

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

Donald D. Trunkey, M.D.

Interview conducted June 21, 2005

by

Richard Mullins, M.D.

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In this interview, OHSU Professor Donald D. Trunkey, M.D., discusses his distinguished career as a trauma surgeon, shares his impressions of prominent American surgeons and describes changes in surgical education and practice from the 1960s to the present.

Dr. Trunkey begins by recounting some anecdotes from his childhood in St. John, Washington, and describing some of his own early experiences with trauma injuries. After suffering a broken arm in the seventh grade, Trunkey became interested in pursuing a medical career. Having received his M.D. from the University of Washington in 1963, he came to the University of Oregon Medical School to take a rotating internship under Dr. J.E. Dunphy. Trunkey describes Dunphy in some detail, discussing his reputation as a leader in surgery, his commitment to compassionate care, and his effectiveness as a role model for younger surgeons.

After a two-year stint in the Army, Trunkey again joined Dunphy, now at University of California, San Francisco, for further training. Working under Dunphy and Dr. William Blaisdell, Trunkey completed two surgical residencies at San Francisco General and UCSF before joining the faculty there in 1972. Trunkey talks about his move to Oregon Health Sciences University in 1986, when he joined the faculty as Chair of the Department of Surgery. He comments on the administration of the University and the OHSU Hospital and discusses his own actions as department chair, touching on the development of a university-wide practice plan and on the university's change from a state institution to a public corporation in the mid-1990s.

Dr. Trunkey has played an important role in the development of trauma surgery nationally, having served as Chair of the American College of Surgeons Committee on Trauma for five years in the 1980s. Trunkey describes his work with that committee as well as early state efforts to designate trauma centers in Oregon. He talks briefly about changes in trauma surgery and the impact of economics on health care, as well as changes in medical education and surgical training over the past forty years. Having seen his name appear in the news many times over the course of his career, Trunkey offers some advice on how to handle public relations.

In closing, Trunkey reflects on his career and notes that he joined surgery "in the best of times," before specialization rendered the practice of general surgery nearly impossible.

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Interview with Donald D. Trunkey, M.D.
Interviewed by Richard Mullins, M.D.
June 21, 2005
Site: Oregon Medical Association headquarters
Begin Tape 1, Side 1

MULLINS: Good morning. This is an interview with Donald D. Trunkey. We're at the Oregon Medical Association in Portland, on Corbett Avenue. Today's date is June 21, 2005. My name is Richard Mullins.

Dr. Trunkey, let's begin with where you were born.

TRUNKEY: I was born in eastern Washington, in the little town of St. John; five hundred people, 499 now. It's in the Palouse country, it's wheat farming country, and it's a good place to be from.

MULLINS: What kind of work did your father do?

TRUNKEY: My father had gone to college at Eastern Washington College of Education to be a school teacher, but when he graduated he taught school for two months and got sixty dollars a month, and so he quit and got a job with the county, grading roads during the daytime and then worked in a machine shop at night.

MULLINS: Did you have brothers or sisters?

TRUNKEY: My oldest brother died at six months from a congenital heart defect, and then I was the next, and then there were three boys and a girl after me.

MULLINS: Were there doctors or nurses in your family's history?

TRUNKEY: No. I was the first person to get interested in medicine.

MULLINS: What was your mother's background?

TRUNKEY: My mom had gone to Washington State College for a year, and then she met my father and more or less dropped out and got married.

MULLINS: And what year were you born, Dr. Trunkey?

TRUNKEY: Nineteen thirty-seven. It was a good year.

MULLINS: You were raised in this St. John?

TRUNKEY: Yes—well, I actually was born in Oaksdale, but we moved to St. John when I was four.

MULLINS: And how long did you live in St. John?

TRUNKEY: Until I went to college in 1955.

MULLINS: Where did you go to college?

TRUNKEY: Washington State University. It was Washington State College then.

MULLINS: And where was that located?

TRUNKEY: Pullman, Washington. It's also in the Palouse country.

MULLINS: And you went to the University of Washington Medical School.

TRUNKEY: Correct.

MULLINS: How did you end up there?

TRUNKEY: Well, when I was in the seventh grade I was playing football, and we— we played tackle football without pads, and I got tackled, and I hit the clothesline pole and I broke my wrist.

My dad came home that night and took me down to the general practitioner's office, and the general practitioner would go in and read a book and then come out and try to manipulate my wrist, because it was an epiphyseal fracture and it was dislocated. And he kept trying to relocate this wrist fracture, and my dad would hold my arm, and then he'd put me under fluoroscope and try to reduce it, then go read the book some more.

Finally, after about three hours, he found out if he cocked my arm out in an ulnar deviation, that it was reduced. And so in the next eight weeks I would go down once a week to get my cast changed, because I continued to play football and the cast was all broken up by the end of the week, and I decided I was going to be a doctor. I wanted to be—I wanted to go back to St. John and just be a general practitioner, just like this guy. He became my hero.

MULLINS: Did he practice out of his home or did he have an office?

TRUNKEY: No, he had an office, and his wife was the nurse, the lab technician, and the two of them provided care there until I was off at college, and then they moved to Whitefish, Montana, and retired.

MULLINS: Was there a hospital in your hometown?

RUNKEY: No. The hospital was twenty-five miles away, in Colfax.

MULLINS: You're obviously a world-renowned trauma surgeon and you've had your own experience with trauma. Do you remember other experiences in your youth with injury?

TRUNKEY: Oh, yes, yes. My very first job was when I was nine years old, and I was punching wires on a baler. That was a filthy job. But the jobs that I got injured on as a kid—I also built elevators, and I can remember one summer I was building elevators—you start off with two-by-twelves, and then you work up to the top of the elevator. You're up about eighty feet. I fell through the scaffolding and, fortunately, I kind of bounced as I went down and ended up with, really, minor injuries.

Then, I broke my nose seven times; twice playing football, once playing basketball, a couple of times I wasn't minding my own business, and one time I fell off of a truck and broke my nose. So I ended up getting multiple doctors to see me, and, actually, my future father-in-law operated on my nose twice, and he kept telling his daughter that he had taken care of me so that when I finally met her we were all prepared.

MULLINS: I see. Well, when did you meet your wife, Jane?

TRUNKEY: I was a sophomore in college.

MULLINS: And she was in college as well?

TRUNKEY: She was a freshman.

MULLINS: And when did you and Jane get married?

TRUNKEY: When I was a senior in college. We got married that summer. I'd been working in the mines up in Kellogg, Idaho, and she was all tan because she was on an archaeology dig down on the Snake River, and I had been in the mines all summer and I was as white as a pillow sheet.

MULLINS: What was it like working in the mines?

TRUNKEY: Very dangerous. I hadn't been there three weeks and my partner was killed.

MULLINS: What happened?

TRUNKEY: A cave-in. I'd gone out for timber, and I hadn't gone a hundred feet, and I could hear the noise and went back, and he was under ten ton of ore.

MULLINS: Did they extricate the body?

TRUNKEY: Yes.

MULLINS: How would they—would they have a funeral sort of process for a worker killed on the job, or did they just ignore it?

TRUNKEY: They had a memoriam. His body—you couldn't possibly have showed it. It was crushed. I mean, just like an ant on a sidewalk.

I learned a lot from that. We had union representatives that would meet with us every noontime down in the mines, and they would try to convince us to join the Communist party. And they also had—way back in 1926 they had set up a fund for the widow of anybody killed in the mine, and there were nine hundred miners at that time, and when the widow—when Moose's widow got the check, it was for nine hundred dollars, and, yet, there were 26,000 miners then. That kind of irritated me, and I brought that up with the union representative, and I was told in no uncertain terms not to go any further with that.

MULLINS: I see. So—I don't want to put you on the spot, but are you or were you ever a member of the Communist party?

TRUNKEY: No, I never did. I never did join that.

MULLINS: You married between your junior and senior year, or after you graduated?

TRUNKEY: No, between my junior and senior year.

MULLINS: And then how did you decide to go to the University of Washington Medical School?

TRUNKEY: Well, I applied to two medical schools, Oregon and Washington—I wanted to stay in the Northwest—and got accepted at both. I'm not really sure why—oh, I know why, because I got in-state tuition.

MULLINS: So you and Jane moved to Washington—

TRUNKEY: To Seattle.

