Group, which we could not belong to in those days because we didn't have a section of hematology/oncology. So when we, in consultation with Dr. Goldman, would arrive at a chemotherapy protocol, then we, the surgeons, gave all the chemotherapy and took total care of all the patients and had some good results from it, too.

MULLINS: And as things improved, the clinic got bigger and—

CAMPBELL: The clinic got bigger. We didn't have a pediatric radiologist in those days, and I campaigned for and got support for a pediatric radiologist, and Dr. Eugene Blank came out from Dr. Caffey's department of pediatric radiology at Pittsburgh Children's Hospital and really helped us out.

Then, I was on the search committee for the new chairman of Pediatrics when Dr. Dick Olmsted moved on; I had known Bob Neerhout—I'd met him at a Pacific Association of Pediatric Surgeons meeting, where he was a guest and gave a paper, and put his name in the pot, and we hired Bob who was a pediatric hematologist/oncologist. So when Bob got here, I was able to pass over the chemotherapy to him. We had a wonderful collaboration during the next twenty years.

MULLINS: It must have been encouraging, because the results did improve.

CAMPBELL: Oh, sure. The Wilms' tumors went from guaranteed death in a patient with metastatic disease to a ninety-five percent cure rate with metastatic disease.

MULLINS: How did Dr. Krippaehne sort of bring into the fold in those—into the University training program the residents from the other programs?

CAMPBELL: Well, when I came, there was a residency-training program at Emanuel Hospital, there was one at Good Sam, and there was one at St. Vincent's. They would train one or two people a year, and I think we trained six. It became obvious that each hospital had its own strengths. We were fortunate to be on the Hill with the Veteran's Hospital, so we could supplement the esoteric kind of cases that came to the University with the kinds of patients that came to the Veteran's Hospital. But, of course, they were, in a sense, very different from the ones at St. Vincent's and Good Sam and Emanuel.

MULLINS: Was it prudent of Dr. Krippaehne to sort of bring them in, rather than try to close them down?

CAMPBELL: Oh, I think so. We talked about it for a long time. Dr. Krippaehne and Dr. Peterson and I went over to Salt Lake City. They had an integrated—you want to use the terms correctly; not affiliated, where you send the residents back and forth, but integrated, where it's one program but it's in several venues. We went over to Salt Lake City, where they had an integrated residency program, and we liked what it looked like and—oh, there was one other person. That was Ben Bachulis, from Emanuel Hospital.

We came back and we said, you know, rather than just integrate with Emanuel, why don't we do it with all the major hospitals in Portland. Providence Hospital, on the east side, wasn't interested; Good Sam and St. Vincent's were, but when Ben Bachulis found out that Emanuel wasn't going to be the only private hospital in the affiliation, he dropped out, so we did it we Good Sam and St. Vincent's.

MULLINS: Was it a contentious period in terms of this, or was it just...

CAMPBELL: No, it wasn't contentious. Why did we do it? We did it to improve surgical education. I mean, we could—first of all, we could draw from a much greater applicant pool, and we had some control over the standards and the quality of the education at the other hospitals.

MULLINS: Do you think it gave a characteristic to the OHSU, the Oregon training program?

CAMPBELL: Oh, sure, sure.

MULLINS: ...that attracted people through the years?

CAMPBELL: Well, then, when trauma became an area of emphasis and Emanuel and the University became primary trauma centers, then Emanuel was interested in the integration, and then they came in after the fact, even though they had been part of the group that was instrumental in starting the integration.

MULLINS: I'd like to briefly talk about the fact that you practiced at Emanuel, because I know in the sixties many of the faculty on the Hill would have practices off the

Hill, Bill Fletcher and some others. Can you just comment about how that worked out for you and how you think it worked out for the other faculty?

CAMPBELL: Well, when I came here in 1967, my salary was \$13,500 a year. You couldn't do it on that, not and go to national meetings and be in on what's new and try to push the frontiers back a little bit.

MULLINS: So you had a flat fee salary?

CAMPBELL: Yes. All the patients who had insurance or had an ability to pay, it was just—I mean, all that revenue was lost. The University didn't do anything with it.

Well, then Dr. Holman, who was the hospital director, who was very supportive of pediatric surgery—he and Dr. Baird and Dick Olmsted, the chairman of Pediatrics, and later Bob Neerhout were all very supportive of me. I couldn't have done what I did without their help.

But then it became obvious that OHSU was losing revenue, so the University started to bill. You'd send in what we had done and they would bill for your services—well, it was a feeble effort. Then the Legislature was starting to get interested in the economics of the hospital, so all of a sudden—I'm getting ahead of myself.

So we were encouraged to go off the Hill and supplement our income. So I would go to Emanuel, and I would go to Physicians & Surgeons, and I would go to St. Vincent's, and occasionally to Good Sam. But that's counterproductive; it takes you away from where you ought to be. Pretty soon, the University began to realize that that was counterproductive and, besides, if we could deliver private care and bill for it and have a practice plan and share it with the University, then it would be a smart thing to do, and that's how that all developed.

MULLINS: Because in the fifties, the new hospital was built, the one you were in.

CAMPBELL: Yes.

MULLINS: And there was some sort of prohibition of admitting to that hospital Portland-area patients, is what I'm told.

CAMPBELL: No, that's not true. You had your family physician and your pediatrician who referred, and where would they refer? They would refer to their hospital where they could visit all their patients even though—and we had a few pediatricians in the community who could see beyond that and could see the benefits of being in a children's hospital such as Tom Olsen. But there was no prohibition against it.

MULLINS: So the pediatricians would see a child who has a hernia—

CAMPBELL: It's just that if we had a private patient, we couldn't bill for him.

MULLINS: You couldn't? I'm sorry, I don't quite...

CAMPBELL: That was just the rules.

MULLINS: You simply couldn't. If the child had Blue Cross-Blue Shield or was willing to pay you a surgeon's fee, you couldn't bill.

CAMPBELL: Not at the University. So they'd say, Well, why don't you go down to Good Sam or Emanuel.

MULLINS: I see.

CAMPBELL: So then, when the Legislature began to cut the funding, then the University could see us as a valuable resource to have our patients here.