MULLINS: To Seattle. What are some of your memories of that first year of medical school?

TRUNKEY: The very first day, the dean came in—his name was Blandau—and there were 85 students, 82 males and three females—and he looked at us, and he said, "Look around. One out of five of you will not be here next year." I looked around that room, and I couldn't see anybody that was dumber looking than me, so I *really* studied that first quarter. I mean, I was—that's probably the only time in my life that I spent that much time studying. At the end of the quarter, I was number one in the class, and I coasted from then on.

MULLINS: Where did you do your surgery rotations as a medical student?

TRUNKEY: My first surgery rotation was at the veterans hospital, and that was a great rotation.

MULLINS: Excuse me. What year would that have been?

TRUNKEY: That would have been 1962.

The rotation was great because I got to do a lot. They would let me do bronchoscopies and things like that. I was pretty pushy, and so I got to do a lot, and did a lot of minor surgery, and it was really fun. But at that time, I was headed into internal medicine. The dean had told us that very first day of medical school that the top ten percent of students stayed in academics, the next eighty percent went into specialties and practice, and the bottom ten percent went into general practice. So I guess I thought maybe I should do something like internal medicine. Surgery was extremely weak at the University of Washington at that time. Henry Harkins was the chairman, and there were only two students in my class that went into surgery. But at the time, I was headed into internal medicine.

For an intern to get a vacation, he had to find a student to take his rotation for a week, and so I did three months of that at Harborview Hospital under Bob Petersdorf. He was one of my heroes. I mean, he was so brilliant, and he was such a—he had an encyclopedic mind. At the end of that rotation, he offered me an internal medicine rotation, or an internship, but I—after that three months, it was just too much chronic disease. It just didn't seem like your patients got better. And plus the fact I was spending a fair amount of time in the emergency room at Harborview, and that was more exciting. So I decided then I was going to do a rotating internship.

MULLINS: Can you describe the emergency room then compared to the high-tech ones we have now?

TRUNKEY: Well, first off, it was incredibly crowded. This was pre-1965, Medicare-Medicaid, and so the emergency rooms—I mean, there were just patients stacked on gurneys, waiting to be seen. And, then, interspersed with all of this would be the trauma that they would get in. In 1962, the standard treatment for somebody in shock was to start a Levophed drip. Shire's work had not come out yet, and so I'm sure the outcomes were poor because we probably hurt those patients.

MULLINS: Who were the surgeons at Harborview that were on the faculty, do you remember?

TRUNKEY: Bob Condon was on the faculty. I'm blanking on the guy's name that was the chief resident then. He was a superb surgeon. I mean, he was very, very good, very common-sense approach to things. He ended up eventually being chief of the veterans administration hospital in Seattle.

MULLINS: You decided, then, in your senior year to apply for internships.

TRUNKEY: Rotating internship.

MULLINS: How did you do that at that time?

TRUNKEY: At that time, you went around and did a few interviews. I interviewed at Oregon, I interviewed at Highland Hospital in Oakland, and I interviewed at San Francisco General and I interviewed at LA County.

I was appalled at LA County, just the hugeness of it and the total lack of any supervision for the house staff. When I interviewed—I'll never forget this. I walked into an examining room on the tenth floor of the hospital. It was huge. I mean, it was twenty-two hundred beds at that time, I think. An intern was doing a scalene node biopsy on a woman in this examining room, and she was obviously very uncomfortable having this intern dig around, and he had never done one before, and I just—I found that not what I wanted.

MULLINS: So why did you choose Oregon?

TRUNKEY: I chose Oregon primarily because Dr. Dunphy was the chief of surgery here at that time.

MULLINS: Did you interview as an applicant with Dr. Dunphy?

TRUNKEY: I did, I did. That was an interesting interview. A good friend of mine, a classmate, also was coming down to interview, and he had just got his pilot's license, and he was flying a Piper Cub 150. We started towards Portland—my interview was at three o'clock and his interview was at two o'clock. We were coming down, and we were at a very low altitude because it was overcast and raining. We ran into a storm, and the stall buzzer came on on this little Piper Cub, and so he set it down in a plowed field, and we walked over to the farmer's house, and we were going to catch a ride to finish our trek into Portland. This was up some place by Centralia.

We looked up, and we could see some blue sky, so we got back in the plane, took off, and followed I-5 all the way down, going through that gorge and it was—the stall buzzer kept coming on. Finally, we got there, and Bill was looking around for the airport. There was one out in Hillsboro at that time, and we ended up landing at the wrong airport. He almost crashed because it was a very short field.

We made it here at about four o'clock, and Dunphy had written me off, and then his secretary went in and said that I was here, so he took me in and he interviewed me, and he interviewed me for about forty-five minutes, and at the end of the interview he offered me an internship.

MULLINS: Did you know Dr. Dunphy by reputation prior to that?

TRUNKEY: By reputation. I'd never met the man before.

MULLINS: So you started as an intern here what year?

TRUNKEY: Nineteen sixty-three, July 1. There were no specialty interns at that time. All thirty of us were rotating interns. I think in the first week one of the interns quit.

MULLINS: Where did you work here at Oregon Health and Science University?

TRUNKEY: I would guess sixty percent of the time I was in the old Multnomah County Hospital, which is the North Hospital now, and, then, forty percent of the time in the University. We did not have any rotations through the VA Hospital at that time. They had their own, separate residency.

MULLINS: And can you—did you get to do surgery when you were an intern?

TRUNKEY: My very first rotation was on general surgery. The second day, I was seeing a patient who was in shock, acute abdomen. I got a trach set and did a tracheostomy. I pulled the drapes off, and he was dead. So that was my very first surgery case here.

MULLINS: And what did he die of?

TRUNKEY: He died of a superior mesenteric artery thrombosis.

MULLINS: Who was the staff on that case?

TRUNKEY: There was a first-year resident who helped me do the tracheostomy.

MULLINS: And this was University Hospital North OR?

TRUNKEY: No, we did it in the patient's bed.

And so the rest of the month I got to scrub with—I think I scrubbed once with Dr. Dunphy. Most of the time, I scrubbed with Bill Krippaehne. He was trying to start a vascular surgery service at that time. Vascular surgery had just started to blossom, and so they were doing a lot of vascular surgery. Long, terribly long, cases, because people were learning, and there were problems with the grafts. The homografts would tend to rupture.

MULLINS: Homografts. What were those?

TRUNKEY: Cadaver grafts.

MULLINS: So they'd harvest an aorta from a cadaver and put it into...

TRUNKEY: Yes. Or sometimes they would hand sew Dacron to make a graft.

MULLINS: Was Dr. Krippaehne a patient surgeon?

TRUNKEY: Yes, he was. He was not a yeller. He was very composed in the operating room. It was taking him—I mean, a typical case would last seven hours.

MULLINS: Did Dr. Dunphy have a particular surgical interest?

TRUNKEY: Yes. He was primarily interested—I mean, his academic interest was wound healing, so he loved hernias. But he also had a real interest in biliary surgery. He wrote a lot on that as well.

MULLINS: Did you have a morbidity and mortality conference?

TRUNKEY: Yes, we did. Every Saturday morning.

MULLINS: And how would that be conducted?

TRUNKEY: Dr. Dunphy conducted it, and we would review every death and every complication by service.

MULLINS: So there was an ortho service and a urology service?

TRUNKEY: Yes.

MULLINS: Did Dr. Krippaehne and Peterson and the other faculty participate in that?

TRUNKEY: Yes, they did.

MULLINS: Was it a challenging experience for you residents to go to M&M?

TRUNKEY: It could be. Some of the faculty were, oh, kind of hard-nosed and somewhat argumentative. But Dunphy kind of leveled the playing field, and he would often stick up for the residents.

MULLINS: What was the chief resident's role in this experience?

TRUNKEY: The chief resident usually did the presentation of the cases.

MULLINS: Did the chief resident run the service?

TRUNKEY: Oh, yes, very much so. You could fire a cannon into either hospital and never hit an attending surgeon at night. It was an intern-run hospital. The mortality every July, including my year, went up thirty percent. The most senior person we had in hospital was a first-year resident at night.

MULLINS: And how many chief residents in surgery would there be?

TRUNKEY: There were four then. They rotated through the University. I don't think they rotated through the VA at that time. They also went through Good Sam and St. Vincent's.

MULLINS: At that time, there was some world-renowned surgery in terms of the heart valve being done here. Do you have any recollections of that?

TRUNKEY: Oh, yes. The ICU for that was on what is currently 7-A. There were four beds there, and that's where the cardiac patients went after Dr. Starr operated on them. Rod Herr was the chief resident on cardiac surgery at that time. He probably was the single best technical surgeon in the University Hospital at that time. He was superb.

MULLINS: Did you have an ICU in the North Hospital?

TRUNKEY: No, we did not.

MULLINS: Tell me what would happen if you did a major biliary resection on somebody that was sick with gangrenous cholecystitis.

TRUNKEY: Oftentimes, we would keep them in the PACU, the post-recovery room, usually on a Bird ventilator, and the interns would manage those patients on the Bird ventilator. As soon as we could get them extubated, they went to a ward bed. Sometimes they would refer a particularly sick patient to the ICU, but most of the time those were filled with heart patients.

MULLINS: And this was the ICU in the South Hospital?

TRUNKEY: Yes.

MULLINS: Was there a medical ICU at the time?

TRUNKEY: Yes, there was, and I'm trying to remember where it was. I can't remember which ward it was on.

I'll never forget one patient. This was a recluse from Hood River. He had burned himself, and after a couple of weeks somebody discovered him in his cabin. So they took him to the hospital in Hood River, and they called the surgical service. He was burned over twenty-four percent of his body and he was dehydrated and comatose. They said he was burned, and the surgical service wouldn't accept him. So they called the medical service and advertised him as a case of tetanus. He didn't have tetanus, but they couldn't open his jaw, so they sent him down. I was the intern on medicine.

Here's this guy, he had no discernible breathing, and, yet, you could hear this very faint heartbeat. So I started resuscitating him, and I put him in a bed back at the end of the hallway on 7-A. At that time, I think we treated him with silver nitrate dressings. I called Bob Hodum, who was the second-year resident in surgery, and he came over and helped me do a tracheostomy. By the next morning, he had a recordable temperature around ninety-four, and his heart rate was now up to eight-eight, and he had a blood pressure of about sixty. Then, over the next two days, he started to wake up, which was hard to believe.

Then I tried to get the surgical service to take him, and they refused. So I started debriding him in the—just in the ward, there. After about three weeks, he was completely—his eschar was completely gone, and he was doing very well. Then, one evening he developed an acute abdomen. I called Hodum back, and they took him to surgery. He had perforated his cecum and he became septic post-op and died.

Dunphy heard about this. I wasn't supposed to be going to the surgical M&Ms, but he made a point that I had to be there that Saturday. So the chief resident presented this case, and then Dunphy just looked square at the chief resident and he said, "Why didn't you admit this patient?" That was the first time I'd ever seen Dr. Dunphy really get cross, I mean in public, with a resident, and he really chastised him. It was interesting.

MULLINS: Well, at the end of that year, what happened?

TRUNKEY: I don't remember what month it was. I think it was April. I had applied to the Berry Plan, and that was on a lottery basis. They gave you—well, first off, they said you either were accepted into the Berry Plan for a full residency, or you were accepted into the Berry Plan for one year of residency, or you did not make it into the Berry Plan. And if you didn't make it into the Berry Plan, you got a lottery number.

MULLINS: Let me just clarify that the Berry Plan was offered by the military.

TRUNKEY: It was. It was the combined military, the Air Force, Army, and Navy. They needed a quota of doctors every year, and they had a planning process where they needed surgeons, and so they'd let you do your full training, or they needed a general medical officer and they would take so many of those.

The bottom line was I didn't make it into the Berry Plan, and my number was 104, so I knew I was going to get drafted, and, sure enough, in May I got a letter saying that I had a choice. I could join the Army as a captain or I could get drafted as an E-1 private. Well, that wasn't much of a choice, and so I joined up.

I went down to the Presidio in San Francisco in May on one weekend and met with the man who decided where you would end up, and I chose the Army. I wanted to go to the base outside of Monterey, because my father had just had a heart attack that summer and I didn't want to get sent to anyplace where I wouldn't be close to him. I hadn't been back in Portland four days and I got this letter saying they were sending me to Germany, and that's where I ended up.

MULLINS: So in June, July of '64 you traveled, you and Jane, to Germany.

TRUNKEY: That's correct.

MULLINS: And what did you do in Germany?

TRUNKEY: I was assigned to a dispensary in Bamberg, Germany. Bamberg, Germany, is just north of Nuremberg, and my job, as a general medical officer, was to take care of seven thousand dependents. We were right at the corner where East Germany, Czechoslovakia, and West Germany came together. We had six battalions on our base. Two of them were armor, two of them were infantry, one was an engineer battalion, then we had two artillery. The engineer battalion—all of them had—the artillery and the engineer battalion all had nuclear weapons, and their job was to go up forty miles to the border and stop any invasion coming through the Fulda Gap. But that would have been hopeless. I mean, they would have been overwhelmed by all of the East German and Russian troops there.

I took care of the dependents, and I can remember it convinced me more than ever I never wanted to be a general practitioner, because seventy percent of what I did was not organic medicine. It was psychological, social, pastoral work, economic. It was terrible. It just wasn't what I envisioned medicine to be.

I set up an Alcoholics Anonymous group, because that was the number one problem among the enlisted people and some of the dependent wives, and then I set up an obesity clinic, because that was a problem. I had fun, I enjoyed what I did.

MULLINS: Did you and Jane travel around Europe?

TRUNKEY: We traveled all over Europe.

MULLINS: So at the end of two years...

TRUNKEY: Our son was born there, too.

MULLINS: At the end of two years—well, who delivered your son?

TRUNKEY: That was tough. I mean, it was luck of the draw. They didn't do any deliveries in Bamberg. You had to go sixty kilometers by ambulance to Nuremberg to the 20th Station Hospital, which was an old German SS—in fact, the tile in the entrance had a big swastika in mosaic tile.

She had an obstetrician, a real, board-certified American obstetrician, but the night she delivered, she went in there and there was an Italian national who was—I wasn't very impressed with his knowledge, so I called the obstetrician—he was a lieutenant colonel—at home and said, I'd like to have you come over and deliver my wife.”

MULLINS: Derek was born right there?

TRUNKEY: Yes.

MULLINS: And so what happened after two years?

TRUNKEY: Well, my wife and I had decided to spend the last week of vacation going to Norway, and this was—I think it was the last week in May. I was supposed to get out in the middle of June. Somehow, the MSO officer at the dispensary knew where I was and he got a hold of me, and he said, “Dr. Dunphy has called and has offered you a residency, and he needs to know within forty-eight hours your answer.” So I called Heisig—he was the MSO—and I said, “Send him a telegram, ‘I accept’.” That’s how it happened.

MULLINS: But prior to that, had you been talking with him?

TRUNKEY: When I went in the military that was the same time that Dunphy was moving from Portland to San Francisco, and he offered me a residency at the end of my military commitment. I think I had been a little bit derelict keeping up with that, though. I assumed that it was just open, but until I got that phone call, that was the first firm offer I’d had.

MULLINS: Can you comment about the influence that Dr. Dunphy had as chairman here at—at that time, it was called the University of Oregon, right?

TRUNKEY: I think he had a very profound impact on the surgical training program.

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

TRUNKEY: When he took over in 1959, it was not considered a great program at all. In fact, he really built it. The other thing that he did is he got along so well with the community surgeons, and actually incorporated two of the separate independent residencies into the university program, the one at Good Sam and the one at St. Vincent’s.

He was one of those individuals who was incredibly charming. He had this great Irish wit, and he was absolutely a masterful politician and could work with people. At the same time, he was a superb academic surgeon, and he really made the program incredibly strong. Also, the number of people who applied to it was just absolutely incredible at that time, much more than, say, Seattle.

I think the thing that set him apart from all other surgeons, though, was that he was such a humanist. He really championed the patient, and you had to do what was right for the patient. You didn’t do unnecessary surgery, or you didn’t do debilitating surgery at the end of their lives. He always talked about the quality of life. I think the thing that I learned most from him is when to operate and when not to operate. That was so important.

MULLINS: What was his background, from your point of view?