MULLINS: I mean, is that prohibition in fact the technique that was used to keep private patients from coming to the—

CAMPBELL: No, I think it was done to keep the faculty—I'm not sure. It didn't ever make sense to me. As I think about it now, it was probably an accommodation between "town and gown."

MULLINS: I understand.

So you and many of the other faculty at that time—

CAMPBELL: Bill Fletcher had an enormous practice over at St. Vincent's, Dr. DeWeese had an enormous ENT practice over there. That's how Al Starr eventually moved over there, because he would take all the paying patients and put the charity patients at the University.

MULLINS: So into the seventies you had established an ability to bill at the University, and maybe the Doernbecher was growing then, in terms of the size. When you first came here, was it a fairly small service?

CAMPBELL: Yes. I didn't have much to do when I first got here. I used to get in the car every Monday morning and drive down to the state mental hospital in Salem, to be a consultant down there, and I used to drive up to Madigan about four or five times a year to the Army hospital as a consultant. I was even a consultant at the Alaska Native Medical Center in Anchorage, Alaska. I didn't do any of those things after a while, because pretty soon we got busy.

MULLINS: And the residents would—was there a pediatric surgery service?

CAMPBELL: There was a pediatric surgery service. General surgery residents staffed it.

MULLINS: And, for the most part, were they pretty good through the years?

CAMPBELL: Yes.

MULLINS: The earlier years I know they were—you know, in the sixties, the chief residents, senior residents, were pretty autonomous, but I would assume you—

CAMPBELL: Well, they were not autonomous on my service.

MULLINS: Yes, sir, I'm sure they weren't.

CAMPBELL: Not because I wanted it that way, but because this was a subspecialty. They had no experience, no concepts. I let them do what they were capable of doing, but it meant that I did a lot of it.

MULLINS: Well, as a resident who went through it, I can say that I think one of the things that you learned was the importance of working as a team. The neonatologists and the pediatricians and the surgical on-call, you all worked together as a team. There wasn't quite the adversarial relationship that existed between adult surgeons and internists at, say, the VA or OHSU. You had an excellent team that you developed.

CAMPBELL: Well, one thing we did was we took pediatric residents on rotations on our service, so, in a sense, "they were us."

MULLINS: Maybe we could just jump ahead, since we're talking about this, and talk about the building of the new Doernbecher. Then I want to go back to some of the things that happened when you became chairman.

Can you tell us about how this evolved to building the new Doernbecher?

CAMPBELL: Well, when I came here in 1967, I said, you know, this community needs a single children's hospital where all the children are admitted. Number one, it increases the volume of these rare and unusual conditions, which means the quality of care will improve; it means you don't have to duplicate or triplicate all the expensive equipment that is used fairly infrequently because of the rarity of the conditions, so we can cut down the cost of patient care. The Portland Business Alliance was all in favor of it.

At that time we had a hospital siting council, the State did—which has since gone out of business; the legislation has expired, I guess—that would look—any time you'd want to increase a bed or add a new program or buy a CAT scanner, you had to get permission to do it. It just wasn't in the cards at that time. Well, that's gone now.

Then there came a time when the—well, then Dr. Laster came, and that was at the time that he was building the Vollum Institute. That was also the same time that an interest in a single children's hospital in the community was being thought about. So between

Emanuel, which had started a children's hospital, and the University, we put together a consulting group. We met once a week for almost a year, and we finally came up with a recommendation that, yes, there should be a single children's hospital, that it was less important where it was sited, and we all agreed that if we were going to build a new one, we would be willing to build it over on the Emanuel campus, where they had all the condemned land from the—I forget what the name of the program is where the rehabilitation of the slum areas was (urban renewal). There was some federal money in it that had bought it. You'll remember, too, that a new Veteran's Hospital was under consideration to be built over there.

So we were willing to—those of us at the Doernbecher were willing to go down there and build the new hospital, if it could be freestanding. Then the hospital administrators got together and started working on it. Well, Emanuel wanted to keep all of radiology, wanted to keep all the food service, they wanted to keep all of the laboratory service, and that's where all the money in the hospital is. So that would have left the Doernbecher and the University with paying for all the educational costs and so forth, and so the effort died at that time.

What we should have done was gone on and built the new Doernbecher then, but Dr. Laster was so involved in the building of the Vollum that that whole concept just lay fallow for five years. That's when Emanuel really developed into the children's hospital that it is now.

MULLINS: So who made the decision to build the Doernbecher where it's currently located?

CAMPBELL: So then, after the Vollum was built, then Dr. Laster had moved on, and we had a new administration, and so then we started to look at it. That was when Dr. Kohler was here, and we went ahead and built it.

MULLINS: Is the final decision maker Dr. Kohler? Did he decide to proceed?

CAMPBELL: Yes.

MULLINS: And it was supported, I remember, substantially by the Doernbecher Foundation.

CAMPBELL: Yes. If you have to raise money for something, probably the easiest thing to raise money for is the health care of children, and so the community was very generous and industry was generous.

MULLINS: When you say "the community," is it just the Portland area?

CAMPBELL: No, people from all over the state.

MULLINS: Were you involved in recruiting them and their support?

CAMPBELL: Sure. The top floor of the Doernbecher, the cancer ward, is—the whole thing was paid for by one of my grateful patient’s families.

MULLINS: And what is your recollection of that experience? Was it hard work, hassle, were you pleased with the way it went, this recruitment outside of your normal fixing TE fistula?

CAMPBELL: Well, the doctors, you know, didn’t do the recruitment. The doctors could suggest leads, but the Foundation, the Doernbecher Foundation, did it. By that time, you know, we had women’s groups and the different Oregon companies, like the United Grocers, and foundations, like the Ford Foundation, that were interested and gave generously. People other than the physicians in the hospital did the legwork.

MULLINS: Did they give money and also want to have things built certain ways?

CAMPBELL: No. You know, we wanted to put their name on it and thank them, but, no, they were very generous.

MULLINS: Were you involved in the design of that big white, arching building?

CAMPBELL: I decided if I was going to be the chief of the Division of Pediatric Surgery that somebody else ought to do it, so I nominated Marvin Harrison, who is my colleague and an excellent pediatric surgeon and on the faculty. Marv was really the one that represented all the surgeons and all the pediatricians and worked with the architects.