TRUNKEY: He had a very strong Catholic upbringing in a town just outside of Boston, near Worcester, and he—I don't know how religious Dr. Dunphy really was. I know he was a fairly strong Catholic, but, more importantly, I think he had a background in caring for people. One of his brothers became a pediatrician and ended up as a professor at the University of Iowa. I don't know how many physicians were in Dr. Dunphy's family, but they had a history of going into medicine.

MULLINS: He had a prestigious education.

TRUNKEY: Yes, he did. Trained at Harvard and then tried to get into surgery, was denied that, and so he did a year as a pathology intern at the Peter Bent Brigham Hospital. Bob Zollinger was the chief resident on surgery at that time, and at the end of December, Dunphy went to Zollinger and said that he wanted to—no, it was before Christmas. He went to Zollinger and he said that he wanted to stay in surgery, and Zollinger said, "Well, have you written anything?" He said, "Well, no." He said, "Well, you can't get into Peter Bent Brigham Hospital residency unless you write something."

So Dunphy canceled his Christmas vacation with Nancy and he spent the entire week in the library, and he looked up the cases of superior mesenteric thrombosis and showed that if a patient was admitted to surgery, they had a forty percent of surviving, and if they were admitted to medicine, it was one hundred percent mortality. He took the paper in to Zollinger, I think the second of January, and gave it to him, and Zollinger put his name first and they turned it in, and it was published, and he got accepted into the program.

MULLINS: Who was his chairman?

TRUNKEY: His chairman was a very famous man by the name of Churchill, Edward Churchill.

MULLINS: How did that training go? Did he come out of it, Dr. Dunphy, prepared to be an academic surgeon?

TRUNKEY: Absolutely. It was during his training program that he got his interest in wound healing. He stayed on at Harvard, ultimately ending up, after World War II, at the Boston City Hospital, Boston University, and worked with a guy by the name of McDermott, but he was chief then at that time.

MULLINS: Chief of surgery of the Harvard service at Boston Hospital?

TRUNKEY: Yes.

MULLINS: Did he ever tell you about his experiences in the military?

TRUNKEY: Absolutely. He was a general surgeon. In fact, he and Zollinger were in the same hospital. It was the MGH Hospital, Boston and Harvard Hospital, Harvard unit. He wrote at least three papers on shock management of casualties during his time there. He even lectured in England, because by this time both Zollinger and Dunphy were getting an established name in surgery.

MULLINS: Did he practice surgery? Was he an operating surgeon in the war?

TRUNKEY: Yes, he was. Dr. Dunphy was never what I would call a spectacular technician. He was not a poor technician by any stretch of the imagination, but he was medium speed, mediocre, not flashy at all. But where he stood out hands above anybody else was in surgical judgment. I mean, the guy was absolutely incredible.

MULLINS: So he served in Europe through the end of 1945?

TRUNKEY: That's correct.

MULLINS: And returned to Boston.

TRUNKEY: He was told when he went away that when he came back he would be made chief of surgery at Peter Bent Brigham Hospital, and that was a natural succession, based on his research work and his skill as a surgical educator. But in the meantime, Franny Moore, who was declared 4F because of his asthma, had stayed at Harvard—one of the few surgeons, actually, that stayed on—and after the Cocoanut Grove fire Franny wrote that up. I'm not sure he actually took care of any of the patients, but he wrote it up, and he really got a reputation—that plus his book on surgical physiology—and they made him chief of the Peter Bent Brigham Hospital.

MULLINS: So from '46 through '59, Dr. Dunphy was in Boston?

TRUNKEY: Yes.

MULLINS: Why do you think he came to Oregon?

TRUNKEY: Well, he looked at a job at the University of Michigan, and he was actually—he had gone twice for interviews. He went back a third time—this was to take Fred Coller's place, and Fred Coller was an absolutely incredible person. He eventually trained about thirty professors of surgery, and Dunphy was to take his place. Dunphy was talking to the dean and asked where his office would be, and he said, "Well, you'll take Dr. Coller's office." And he said, "Where will Dr. Coller's office be?" "Well, he won't have an office." He says, "Then I refuse to come here, because I will not work in a university where you do not honor the past chairman." And that was it.

Shortly after that, he was invited to look at the job here in Portland. I don't think it was a rebound phenomenon, but he took the job, and I think—to be very honest with you, I

think the reason he did is because he thought he could build something. I mean, you just couldn't get any worse than it was.

MULLINS: At that time, were there several kingmakers in American surgery that kind of influenced where these people would go?

TRUNKEY: Oh, yes. Franny Moore was certainly one of those people. I would guess that Blalock was a kingmaker at that time.

MULLINS: How about Ravdin?

TRUNKEY: Ravdin certainly, particularly in pediatric surgery, but also in general surgery as well.

MULLINS: So would Dr. Dunphy have consulted with those senior wise men before taking a position?

TRUNKEY: You know, I don't know the answer to that. I don't think he would have with Ravdin. He never had very kind words about Ravdin. You know, Ravdin was such an autocrat. Ravdin had a reputation of demeaning the residents, and that was just contrary to Dunphy's style.

MULLINS: And just to be sure I understand, so from '46 until he came here he was chief of the Harvard service at Boston City.

TRUNKEY: No. He was at Peter Bent Brigham for I'm not sure how many years and then moved over to the Boston City when Franny was appointed chief.

MULLINS: And he arrived here and was here and then moved to San Francisco.

TRUNKEY: Yes.

MULLINS: And, Dr. Trunkey, you joined him in San Francisco in the summer of '66?

TRUNKEY: That's correct.

MULLINS: How did that go?

TRUNKEY: Well, my father-in-law had been trained in eye, ear, nose, and throat, and he wanted me to come back to Colfax and practice with him, and he was putting a little pressure on me, and so I kind of vacillated. He actually had called Hopkins. Johns Hopkins had the best reputation at that time for eye surgery, so he actually talked to Kaufman, and Kaufman called me and offered me a job. But I went to Dr. Blaisdell, because I really, truly loved general surgery, and Blaisdell—we hadn't talked five minutes, and in no uncertain words he told me what to do.

MULLINS: So we're talking about you as a first-year resident at—

TRUNKEY: I was at San Francisco General at that time.

MULLINS: Is that where you did most of that training or did you also go up to Moffett?

TRUNKEY: I went up to Moffett. I was on Dr. Dunphy's service in November and December of that year, and then you also had to rotate through one of the private services. But then I also went to the VA. Our favorite program—I mean, the residents loved to go to the General or to the veterans hospital because you were more autonomous.

MULLINS: And Dr. Blaisdell ran—was the chief of surgery at the General Hospital?

TRUNKEY: Dr. Blaisdell started July 1, 1966, at San Francisco General Hospital. He had been at the Veterans Administration hospital in San Francisco as chief, and they incorporated that into the residency, and he was given the job as chief of surgery at San Francisco General Hospital.

Now, this is 1966, and so Medicare was on board, and all of these older people who had traditionally come to the county hospital no longer did that. Blaisdell asked, "Well, what can we offer the city that is really unique?" Trauma. So starting in July of '66 the ambulances brought all trauma patients, based on Blaisdell's promise that there would always be a surgeon to take care of the patients.

He only had one other surgeon on the staff at that time, and that was Tom Hunt. Then he was able to co-opt a private surgeon, Bill Herr, to also help out. So by the time I had finished my rotation, we had three staff surgeons. That was remarkable in those days, to have an actual attending surgeon that would come into the hospital at night.

MULLINS: So from '66 to when did you get your training as—

TRUNKEY: I did a year of laboratory work with Fred Belzer in '69, and I finished the program in '71.

MULLINS: Did Dr. Dunphy ever come to San Francisco General?

TRUNKEY: When I was chief resident in January and February of 1971—that was my chief year. I did four months there, two months on elective and two months on trauma. It was traditional by Blaisdell that when you were chief resident you were able to select a visiting professor to come and spend a week, and the visiting professor would actually live in the 320 Club, which is where all the surgical residents slept, and that person would scrub on all the cases. So I asked Dr. Blaisdell to invite Dr. Dunphy, because Dunphy was chairman of the American College of Surgeons at that time, the board of regents, and he was also—he had one other national post. So he was traveling all the time, so we didn't get an opportunity

to really spend some time. So Dunphy set aside a week, and he came over to San Francisco General to be the visiting professor.

MULLINS: Well, how did it go, Dr. Trunkey? Did you have any cases?

TRUNKEY: Well, see, you have to—in 1966, when I started my residency, there were about a hundred to two hundred penetrating wounds a year at San Francisco General. By the time I was chief resident, we were getting a thousand gunshot wounds a year. The city was so violent because of Haight-Ashbury and all the drug trafficking.

Dunphy was up unpacking—this is three o'clock Sunday afternoon—and we had a stab wound to the heart. So I opened his chest in the emergency room, put my finger on the hole, and I had the nurse hold the phone for me. I said, "Dr. Dunphy, I'll meet you in the west amphitheater. We have a stab wound to the heart." By the time we got the patient there, Dunphy was standing there. He had already changed into his greens. I said, "Dr. Dunphy, I would be happy to help you with this case." And he was absolutely ecstatic. I mean, here he was, he was repairing a stab wound to the heart.

I'll never forget this, because this guy had really long hair and was really scruffy looking, probably right out of the Haight-Ashbury. Anesthesia in those days, you know, if you were stable at the end of the case, they extubated you. They did that, and the minute this tube came out of his trachea, this guy started swearing and yelling and clearly was on drugs. Dunphy said, "I'm not sure we did the right thing here" [laughter].

Then it was just downhill from then on. We operated all Sunday night, and Monday morning Dr. Dunphy was supposed to help with elective cases. He went to bed for about three or four hours and then got up and helped with a common duct exploration with a fourth-year resident, and then he had just gone back up to the 320 Club and we got this guy who was a twenty-one-year-old guy who was shot in a liquor store holdup. He was the son of the owner of the liquor store.

He came in basically moribund, and he had had two .357 magnum wounds. One had gone through the aorta, the inferior vena cava, into his right kidney. We got him resuscitated, did the surgery and were now into him about thirty-five units of blood, and he's cold and coagulopathic. So we took him to the ICU, and the next morning—oh, we had a couple more stab wounds that night.

Blaisdell came in the next morning, and Dunphy and I were making rounds in the ICU, and he said, "When are you going to take him back?" And Dunphy said, "I don't think he needs to go back." And Blaisdell says, "Yes, he does." Because it was routine then to do second looks. That was the one thing you learned from Blaisdell. So Blaisdell and I took him back to surgery, and Dunphy got up from bed—this was about noontime—to come down. The night before, we had done a medial visceral rotation to get access to the aorta, because the wound was near the renal artery and so we had had to mobilize the viscera to the right side of the patient. We must have thrombosed the splenic artery, because when I

reached in to repeat that maneuver in that second-look operation, the spleen just fell out in my hand. And Dunphy said, “Well, now I know why you guys do second looks” [laughter].

The bottom line is that kid, he was so sick. He lived nine months in the hospital, and it was about that time George Sheldon came back from his lab year, with time at Peter Bent Brigham, and became an attending, and I think he was the first patient we ever did TPN on, and he lived, and he lived and lived, and then he died of sepsis at nine months. It was so sad, because his family were so devoted and such nice people.

MULLINS: So trauma has been a tough business through the years, Dr. Trunkey.

TRUNKEY: Oh, yes. Well, I went away and did the NIH fellowship at Parkland Hospital with Tom Shires, because I just knew what I wanted to do for my surgical career. I wanted to stay in academics, I wanted to teach, and I wanted to do trauma. So I knew that it would be better if I had additional training, and particularly if I could get some research training. So I spent a year with Tom Shires at Parkland. Of course, that place is even a bigger zoo than San Francisco General Hospital, but that was a good year.

Then, I looked at three jobs at the end of that year. I looked at a job at Cincinnati with Altemeier; I looked at a job with Dave Sabiston at Duke. Altemeier was really at the end of his career and was already showing signs of maybe a little dementia. It was sad, and I just didn't want to do that. And Sabiston was such an autocrat, I just knew I wouldn't be happy there. So I came back and worked at San Francisco General Hospital for the next fourteen years.

Initially, it was—you know, you were on trauma every third month, then you did elective surgery for a month, and then you did dirty surgery for a month. Dirty surgery was a rotation where the chief resident was a third-year, and you did all of the abscesses—the diabetics, the drug addicts—and then you did all the burns and you did all of the hand injuries. That was a great chief resident role for a third-year resident.

On the elective surgery, we would—at that time, we were getting about fifteen-, sixteen hundred cases a year, and these were always advanced disease, because San Francisco was an immigrant community, and so anybody from, say, Vietnam or Cambodia or the Far East, India, when they came through and started their life in the Bay Area, they had to get their medical care at San Francisco General. So we would see lots and lots of tuberculosis, cases of Hansen's disease, and it was a phenomenal elective surgery practice. Incredible.

MULLINS: So up to this point, and we're now the mid-seventies, you'd been strongly influenced by two leaders in American surgery, Dr. Dunphy and Dr. Shires. Can you just compare and contrast them as chairmen, as leaders of departments?

TRUNKEY: Shires was an individual where everything had to be done his way. I'll never forget the first night I took call at Parkland Hospital. A guy came in with a perforated ulcer, and I did a vagotomy and a gastrojejunostomy and over-sewed the ulcer. And, boy,

that Thursday at M&M Shires created a new orifice for me. I violated his tenet, which was you did a subtotal gastrectomy. I mean, you just didn't deviate from that.

It was so—I mean, his style was so different than Dunphy's. On Dunphy's service—as a resident, you worked up the patient, you presented it to Dunphy, and—you knew what he liked to do, but sometimes you would say, “I would like to try this.” He would say, “Fine, let's do that.” It was a real learning experience.

MULLINS: Are you saying you never had cross purposes with Dr. Dunphy as a resident?

TRUNKEY: Oh, a couple of times, but—I think you got more trouble from Dunphy if you hurt the patient. I'll never forget, he—it was so characteristic of him. We had this patient who came in to San Francisco General Hospital, and one of my colleagues—this patient had carcinomatosis and had a bowel obstruction—he went in and did a colostomy. It was a rectal carcinoma. Dunphy was absolutely livid. He said, “What have you done? This patient is going to have pain for the rest of their life. You have done nothing for his bowel obstruction. All you've done is to make sure that he will be in pain the rest of his life.” That was the quintessential spirit of Dunphy. You did not hurt the patient.

MULLINS: I think both Dr. Shires and Dr. Dunphy were chairmen for decades.

TRUNKEY: Yes.

MULLINS: How would you compare them in terms of producing a generation of academic surgeons?

TRUNKEY: Oh, night and day. I don't think Dr. Shires has trained very many professors, whereas Dunphy has trained a tremendous number of people who stayed in academic surgery and did well. The other love that Dunphy had besides protecting the patient was just simply—he was a superb educator.

MULLINS: Can you be a little more detailed? What do you think was the key to his success?

TRUNKEY: I think that he set by example how you conduct yourself from a professional standpoint. Bedside rounds: I don't think I ever walked around with Dr. Dunphy where he simply didn't just take the time to touch the patient. He would hold the patient's hand or he would put his hand on their shoulder, and he would talk to them on rounds. Those simple things. I don't think I ever had a single patient that Dr. Dunphy cared for that they didn't remember him.

MULLINS: How about in your own case? How did you decide to become an academic surgeon?

TRUNKEY: Well, I think it was kind of a reverse role model.

MULLINS: You told us your father-in-law wanted you to go practice with him.

TRUNKEY: Well, I knew—I didn't think I'd be very happy in ophthalmology, but Bill Herr, who was the private doctor who came over from Franklin Hospital—it was then Franklin Hospital, it's now Ralph K. Davies—to help the residents and take trauma call at San Francisco General Hospital, the poor guy was absolutely bored to death with his private practice. You do a thousand gall bladders and then you do a thousand and first, it's not very exciting. He said, "Don, look at the private practitioners here in town. They all have a hobby. They either fly, they go fishing, or they do something. They're bored to death." He says, "If you want to stimulate your mind, you stay in academic surgery."

MULLINS: Did Dr. Dunphy provide you advice about an academic career?

TRUNKEY: Oh, yes.

MULLINS: What kind of advice?

TRUNKEY: Well, I went and saw him in December of my chief resident year, and I said, "Dr. Dunphy, I've thought this over." I said, "I really think I want to stay in academic surgery." And he said, "Well, what do you want to do?" And I said, "Well, I would really like to do trauma." He says, "Well, there's only one thing to do." And he got on the phone right then, and he called Tom Shires, and he says, "I want to send somebody down July 1. Can you take him?" "Yes." And that was it. I didn't have any choice in it [laughs].