We had wonderful architects. They did it all on computers (Computer Assisted Design ‘CAD’), where they would come in on every Friday and review with our group their plans, and if we’d look at a door on the plans and say, Well, we’d rather have the door over here, they’d sit there on the computer right in front of you, and they’d move the door over.

MULLINS: It must have been a lot of fun in some ways.

CAMPBELL: It was.

MULLINS: Are you satisfied with the final product?

CAMPBELL: It was especially a lot of fun for Marv, because he got a big kick out of it.

Yes. It’s a wonderful hospital. Too small already, we’re already building some additions to it. The footprint is such that it can be expanded, and I think that’s going to be the next push.

MULLINS: Dr. Campbell, I think that the Doernbecher Hospital is a vivid symbol of the transformation of OHSU over the last fifty years. That would be my sort of hypothesis. Would you agree that there are other areas that we’ve changed here at OHSU?

CAMPBELL: Well, if you look at the surveys that are done, the hospital with the greatest name recognition in the state is the Doernbecher Children's Hospital, far above any other hospital. I'd like to think it's been a prototype, but—well, the new cancer center is obviously another example of that, and women's health care; and the fact that we finally got an obstetrical unit where we wouldn't mind sending our own family.

MULLINS: That occurred after OHSU became a public corporation. Do you want to talk about that '95 decision to go from being part of the Board of Higher Education to...

CAMPBELL: Well, personally, I think it was a good idea, and I wish we could have done it sooner, because it made us competitive. Being a state institution, a public institution—the laws say you have to reveal all your public information—the Freedom of Information Act—so we could never start a new program because it would never be competitive unless we were the only ones that knew the details, if we had to turn over everything. So just overnight we became competitive for the first time.

I can remember one time when University Hospital ran out of Foley catheters, and we couldn't get any more because we'd spent all our budget—I mean, we were doing more business, the hospital was making more money, but we'd already spent the budget for Foley catheters and we couldn't buy any more Foley catheters without State approval. Well, you know, you rob Peter to pay Paul. But it made it very difficult to operate like every other hospital in the community. So it's made it possible to do the things we're doing now.

[End of Tape 1, Side 2/Begin Tape 2, Side 1]

MULLINS: This is the beginning of tape two of the interview with Dr. Jack Campbell.

Dr. Campbell, I'd like to talk about medical student education at OHSU. When you came in 1967, what did the medical students do at OHSU, in terms of learning surgery?

CAMPBELL: Well, you know, I'm probably not the best person to ask this, because the students that rotated through my service were pediatric students, and then, when they were withdrawn because there were so many competing activities for them, we had surgical students. Then there were so many competing activities for them that it became strictly an elective. So we haven't had the students on our service day in and day out, month after month.

MULLINS: OHSU is recognized as one of the leaders in training primary care.

CAMPBELL: That's right.

MULLINS: On the one hand, your father was a primary care physician; you know exactly what that means. And, on the other hand, you're a super-specialist.

CAMPBELL: That whole concept started at Kansas, and some of the early faculty here were Kansas people, like Laurel Case. So I'm very familiar with it. It was an education of rural physicians. We used to go on a circuit course, where we go out to the various communities in Kansas and teach; and then here at Oregon.

MULLINS: Do you endorse that emphasis on the primary care physician, producing another generation of doctors like your dad?

CAMPBELL: Well, I don't know quite how to answer that, because I think the people that are going to make that decision should look at what the public wants and needs and what the public will accept. I think that certain areas, like rural areas, need very well trained primary-care physicians. But when you get to a city like Portland, the need is not as great. So I don't think you ought to put all your eggs in one basket and make sure the tail doesn't wag the dog.

MULLINS: Do you think there are enough pediatric surgeons in the United States today?

CAMPBELL: Well, I was part of a manpower committee with the American Pediatric Surgical Association, headed by Jim O'Neill, and the consensus of our committee was that we were training enough pediatric surgeons. Well, things have changed. Every large hospital wants to have pediatric surgery—Emanuel, St. Vincent's—so if you're going to do that, you're going to need more pediatric surgeons to staff them. Well, you know, the whole push used to be centralization of medicine so that you can improve the quality of care and reduce costs. If we're not going to follow that paradigm, then we're going to have to have more pediatric surgeons.

MULLINS: There's a lot of emphasis on specialization in surgery training these days. Through the years, are you satisfied with the crop of residents we've produced? One other way to ask that is, are you satisfied that the trainees who have come through our program and gone out to smaller communities and done pediatric hernias are well trained and prepared to do that kind of thing?

CAMPBELL: Yes, what I tried to do, when all the residents came through my service, was show them esophageal atresia, show them childhood cancer, and let them be involved to the place where they would realize that they should not be doing it outside of a children's hospital, and I think I've succeeded in that.

What I tried to do was to teach them all how to do safe hernia repairs in children, since that's the most common operation in children, and teach them how to do safe pyloromyotomies for pyloric stenosis, which is the second most common operation in children. Those are the kinds of operations that general surgeons can do, and can do safely if they are well trained. My biggest worry regarding the safety of children's surgery in

community hospitals is anesthesia given by anesthesiologists that only care for occasional children. So I tried to put my emphasis on training general surgeons how to do those two operations and let them realize—give them the exposure that would show them that they shouldn't be doing anything other than that.

MULLINS: And as you look back, have you succeeded?

CAMPBELL: I think so. And how do I judge that? Well, I judge it by how many failures or disasters come to the children's hospital to be bailed out, and I think each year we see fewer and fewer.

MULLINS: I'd like to talk about the care of injured patients at OHSU.

CAMPBELL: Okay. Now, that's, of course, another leading—it is the leading cause of death in children under eighteen. We, as pediatric surgeons, absolutely endorse first-rate trauma care and the designation of different levels of care, and so forth.

MULLINS: So, 1979, OHSU is not a trauma center, and, frankly, doesn't see very many injured patients.

CAMPBELL: No we didn't.

MULLINS: By 1985, '86, it becomes a designated level one trauma center. Can you talk about that transition and what brought it about?