MULLINS: So you returned in the mid-seventies to San Francisco and began to develop an experience and an expertise as a trauma surgeon.

TRUNKEY: Yes. I had some interesting vignettes. The first is, I came back, and I was convinced that these patients who came in moribund or dead, that the secret to resuscitating them was to put them on cardiopulmonary bypass. So I got the Travenol detail man to give me some Travenol membranes. So I think—I did about fourteen cases. These patients would come in without vital signs, I did femoral-femoral bypass, and, you know, it—well, after fourteen of these I had fourteen deaths. None of them, none of them, none of them got anything back. Nothing at all. Blaisdell called me up to his office, and he says, "Trunkey, no more cadaver surgery, okay?" So that was it.

MULLINS: So were you working for Dr. Blaisdell when you came back?

TRUNKEY: Yes.

MULLINS: And how was that as a faculty versus as the resident?

TRUNKEY: Well, Blaisdell, when he was my mentor as a faculty member and I was a resident, you'd go around to see your patients, and he had always, *always* been to that patient's bedside before you. And you knew it, because he wrote all of his notes in green

ink. And if everything was okay, that's what he would say in his note. But if you weren't doing what he considered the right thing, he would say, "Cut now." And he would write that on the patient. I mean, he'd write it in green ink, and he'd show where he wanted the incision to be. I mean, he was trying to show us that, number one, he knew more about the patient than you did, and, two, he had been there before you, and you better get cracking on doing something.

He was very much of an in-your-face kind of guy. And ninety percent of the time he was right-on. Now, ten percent of the time he would shoot from the hip and it wouldn't be so good. But he was a hard charger.

MULLINS: Now, when you were a faculty member, how did he handle you?

TRUNKEY: He treated me like a son, and it was remarkable. I thought I had a second father. Of course, I felt the same way about Dunphy. It was just a totally different relationship as a faculty member. I guess the word that would epitomize his relation then was nurturing. He wanted me to succeed.

MULLINS: At that time, that was an exciting time in American trauma surgery.

TRUNKEY: Oh, it was absolutely incredible.

MULLINS: There were a number of you young surgeons kind of setting the new set of rules; is that correct?

TRUNKEY: Yes.

MULLINS: What were some of your experiences as a young academic surgeon kind of discovering?

TRUNKEY: Well, let's see. I started in '72, and 1976 was when the first optimal criteria book came out from the American College of Surgeons. That was a disaster. The reason it was is the committee that put that together was made up of I think about three docs, surgeons in private practice, and the rest were all academics, and they based the whole classification, level one, level two, as to whether or not you were in an academic center or not. And all that did was just cause intense heartburn out there. So it was not great.

Then, in '79, in the next iteration, we changed it. The level ones and twos were ostensibly the same as far as caring for patients, and the main difference was the academic goals of teaching and research in the level ones.

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

MULLINS: In the late seventies, early eighties, your career is emerging as a leader in trauma care. Could you comment about the role of the Committee on Trauma in the American College of Surgeons in bringing about changes?

TRUNKEY: Well, the College at that time, and to some extent now but not as much, was very, very conservative, incredibly conservative, the leadership and the Board of Regents, and certainly the Executive Director at that time was almost impossible to deal with. He just didn't want to change.

MULLINS: Who was that?

TRUNKEY: That was Rollo Hanlon. He had taken over the College from Loyal Davis, who had run it for years, and it had gone into disrepute. But the bottom line was Rollo is an incredibly autocratic, very conservative individual, and he didn't want to rock the boat.

The Committee on Trauma, as you implied, were these young people who were doing trauma surgery, and they wanted to change the way we provided trauma care in the United States. There were so many things we wanted to do. ATLS [Advanced Trauma Life Support program] came on, and then we wanted to translate that into foreign languages, and then we wanted to have a registry, a national registry. We wanted to go around and review those programs that had been appointed in the various states as level one or two centers and then verify them. There were just a number of programs that we wanted to get up and going, and we met absolute, incredible resistance.

ATLS, it took almost a year to get that through the Board of Regents, and then they finally approved it and that came in in '81, and we started teaching the course, and that was good. And at the same time, we changed the optimal criteria. We took on some tough issues there in regards to transport: Who is responsible? Is it the referring physician or is it the receiving system? So there were a lot of things going on.

In '82 they made me chairman of the Committee on Trauma.

MULLINS: How did that come about?

TRUNKEY: Well, I'd gone on the committee in 1978, and, for reasons I'm not sure, I immediately became chairman of the education committee, and then also on to the 1979 and the 1983 optimal criteria booklet.

But what was frustrating this—the way the committee structure worked—is the chairman of the Committee on Trauma did not get access to the Board of Regents. It had to go through an assistant director, and this was an old navy orthopedic surgeon, and he was a nice guy, but he wasn't in any way going to take on Rollo Hanlon, I can tell you that; Rollo could veto any business item that you had capriciously; and then, if you ever did get it to the Board of Regents you had only one person on the board at that time who understood trauma, and that was Tom Shires. It was kind of like you were yelling into a canyon, and there was no echo. So it was really problematic, and we were frustrated on the Committee on Trauma.

So in September of '83 I flew back to—from San Francisco to Chicago on my own expense, and I had a one-hour meeting with Dr. Hanlon, and I said, “These are the things that the Committee on Trauma wants to do. I’d like to have your blessing, and we can move ahead on these things and get it discussed by the Board of Regents,” and things like that. Well, he just sat there and nodded his head. And so I went back to San Francisco, wrote a letter outlining these are the six things we want to do over the next year, and stuff like that, sent it—and this was in September, and the College met in Chicago that year.

I went back there, and people came up and said, “You’re in real trouble. You have challenged the authority of Rollo Hanlon.” And so—and they said, “They’re not going to appoint you for your second term as committee chairman. And so, well, that’s—life is like that. About two weeks later, I got a letter stating that I had been reappointed as chairman and that I was to meet with Dr. Hanlon and the Board of Regents in February and I was to bring the executive committee of the Committee on Trauma.

Well, I went back—this was February 9, or something like that. It must have cost the College twenty-thousand dollars to fly all of these people in, and they proceeded over the next six hours to slap my wrist. Howard Champion and I got a \$600,000 grant from the Robert Wood Johnson Foundation to move the trauma registry that we had started in Washington, D.C., to Chicago, move it lock, stock, and barrel, and this was the startup cost, and Rollo had canceled that. Just pure, you know, maliciousness he had canceled it. We were not to verify hospitals, we were not to—we were not to translate ATLS. I mean, basically we were told “Stop in your tracks.” So the next two years were just kind of repair work, and finally within that period of time we did start verifying and we did start translating.

But, you know, it was just kind of a—if I had been a better politician, maybe we could have—but I didn’t think I had done anything offensive.

MULLINS: But the question relates to you felt it was important to work within the College of Surgeons venue, or organization, to try to bring about change.

TRUNKEY: Absolutely, because you have to remember at this time emergency medicine was starting to really build up a very strong base, and my sense was that they would have been more than willing to handle the trauma problem as far as the emergency room goes. And I thought, quite frankly, you should have a surgeon down there.

MULLINS: Well, can we get back, then, to Dr. Dunphy? What’s his advice to you during all of this?

TRUNKEY: Well, unfortunately, it was at about this time that Dr. Dunphy—when he was here in Oregon, he had had a rectal exam and had a nodule, and I don’t know what happened, if they biopsied it or anything. I really don’t know. But in '84, he developed some rib pain, and they biopsied that, and it was prostatic cancer. He got radiated, and then he had the most terrible consequences of the radiation. Here’s a guy who had championed good cancer care, good quality of life care, and now he’s in the situation where he had two

episodes of septicemia and he was having tenesmus all the time. It was just very sad. Then he developed overwhelming metastasis and died. It was a bad time. It was just...

MULLINS: How about Dr. Blaisdell?

TRUNKEY: Blaisdell was incredibly supportive. I think he thought I was a little bit rambunctious sometimes, but he never once didn't support me.

MULLINS: Did Dr. Shires have any advice for you?

TRUNKEY: Yes. Cease and desist.

MULLINS: Well, it's about that time that you're looking at Oregon. Can you tell us about the sequence of events that led you to become chairman of Oregon?