CAMPBELL: Well, I can tell you how it happened. Exactly what brought it about I'm going to ask you. What did bring it about, Rich? Was it a national trend? Was it the public crying for improved care? Or was it leaders saying we've got to improve here? I think it was probably that, but you confirm. Am I right?

MULLINS: Well, I think that at the time people like Don Trunkey—and, frankly, he was one of the few leaders—was saying that there are preventable deaths occurring in the United States. That became a very popular concept that drove, I think, public authorities, in government, to say this is unacceptable. Now, let me be specific. Dan Lowe joined the faculty in 1979, I think.

CAMPBELL: I believe that's right.

MULLINS: He did a study, and he decided he was going to have a trauma center at—

CAMPBELL: Well, he was hired for that purpose. Dr. Krippaehne hired Dan Lowe who was an OHSU medical student, who had had his surgical residency at Indiana and was at Indiana, to come back and start up a trauma service for us.

MULLINS: So we can give some credit to Bill Krippaehne deciding that they needed to have—

CAMPBELL: Oh, sure, sure.

MULLINS: I can remember attending a very controversial—or, very agitated group of doctors meeting before I left in the spring of '80 saying we don't need a trauma center, that we ought to just distribute these patients all over. There was a lot of opposition to a trauma system in Oregon.

CAMPBELL: Well, I think, number one, hospital administrators had their influence on their doctors. They didn't want some hospitals to have it and others not have it. Then, I think physicians realized that they'd have to be on mandatory call schedules with very little remuneration. My guess is that probably outweighed those people who wanted improved care at that moment.

MULLINS: So when did you become chairman?

CAMPBELL: I became chairman in '84, through '86.

MULLINS: Of course, Dr. Krippaehne had pancreatic cancer and stepped down. Was he still actively involved till his death?

CAMPBELL: No, no, he wasn't. Bill was very sick.

MULLINS: So how was that? It must have been difficult for you to step in.

CAMPBELL: Well, of course, we all knew and loved Bill. We knew what Bill wanted, and so it wasn't hard to carry on the tradition that Bill had started. So, no, I didn't find it hard.

I guess the hardest thing for me was that I couldn't do everything I wanted to do just because you couldn't rock too many boats. I remember a couple of times when I went to the Dean of the School of Medicine and sought his permission to do certain things and got his permission, only to have him reverse that decision. I was an activist; I wasn't just a caretaker.

MULLINS: So, getting back to trauma, you were there when there was—Bill had started it, Dr. Krippaehne had started it, and you were there, supporting Dan Lowe as he was an advocate. How did that go down? Did this pit the University against downtown, for instance?

CAMPBELL: I think it worked out pretty well. The American College of Surgeons Committee on Trauma, of course, was one of the real leaders and pushers for this, and the Oregon chapter of the college had its own trauma committee. I suppose if there were any fireworks, it probably occurred there, where different constituencies were competing. And

personalities had a lot—as they do in everything, played into that. But it all worked out for the best.

I know I was asked to serve on a State of Oregon-convened committee representing the Oregon Chapter of the American College of Surgeons, and I thought, well, you know, you probably need somebody that's more neutral in the community, so I asked Bolek Brant to represent the college to do that. Bolek was at Providence Hospital which did not have any aspirations as a trauma center.

MULLINS: How about at the University? Was there widespread support for OHSU becoming a trauma center?

CAMPBELL: I don't know that there was widespread support, but I don't think anybody was against it. I suppose you'd say the leaders in trauma had the enthusiasm, and those whose primary interest wasn't trauma didn't have as much enthusiasm, but they weren't obstacles.

Do you think that's fair?

MULLINS: Yes, I think so, although I wasn't here at the time.

How about from your perspective as a pediatric surgeon? Obviously, it increased the number of children who came here from around the state.

CAMPBELL: Well, I think that was very positive. I mean, if you accept the fact—and it is a fact—that the biggest killer of kids under eighteen is trauma, then, you know, that should be our first goal.

MULLINS: Part of the problem is brain injury. Who were the advocates for brain injury treatment in those days?

CAMPBELL: Well, they were—it was Tony Gallo, I guess, who was at the very beginning of that. I'm not sure whether Tony overlapped into the designation of a trauma center. I think he did.

MULLINS: He was a tremendous gentleman.

CAMPBELL: Yes. Tony was very thoughtful and very committed. Tony's primary interest was in pediatric neurosurgery, and, of course, trauma was part of it. He was very dedicated in the treatment of hydrocephalus and the congenital neurosurgical conditions.

MULLINS: Who were the other surgeons committed to pediatric trauma care in your era?

CAMPBELL: Well, then there were a group of young Turks that were in the Division of Neurosurgery: Cal Tanabe and Rick Waller and Errett Hummel, and of course the chief, Harold Paxton. Later Joe Piatt as actively involved.

MULLINS: How about in orthopedics or ENT?

CAMPBELL: In orthopedics, I can't remember the name of our first pediatric orthopedic surgeon, but the entire ENT faculty pitched in.

MULLINS: And Dr. Beals?

CAMPBELL: Dr. Beals, yes, but I don't remember him as being into trauma that much. Rod was one of the leaders in American pediatric orthopedic surgery and congenital anomalies, little people and dwarfism. Rod was considered for, and I think offered the job of being head of orthopedics at Boston Children's Hospital at one point, but declined. But I don't remember him as being a pusher in pediatric trauma.

MULLINS: What other issues do you recall from your period when you were chairman? What were some of your successes?

CAMPBELL: Well, I guess one of the successes was that we didn't lose our accreditation during that period, because, you know, there were a lot of changes in the requirements for conferences and scheduled academic conferences and experiences. We met them all, there was never a question about it, and that was a real challenge. We established really structured conferences, we got the basic scientists involved, we had the pharmacologists come over and talk about antibiotics and opiates, and, you know, we—we had the geneticists come talk to us. We set up a very good didactic program for the residents.

MULLINS: Was there a lot of change in the clinical program through the eighties into the nineties at OHSU, the kind of surgery that's being done, and that sort of thing?