TRUNKEY: Well, this was at the time that Paul Ebert was stepping down as chairman of the Department of Surgery at San Francisco, and in a sense I thought that I was an internal candidate to be chief of surgery there, but I had publicly criticized the dean of the School of Medicine. He was a womanizer, and he couldn't have possibly gotten away with the kind of things he did now as he did then. But I had publicly criticized him for this, and I may have been a little bit brash about that. But anyway, the bottom line, I knew there was no way that he was going to appoint me Chairman of Surgery. So I looked at about seven jobs: San Diego, Lexington, North Carolina, Denver, Nebraska, and Oregon. I almost took the job at Lexington, but fortunately I didn't.

MULLINS: Lexington, Kentucky?

TRUNKEY: Yes, University of Kentucky. The reason I wanted to go there was because it was a department that had really hit bottom, a little bit like Oregon. That failed, because I just didn't have a sense that the dean at Lexington was being totally honest with me, and when I—and subsequently, in six months they fired him. But anyway, the bottom line was I came up here and I dealt with John Kendall.

John Kendall is probably one of the most fair, honest people you could possibly have. He was incredibly honest, very straight forward. If John Kendall promised you something, he'd do it. So I had a good relationship with John, and so I took the job. It just looked like an opportunity to build something.

MULLINS: What were some of the factors that made this job attractive, from, like, a technical point of view?

TRUNKEY: Well, the year before I came, in '85, there were two general surgeons, Dan Lowe and Clare Peterson. They had collected \$88,000. That's an embarrassment. Nobody was doing general surgery. Bill Fletcher was doing most of the surgery, but he was chief of oncology at that time. It was just a bunch of fiefdoms, just out of control. Three of the fiefdoms, plastic, cardiac, and ortho, were on probation—or, neurosurgery, I'm sorry. It

was neurosurgery, ortho, and cardiac were on probation from the RRC [Residency Review Committee]. So there was a lot of work that had to be done. I said, “This is what I want to do.”

MULLINS: I have a picture of you and Dan Lowe meeting. Can you tell me about Dan Lowe and you meeting?

TRUNKEY: Well, Dan—Dan was basically a good guy. I mean, he had his heart right, but he just was the worst politician you could possibly have. He would get into a room, and he would immediately polarize everybody else in that room against him, because he never—when he would argue with somebody, he would never put himself in the other person’s shoes. He wouldn’t try to understand where they were coming from. It was like putting out fires in a wheat field. You know, you just kept going from one fire to another.

MULLINS: Dr. Trunkey, in 1979, you were one of the authors of the Orange County paper that said that when they implemented a trauma system, preventable death rate dropped. A year or two later, Dan Lowe repeated essentially the same study here in Portland and showed the same result. Did he seek your consultation on that?

TRUNKEY: I had actually come up here in ‘82, at the invitation of Bill Long, and I spoke in this very building to the Portland Surgical Society in regards to how to set up a trauma system. I gave them some of the Oregon County data, but then I showed what we were doing around the country through the College with the Committee on Trauma at that time and strongly encouraged them to move towards a trauma system. Bill took the leadership there, too, to get it through the State Legislature.

At that time, Dan asked me about the Orange County study, how we had done it and everything like that, and it was shortly thereafter that he went ahead and did it.

MULLINS: So was Oregon Health & Science University a trauma center when you became chairman?

TRUNKEY: Absolutely not. I got here on April 1, which everybody says was proprietous. Anyway, the...

MULLINS: April 1, nineteen eighty...

TRUNKEY: Eighty-six.

MULLINS: Eighty-six, thank you.

TRUNKEY: At that time, the University Hospital was on divert fifty percent of the time. I’ve still got the record for the first part of that year on my desk. They weren’t committed at all. And the number one reason they were on divert was OR availability; number two was CT scans; but number three was no surgeon. I mean, there just was no commitment.

MULLINS: So how did you bring about a change?

TRUNKEY: Well, the first few months that I was here I was taking a hell of a lot of call, I remember that. And I was doing a lot of general surgery. I was operating both at the VA and at University. One of the reasons was to provide general surgery support for the medical service and show that general surgery was alive and well, and the second reason is I was able to get five new positions from John Kendall to start recruiting, but there was only thirty thousand dollars per position. So all of the money that I was making on surgical fees was going into a pot so that I could support people as I recruited them.

MULLINS: The health division of the State of Oregon decided to designate five hospitals in Portland as trauma centers. Was that about the same time that you arrived?

TRUNKEY: Yes.

MULLINS: OHSU became one of them.

TRUNKEY: Yes.

MULLINS: How did that go in the next year and a half or two before that first site survey?

TRUNKEY: I think it was exceedingly politic and fractious.

MULLINS: Here at the University, were the majority people in support of it being a trauma center?

TRUNKEY: No.

MULLINS: So how did you bring about change? Because, Dr. Trunkey, we're a trauma center today.

TRUNKEY: I think that the most positive thing that happened was that once we made that commitment and I said—I told the hospital administrator and the chief of the medical staff, I said, “We are not going to go on divert unless you talk to me.” So we immediately fell—I think over a three month period we fell to zero divert. Then the amazing thing that happened is the OR became busy, and the nurses in the operating room loved it. And the other thing that happened is the nurses in the ICU: “This is great. We're taking care of young people, they're getting better,” you know, and stuff like that. So it just changed the morale and the tenor of the hospital, I think.

MULLINS: There was a site survey, I think, in, what, late '87?

TRUNKEY: Yes, I believe that's right.

MULLINS: When they decided to go from the five hospitals to two. Do you have a recollection of that experience?

TRUNKEY: Again, it was very fractious, because I think the intent at that time—and again, speaking from the College standpoint, it would have been optimal if there had only been one trauma center, much like Harborview in Seattle, because the volume at that time was such that they could do it. To be very honest with you, I don't think the University could have been the single level one, because at the same time that we were trying to build up trauma I had recruited somebody to do liver transplants and we were changing over our cardiac program. The bottom line is I don't think we could have done it, because we just didn't have enough ICU beds, and so having two level ones was okay. It didn't make everybody happy, but that's the way it was.

MULLINS: Did the other three that weren't designated indicate any disappointment to you or bring any pressure to bear on you?

TRUNKEY: Yes, they did. I think they were all, number one, disappointed, because they had gone through the process of getting surgeons being available during the previous year, and so they were clearly disappointed. I also think they thought it was all politically determined.

MULLINS: And so over the years, how do you see the trauma program as sort of a strategic decision? Was it a good idea for OHSU to get into that?

TRUNKEY: Oh, I think it was absolutely imperative that we got involved early on, and the reason is, is because of what it did for the hospital in regards to having excited nursing staffs, and as we recruited more surgeons, they got involved. And, as you know, having an active trauma service is also helpful to transplant. But it just—it set the tenor, if you will, for the other programs.

Now, having said that, urology and vascular surgery were strong from the very beginning, when I got here. John Porter had run a great vascular surgery program, and John Barry had run, I think, an outstanding urology program. But the other programs were in big trouble.

MULLINS: So was it a gradual transformation of a lot of people sort of adjusting? I'm trying to understand your perspective of how changes occurred at the University.

TRUNKEY: Well, inevitably, you have to make some tough decisions, and in regards to neurosurgery, ortho, and cardiac I made some tough decisions.

MULLINS: Would you want to elaborate on those?

TRUNKEY: Well, we got new program directors, new chiefs. And in two instances—well, in one instance it went extremely well. I met with one of them, explained

what I was doing. I said, “You’re on probation.” And he just said, “Oh, you’re a godsend.” He says, “I want out of this.” So he welcomed a change.

MULLINS: Was that Dr. Paxton?

TRUNKEY: It was. And he’s been a friend ever since. A good friend.

Ortho and cardiac did not go well. It was very confrontational.

MULLINS: How about leadership at the top, the hospital director and the Dean and the President? As a chairman trying to implement a change, how do you interact with the leaders at the top? What are some of the things you did that were successful?

TRUNKEY: Well, the hospital administrator when I came here was Dave Witter, and I don’t know how long Dave was here. Maybe until ‘89, ‘90, something like that, and then Tim Goldfarb took over. I always had great relationships with Tim. Initially, Dave was ecstatic, because the revenue for the department started going up arithmetically. I think the year I got here, at the end of ‘86, the department had collected about four hundred fifty thousand dollars, and the next year we were almost two million, and then it just kept going up every year after...