CAMPBELL: Well, I suppose the thing that I remember—the greatest thing that I think I remember was in orthopedics. It seemed like orthopedics was expanding its technology more than many others; and vascular surgery, too. There were some real technological advances and advances in treating patients in orthopedic surgery. And, of course, neurosurgery, the advances in neurosurgery don't come as quickly and as easily as they do in orthopedic surgery and vascular surgery.

MULLINS: How about in pediatric surgery? We talked, you know, about the improvements in chemotherapy making a difference in Wilms' tumor, but what about in the actual surgical procedures in infants and children?

CAMPBELL: Well, when I first came, omphalocele was—and gastroschisis, where the intestines are outside the abdomen at birth, those are real killers. We could fix them, we could get them back inside, but before the intestine would start to work again, the kid would starve to death.

Intravenous hyperalimentation has got to be one of the big advances in the surgical treatment of newborn anomalies. As I alluded to earlier, it started at the Children's Hospital of Philadelphia, and I was aware of it, and so we—our service was the first to use intravenous hyperalimentation out here. Dr. Babson, who was head of neonatology, was trying. He was using intravenous alcohol, because there are more calories per cc of alcohol than there is in any other thing you can feed. But, you know, you're limited in how much alcohol you can give.

But then, when Dudrick and Wilmore made their advances and started learning more about the problems, then we applied it. We made three formulations—a high (HAHP, which was the HP, higher protein, the most concentrated), a low (HA10—ten percent glucose), and an intermediate strength—and we called them HA13, because it was thirteen percent glucose. Then when I would go down to the community hospitals I'd find that all our formulations were being used down there on the adult services—with the same names and formulations, taken there by the general surgery residents who had rotated through pediatric surgery.

In collaboration with Neil Buist we implemented the double-antibody radioimmunoassay for insulin and began performing near-total pancreatectomy for hyperinsulinemia in infants before brain damage occurred and put together one of the early large series of patients so treated. Also, with Dr. John Isom we developed a large series of trans-cervical thymectomies in children with myasthenia gravis, which was the precursor of thoracoscopic thymectomies. I acquired the second set of Storz endoscopes and Hopkins telescopes on the West Coast which revolutionized the diagnostic and therapeutic tools available and set the stage for the first minimally invasive surgery performed in children. Other firsts in Oregon were total thyroidectomy for medullary cancer of the thyroid and parathyroid cryopreservation and auto-transplantation when operating on patients with hyperparathyroidism.

MULLINS: At the end of your tour as chairman they hired Dr. Trunkey. Can you tell us a little bit about the recruitment of a chairman at that time? I'm interested if OHSU is going to be able to attract somebody to be chairman.

CAMPBELL: Well, I think we did. I think we proved—answered your question by whom we attracted. We had a number of excellent candidates. Don rose to the top.

MULLINS: What were you looking for, in 1985, to lead the Department of Surgery?

CAMPBELL: Well, in 1985, we were looking for an excellent surgeon. I don't think—unless you're a good surgeon, what else can you do? I mean, a chairman who's an administrator only and not a surgeon, doesn't succeed; a chief who is only a surgeon and not an administrator doesn't succeed.

MULLINS: How about somebody with NIH grants?

CAMPBELL: Well, I think if that's all you've got and that's all you do, you probably wouldn't succeed. You've got to have—you know, we talk about teaching, research, and patient care, and I guess, in my opinion, if a surgeon's going to succeed, he's got to be all three, a "triple hitter."

MULLINS: Can you mention who were some of the candidates that you looked at?

CAMPBELL: I can say that Don's name just rose to the top.

MULLINS: And how would you describe his transition period, when he became chairman? Did he decide to change things?

CAMPBELL: Well, the structure of the M&M conference changed a little bit. And there were some new mandates for a new chairman, like quality assurance, and we developed, I think, a very good quality assurance program. He carried on the resident conferences that we'd set up already, and—and, of course, another reason I'm sure Don was chosen is because he had the credentials to lead us in trauma, which he, of course, has done superbly. With a nationally and internationally recognized name like Trunkey as chairman, the number of resident applicants increased.

MULLINS: I think there was a transition period there. Senior surgeons, Dr. Vetto, Dr. Clare Peterson and, to a lesser extent, Dr. Fletcher, kind of moved on, and—it seems like Dr. Trunkey has hired a new group of faculty.

CAMPBELL: Well, Dr. Vetto, who was chief at the VA, retired, and then, in his retirement from the Veteran's Hospital, went to become chief of surgery at St. Vincent's, and, of course, was very supportive of the integrated residency. Dr. Peterson was older and I don't think vigorous enough to take trauma call, and that sort of thing, and it wasn't expected of him. And Dr. Fletcher had his hands full running the adult cancer program. And we were growing, so we needed more faculty. I don't think anybody was hired to replace any of those people, with the exception of Mark, who had retired.

MULLINS: I think what Don told us earlier is there was an opportunity to generate more revenue. That became very important.

CAMPBELL: Well, I alluded to that earlier, and this was just an extension of that.

MULLINS: I guess this is a good transition time. We'd like to talk now, if it's okay, about money at OHSU.

We know from your previous comments that in the sixties and seventies you were actually prohibited as an operating surgeon from sending a professional bill if you operated on the patient at OHSU. How did that change?

CAMPBELL: Well, the University was growing, expanding, state support was decreasing, and the University needed the money. So what better way to increase hospital

revenues than to recall your faculty from the downtown hospitals? And how do you do that? You let them do at the University Hospital what they'd been doing at the community hospitals, and then that improves hospital revenue because OHSU has more paying patients in comparison to what had been pretty much a charity load before that.

Then, it was the formation of the University Medical Associates, an organization started by, funded by, and managed by a board of directors composed of only faculty, not administration, which was the billing agency for the faculty, to improve faculty salaries and to improve medical education, just like the name says. And practice plans were developed where portions of the revenues generated went to the department and to the dean to improve medical education.

MULLINS: So this was the UMA.

CAMPBELL: UMA, which has come to be called UMG.

MULLINS: And UMA started in the seventies?

CAMPBELL: Yes, I believe it was the seventies.

MULLINS: And do I correctly understand that various groups had their own people that did the billing?

CAMPBELL: Initially.

MULLINS: John Porter's group had their own person who filled out their own bills. Was that true in ped surgery as well?

CAMPBELL: Well, we did it all through my office.

MULLINS: So, then, you would turn those charge tickets into UMA.

CAMPBELL: Well, no, we would bill on our own. Then, when UMA was formed, we billed through this billing group. A fellow by the name of Joel Massey was hired to start it. At that time, it was all pencil and ledger, no computers. Then Joel got the first computer, and then over the years it evolved to the place where we had mainframes and good reports and we could tell what we were doing. Then they took over the function of sharing revenues with the department and with the dean with the data from the UMA computer. By then Hap Sermol was the executive director of UMA.

MULLINS: I think UMG was founded after Dr. Kohler became President of the University. How did UMG—

CAMPBELL: No, it was formed before that. It was formed at a time when Lewis Bluemle was the President, because I remember he hired consultants to come in and recommend how everything should be done. We had already set up UMG prior to that.

Then, the consultants came in, and, of course, the recommendation of the consultant was that more of the revenue should go to the dean and not to the department or the individual. I remember asking how they came to that conclusion, and the answer from the consultant was, “Well, Doctor, you didn’t pay for the consultation.” So what I learned right there was it all depends on who’s paying the bill what answer you get from a consultant.

MULLINS: Was it a contentious transformation from the individuals billing to the UMG?

CAMPBELL: It was. To most of your questions about conflict, I have answered no. This was the exception.

MULLINS: Do you want to comment for history about—was that good or bad for the University?

CAMPBELL: Well, I think, it flushed out a lot of things that were going on that could be done better, so I think that it added a little more honesty to the situation, and, yes, I think it was good.

MULLINS: Was there an element of lack of equity and fairness in terms of reimbursement?

CAMPBELL: Yes, I think there was. And one of the things that I did when I was the chairman was that I tried to equalize salaries. Some people were getting paid nothing, almost nothing, and some over the years had somehow gotten special deals. I tried to level that out. But if you’re going to do that, you have to level out the private billing and make sure that’s done equitably, so we worked on that, too.

MULLINS: Into the nineties, was that ultimately healthy for the entire University to have virtually all of the providers billing through UMG?

CAMPBELL: I think so. I mean if you look at the growth of the University, it has to be one of the contributing factors to the success of the University.

MULLINS: Do you think there are some providers on the campus that left and went into private practice because they were dissatisfied?

CAMPBELL: I think some left for that reason. Not that they were dissatisfied with the system, but they didn’t want to be part of the system.

MULLINS: And despite that kind of downside, eventually it paid off so that we have a university with a very clear characteristic as far as billing. Not to interject too much of my own into this, but I came here from Louisville, where it was the opposite system, where you got paid a small salary, and then you went to a private office, and if you could go down and find more work, you got paid more money.

CAMPBELL: Well, but you see, it still rewarded incentive, because the major portion of it inured to the individual practitioner or to the division. But it also recognized that collegiality needed to be observed. Some specialties that are very important to a university just don't pay as well as some others, and so, in my opinion, you need some collegiality so that all of the players are fairly rewarded. Now, I didn't say equally rewarded, but fairly rewarded.

MULLINS: It seems like if you're having this kind of a transformation you need some people with your kind of a perspective on it that have the bigger picture in mind. Were there many others who shared your support for having a—

CAMPBELL: Yes. I think the only people in the department who didn't go in willingly were vascular surgery and oncologic surgery. They're all in now.

MULLINS: Was the dean the driving force for this, was it the consortium of chairmen, or was it the President?

CAMPBELL: The answer to your question is—it was the faculty that organized itself, with the support of the departmental chairmen, and the blessing of the Dean of the School of Medicine. When I first came, the university was a medical school. It was the University of Oregon Medical School. The Dean of the school of medicine was also in charge of the school of nursing and the allied health, but not dentistry. The school of dentistry had its own dean. Then the Legislature, in its wisdom, decided that we should be a Health Sciences University, and so the Dean of the School of Medicine for a short time really became superfluous. The president was really in charge; he had under him all these subordinate deans.

Well, the problem for the School of Medicine was that all the resources of the School of Medicine went to the President's office, and they were left with, I think, one secretary and one financial officer. Well, you know, a medical school can't run on that. So, for a while all the decisions in the School of Medicine were made in the President's office.

[End of Tape 2, Side 1/Begin Tape 2, Side 2]

CAMPBELL: It's better now than it used to be, but if you look around the country, that isn't the way most medical schools have been set up.

MULLINS: Well, what do you see as the future of OHSU, maybe first in terms of medical education? What do you think we're going to be doing in the future?

CAMPBELL: Well, the eighty-hour workweek has been a real change. I don't know whether or not it's going to be possible to make some amendments to the eighty-hour workweek. I think if you could ever make a case for it, you could make a case for it in

surgery, because continuity of the learning experience and continuity of care for the benefit of the patient are so important. And the eighty-hour workweek doesn't allow for that. I mean, when you're eighty-hour workweek is over, you're making rounds, it's my—I'm not there, I'm not part of it, but it's my understanding that you're told to leave; is that right?

MULLINS: Yes.

CAMPBELL: Okay. I don't see how that lends for good learning of the patterns of disease, the preoperative, the intra-operative, and the postoperative experience. You pick it up bits and pieces, but you don't have the continuity. So maybe there's some way to make some changes in surgery. Otherwise, we're going to have to adapt to it.

Now, in Europe, the economic union, European Economic Union, is down to a forty-eight-hour workweek, and those same rules are being applied to resident education. If you read the articles out of Europe on medical education, it's hard to understand or hard to believe the accommodations they're making to deal with that. As a surgeon, I worry that the educational experience isn't going to be what it has been in the past. I hope I'm wrong. I'll follow it with interest.

MULLINS: Second issue is OHSU, as a hospital, as a place where people go and get treated. What do you see as the future?

CAMPBELL: Well, if you compare our hospital, OHSU, with a lot of medical school hospitals, we haven't sold out to the healthcare companies. We're making our own way successfully.

MULLINS: Could I just pause? You know, there was a time when HMOs were being implemented in the early nineties, and people said they were going to kill the University, just starve it. Do you kind of remember something about—

CAMPBELL: Yes, and I think they did kill some, because some university hospitals sold out to those healthcare companies.

MULLINS: At the time, did they say they weren't going to pay for pediatric surgery to be done at Doernbecher Hospital? Did you encounter that, where some insurance companies refused to pay?

CAMPBELL: Well, healthcare plans direct their patients to certain places. I don't think a pediatric surgical patient has ever been denied in Oregon to be cared for by a pediatric surgeon.

MULLINS: No, I'm not saying that, I'm saying but you wouldn't get paid. They'd say you can do it, but they're not going to pay you.

CAMPBELL: Well, I can remember two diseases for which that ever happened. One was funnel chest (pectus excavatum), and they pay for it now because there's data to show

that physiologically it's important; and gynecomastia, which is abnormal breast development in males, which was considered a cosmetic condition but, when you think about it, is a terrible psychological burden for a young male—and that's now paid for. So I don't think there were many conditions that insurance companies are denying payment for. Those are the only two I can remember.

MULLINS: And did you have to go to the mat and fight for having those reinstated?

CAMPBELL: I did. And then, of course, when the Oregon Health Plan came along, they were not going to pay for the repair of inguinal hernias unless, number one, they were incarcerated or unless there was bowel obstruction. Well, the whole idea of fixing a hernia is to prevent incarceration and bowel obstruction.

MULLINS: So as the professor of pediatric surgery, your voice was heard when you went—who did you talk to?

CAMPBELL: Well, I had a couple of patients whose kids had been denied. I sent them to the health commission and got it changed. And I put my word in for it, too. Karen Deveney followed my lead and got the problem solved for adults with inguinal hernias.

MULLINS: I cut you off, here. I was interested in your vision of the future of OHSU as a hospital.

CAMPBELL: Well, I think if we do it right, we have a bright future. We certainly have the people. I mean, what makes a good medical center? I mean, bricks and mortar are important and all that, but—and your equipment is important, but it's really the brains and commitment that go into it, and I don't think we'll ever be at a loss for that. Now, we'll have our ups and downs perhaps between recruitments.

MULLINS: What about the research agenda of the University, and specifically the Department of Surgery? Should research remain a high priority for us?

CAMPBELL: Well, I saw in the paper just this week that OHSU is now in the top twenty-five medical schools in getting NIH grants, and I think that's great. I don't think we can remain viable as a university hospital that is at the cutting edge in making the kind of contributions we're capable of unless we have a research arm. Now, there are institutions where research has come to rule the department and very little clinical care is being given, and I think we have to be sure that we strike the balance, but I think teaching, research, patient care are all equally important.

MULLINS: As you look back at thirty-plus, forty years of pediatric surgery—and we, for instance, talked about intravenous hyperalimentation—what are the important advances? Give me a couple of examples of the important advances. We talked about Wilms' tumor; we talked about hyperalimentation—are these things that were research-based, or is there something else that brought about these changes?

CAMPBELL: Well, hyperal, of course, kids were starving to death, so if you ever were going to do research, there's a problem that claimed a lot of lives that if you could just solve it—so that resulted. Biliary atresia used to be thought of as untreatable. Well, we now know it isn't.

MULLINS: And the men and women who sort of developed these treatments, you knew some of them, obviously. How did they do that? How did they accomplish making new ideas...?

CAMPBELL: Well, biliary atresia, the treatment of that was changed by Morio Kasai in Sendai, Japan. Regulations weren't quite as tough over there as they are in this country. He just operated and operated till he got an operation that worked. Then he came to this country and talked about it, and nobody believed him. I can remember national meetings where people would get up and basically call him a liar, you know.

In 1972, I went over and visited Dr. Kasai in Sendai. One Sunday morning we sat in his office and he got out all the slides from all the patients with biliary atresia that he had operated on, and he showed us that there were bile ducts and that if you could get those connected with the major drainage system to the liver, you we could cure biliary atresia. And biliary atresia is not something that's present at birth, it's something that develops after you're born. Babies are not jaundiced at birth, they become jaundiced.

The leading thought about the cause is that it's pancreatic reflux up into the bile ducts from a long common channel. So what the Kasai operation did is it separated the pancreatic drainage from the biliary drainage so there couldn't be continued reflux. That's why in the treatment of biliary atresia, it's so important to get there early before there is extensive damage. I mean, the one thing more than any other that explains the outcome is how young the patient is when they're operated on, which means you intervene to stop the reflux as early as possible.

MULLINS: So was Dr. Kasai a confident man or a visionary?

CAMPBELL: He was visionary, but he was also confident he could find the answer. As an indication of his confidence, his wife walked twenty paces behind him. We went out for dinner one night, and she walked twenty paces behind him in the Ginza.

MULLINS: And did he eventually get the recognition he deserved?

CAMPBELL: Yes, he did. He received the Ladd Medal from the Surgical Section of the American Academy of Pediatrics. He's been recognized.

MULLINS: Well, I guess, in closing I thought maybe you could just comment on what are some of your favorite memories over the last few years at OHSU, in the Department of Surgery in particular and OHSU in general.

CAMPBELL: Well, as I said, Dr. Krippaehne was terribly supportive of me. He made a salmon fisherman out of me. I think you've been out salmon fishing with him, too. He loved that. He introduced us to all the flora and fauna of the Northwest.

Dean Baird was terribly supportive of me; Dr. Holman, as hospital director, was. I think I mentioned all these things before.

MULLINS: But as a young person, young faculty member, you were supported at a critical moment.

CAMPBELL: Absolutely. I couldn't have been better supported. And I'm sure I've left out many names that I should mention.

Funny incidents? Well, I guess I can't remember too many of those. I know when Dr. Koop retired, we all went back to Philadelphia for his festschrift, and Barry O'Donnell, who was a pediatric surgeon at the Dublin Children's Hospital and president of the British Association of Pediatric Surgeons, had come over to represent them at his retirement party.

Barry, by the way, has relatives down at Lakeview, Oregon. The O'Donnells in Lake County, Oregon, brought all the sheep over from Ireland for the big sheep enterprise down there.

Dr. Koop was Surgeon General at the time, and he had a long beard, and Barry said that whenever he looked at Chick, he reminded him of Moses; that he was just glad that God sent Moses to get the ten commandments, because if he'd have sent Chick he'd have come back with a hundred [laughter]. Because, you know, the Surgeon General said, "Don't smoke, don't do this, don't do that."

MULLINS: Well, perhaps the last question is, there have been some surveys of surgeons who are older, and they report—ten, twenty percent report that if they had to do it over again, they wouldn't go into surgery. You know, they were successful and they accomplished their work, and all that, but—first of all, do you have any regrets about being a pediatric surgeon?

CAMPBELL: I don't have any regrets about being a surgeon or a pediatric surgeon or any of the courses that I've followed.

MULLINS: And as a man who's trained a lot of surgeons through the years, does it kind of make you pause to hear that some people eventually say, Gosh, that going into medicine was a mistake?

CAMPBELL: Well, as I look back on those people who say that, pretty much to the man they'll tell you that they didn't want to go into medicine in the first place, that it was a family, father decision that kind of pushed them. So I think if people do it on their own volition, it's a good decision, but I don't think you can push somebody into medicine. I think you know the example I'm thinking of.

MULLINS: Yes.

CAMPBELL: As far as the new generation is concerned, the number of applicants for surgical training programs is increasing. And what are the reasons that the number is increasing? They're down in medicine, they're down in pediatrics, and the surgical specialties are the ones that are increasing their number of applicants.

Some people think it's the eighty-hour workweek, which means that they can achieve what they really want to achieve without quite the rigors that they would have had to follow in the past. If that's true, then maybe the eighty-hour workweek is good, because it's going to attract a lot of the good people that shied away from a surgical career for that reason alone. On the other hand, I think they have to have the personal commitment and the love for it. If they don't have that, it'll just be a job for them.

MULLINS: Well, Dr. Campbell, you've lost a lot of sleep through the years. You know what I'm talking about.

CAMPBELL: Yes.

MULLINS: You have gotten out of bed and pulled many a foreign body out of a trachea, for instance. It's been hard, I suspect, at times, but...

CAMPBELL: Well, it's also rewarding. Even if it's hard, if it's rewarding, it's worth it. I guess I can't think of a—I mean, I got exasperated with people sometimes who hadn't done what they should have done and created nighttime events, but I don't ever regret having to go in for a real emergency that I could deal with.

MULLINS: Well, thank you very much.

CAMPBELL: You're welcome.

SIMEK: Can I add one to that?

MULLINS: Yes.

SIMEK: Can you just look into your crystal ball a little bit and, based on the advances of medicine that you've seen in the last thirty years, where do you see medicine thirty years from now? Where do you see surgery thirty years from now?

CAMPBELL: Well, I think we're going to apply some of the advances that are being applied in industry, and I think that's going to make it possible for us to do a lot of the things with a lot more ease and efficiency than we're doing right now.

I just finished reading the book by the president of Intel, Andrew Grove, *Only the Paranoid Survive*, and he talks about strategic inflection points that occur in—well, that

occurred at Intel and all of industry, and they occur in medicine, too. I think if in administering departments and administering education and the whole healthcare system, if we apply some of these techniques and look for our strategic inflections and deal with them appropriately and in a timely manner, we'll be ahead of the game.

MULLINS: Is that like building the Doernbecher?

CAMPBELL: Yes. And I think the University is at some points now where we have some inflections that need to be looked at. As Grove points out, the people that are running the show right now can't always see the inflections. People down in the trenches see them, so I think it's important to listen to people in the trenches. As he said, "Snow melts at the periphery and you've got to listen to the periphery."

But I think we're going to computerize the medical record, like there is such a push to do. The trouble is there are a thousand systems competing. It's got to be one system, or at least systems that are totally interchangeable. When I think about how hard it was to find x-rays in the past, my God, I could have had another career if I had all that time back trying to find x-rays. Well, now everything is digitized and on the computer. All you have to know is the patient's name, and you can find all the x-rays; same way for medical records and laboratory reports. But there has to be a way to share them with other institutions.

Now, if somebody can bring us the CAT scan on a disk from Eugene, we can put the disk in our computer because we've got their program in our computer; we can display it. Well, pretty soon there's going to have to be a common recording system so that they can just e-mail it to us. All of these technological advances that can be applied. So maybe if we do that, an eighty-hour workweek will work. But I worry that it's going to be sporadic, that they're not going to see the problem through from the beginning to the end.

And I think the physical exam has got to be brought back. I mean, what's the first thing that's done now? A CAT scan is ordered. Well, you know, if you take a good history and do a physical examination, in many cases you go straight to the operating room. Think of the money you'd save. And somehow we've got to go back to those old Hippocratic principles that are so important.

But I think the future is bright, and I think we've just got to—well, virtual surgery. I mean, Dr. Hunter is working on that. You know, at first it sounds like a crazy idea, but there are going to be ways to deal with it. Diaphragmatic hernia in infants, we're now fixing them through the scope, through the thoracoscope. No great big incision. That's got to be an advance. And all—well, the Monday conference was on adrenal surgery through the laparoscope.

We've got to be unafraid of the advances, and we've got to weigh them and embrace them and apply them when we can. Sometimes it takes a new person to look at it, not be afraid of it, to apply it.

MULLINS: The next generation.

CAMPBELL: Yes.

MULLINS: Are there going to be any Campbells in the medical profession?

CAMPBELL: Not medicine.

MULLINS: Maybe the next generation.

CAMPBELL: Well, could be.

MULLINS: What do your children do?

CAMPBELL: My daughter Kathryn is Director of Investor Relations for Metropolitan Life Insurance Company in New York, and—I should say she lives in New York, but all of Met Life moved to New Jersey after 9/11, so she commutes to New Jersey instead of the other way around. My son John is an investment banker who works for United Bank of Switzerland in San Francisco.

MULLINS: He was the one that traveled the world, right?

CAMPBELL: Yes. Then, I have another son George, here in Portland, who is my hunting and fishing companion in my retirement.

MULLINS: Well, perhaps it'll be the grandchildren that...

CAMPBELL: Well, maybe.

MULLINS: This interview with Dr. Jack Campbell took place June 21, 2005, at the Oregon Medical Association in Portland, Oregon. My name is Dr. Richard Mullins.

[End of Interview]

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