MULLINS: So did the hospital revenues go up?

TRUNKEY: Oh, absolutely. They went up really fast.

Then, I don’t think John Kendall and I ever had a bad word during his deanship. He was very, very good.

MULLINS: And at the very top, the President of the University, what role did he—

TRUNKEY: Laster.

MULLINS: ...have?

TRUNKEY: Well, he was somewhat instrumental in my recruitment, because he even called Hatfield’s office, and Hatfield called me and encouraged me to come.

But Laster was a weird duck. He was more interested in research than clinical care. Now, having said that, I think he was important to the University because he was the one that got the Vollum Institute off the ground, fundraising through the Vollum, and was able to recruit basically a nucleus of neurobiologists that was going to attract more NIH dollars. And it’s done exactly what he said it would do.

And, subsequently, out of that came more research dollars under Kohler’s leadership. Both Laster and Kohler are non-clinicians, and so in some respects clinical programs suffered under both of their leaderships.

TRUNKEY: Now, you've traveled the country, and the world for that matter, visiting universities. Would you just want to comment on a successful formula for a university here in the United States in the new millennium?

TRUNKEY: I think you have to divide the universities into private universities and state-run institutions. You know, I don't think there's any question that some of the best academic institutions from a pure research standpoint are some of the private hospitals: Harvard, Stanford, Johns Hopkins. They do very well. Now, that doesn't say that state institutions can't do it either. I think the University of Washington, UCLA, Michigan are all examples of very well-endowed state institutions. And that comes about by leadership, vision by the legislatures to fund it at an appropriate level.

And, in all candor, Oregon has never funded this medical school at a very high level. In fact, it's gone down, I think. Eleven percent when I got here, and it's now down to four percent of the total budget comes from the state. So it doesn't have the vision, I would say, that the legislature in Michigan or, say, Washington State have.

As a state-run institution, though, your primary mission is to train more doctors, clinical doctors for that state. That's how I would guess that most state legislatures view having a medical school in their state. You're going to turn out doctors for the state. And, you know, we've gone through that as far as family practice goes. Turn out more family practitioners; we don't need specialists. But as we go into 2010, we're going to need surgeons. We have a major shortage here right now, because when the baby-boomers hit sixty-five, they're going to need surgery, they don't need a family practitioner.

MULLINS: Is it an irony that the state government has withdrawn its support progressively over the years—I assume you've seen it virtually every year, is that correct, that you've been here?

TRUNKEY: Yes. But it's been—

MULLINS: And, yet, the university has prospered. It's grown in size. How much bigger is it today than when you arrived?

TRUNKEY: Well, in my opinion, our medical system is broken. It's become a for-profit system instead of a nonprofit system. And the engine that drives the medical school now, quite frankly, is the hospital. That's the source of the income. And there are a lot of problems, with that, a lot of problems. The other thing, though, is that the old state system—and I think Kohler was right in forming this public corporation, because that got us out from underneath the State's employment policies and also out of the purchasing policies, so it made us more competitive, if you will, with other hospitals as far as cutting costs and being competitive. On the other hand, losing that State oversight I think also reinforced to the Legislature that they could reduce the budget essentially to nothing if they wanted to.

MULLINS: Well, you were chairman at that transition point when OHSU became a public corporation.

TRUNKEY: Yes.

MULLINS: Did that make your job easier or more difficult?

TRUNKEY: Both. I mean, I think we benefited somewhat from the contracts that the State imposed upon us. On the other hand, that was at the same time that HMOs came in. Between 1986, when I became chairman, and 1994 I had absolutely the greatest time I've ever had in academic medicine. And the reason is, is because you could build. And if you provided good care, you could put money into some of your research programs, you could recruit. HMOs ruined that, absolutely ruined it. And, then, HMOs is what made hospitals greedy, and it's, quite frankly, what made doctors greedy. So it's—that was a pivotal change in American medicine.

MULLINS: You talked about how when you came to OHSU there were fiefdoms. How did the fiefdoms work out? Your majesty [laughs].

TRUNKEY: Well urology has continued to thrive; vascular surgery lost its leader a few years ago. I think Dr. Moneta has done a good job, but he is not a John Porter. John had a national visibility. He was a curmudgeon, but you know something? He was a very good academic surgeon. If you just got over that gruffness and some of his gender biases, he was a good guy.

MULLINS: What I'm getting at is, was there a consolidation of power? What I'm really getting at is, let's talk about the practice plan.

TRUNKEY: Yes. Well, the practice plan had been introduced back in 1974, but it didn't go anywhere, except for Al Starr, for years and years. In pediatric surgery, for example—I mean, pediatrics is always underfunded from a physician standpoint and from a hospital standpoint, so they weren't very successful in being able to bring in dollars to their division or to the hospital. Now, the children's hospital has changed that somewhat, but it's still underfunded compared to the adult side of things I think.

I guess what I did to change things is I installed an M&M modeled after what Dr. Dunphy did where every division every week had to present all their deaths and complications. To be very honest with you, I taxed the divisions based on their ability to produce dollars. As a consequence, I was able to shift some dollars around within the departments so that we could recruit. That became very important in pediatric surgery, and it actually became very important in plastic surgery.

MULLINS: In the mid-eighties there were multiple billing groups, and over the last fifteen, twenty years they've been consolidated into UMG. Was that a good or a bad thing?

TRUNKEY: Both. I think it was a plus, because when you consolidate, in theory what we were headed for is that the hospital and OHSU MG would bill simultaneously, possibly even one bill, which would have made the insurance companies extremely happy. But having fragmented bills from various divisions was absolutely a terrible concept, because if you were effective with your billing, that whoever went in first, you got rewarded. People who for reasons—trauma was a classic example. You were dependent on personal injury protection, you were dependent on getting them onto Medicaid, you were dependent on a lot of things. By the time you got funded, you got one cent on the dollar. So that was a problem.

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

TRUNKEY: Another problem, from the patient's perspective, was the loss of continuity of care. What it's forcing almost all specialties to do is to do shift work in order to meet the eighty-hour—well, when we have to meet fifty-six hours, like they do in Great Britain, or forty-eight hours, like they do in Germany, it's going to be even more aggravating.

We're going to have to evolve. We're going to have to come up with a shift-work model where we still can maintain continuity of care. And I think you're going to have to have overlap of the various teams as they hand off the baton. It's going to be tough, it's going to be very tough.

MULLINS: What are your observations on medical students in the new millennium compared to forty years ago?

TRUNKEY: Every generation has a personality, and I'm not very impressed with the Y generation and their commitments. This is expressed not only in their commitment to, say, patient care, continuity, but their commitment to their country. Look at the problem we're having in the military now. We cannot get military physicians and surgeons. I find this an anathema.

MULLINS: How is the education of a medical student different today than, say, when you were a medical student?

TRUNKEY: I think that when I was a medical student we had very few electives. You had core courses that you were expected to participate in and to master. We had gross anatomy for a full year, we had physiology for a full year, we had biochemistry for two out of the three quarters, we had pathology all year. Those were the fundamentals. That was the ABCs of medicine; I mean the reading, writing and arithmetic, if you will.

Now the medical students, for all kinds of reasons, are getting extraneous information during these years, things that we never even would have considered as part of the core material. Is that making them better doctors? Well, my interpretation is we have not measured it. We don't know if what we're doing now in medical education has had a plus or a minus.

MULLINS: OHSU is frequently cited as one of the leading primary care training institutions. Was that your impression of the medical students when you were chairman?

TRUNKEY: It became my impression. The push towards family medicine didn't really start, I don't think, until about 1988, '89, and then it became a big push.

MULLINS: Were you able to still find students interested in surgery when—

TRUNKEY: Well, it was shortly thereafter that Surgery started teaching gross anatomy.

MULLINS: How did that happen?

TRUNKEY: Because Cell Biology that had it had done a miserable job. Our students were performing at the fortieth percentile in part one of the national boards. They put a couple of people down there that couldn't get tenure. They just said, "Go teach them anatomy." It was unenthusiastic teaching, although I have to say that one of them was an outstanding person. When we took it over, she just really grabbed the ball and ran with it.

MULLINS: How did that come about that Surgery got—

TRUNKEY: I went to the dean and I said, "This is unacceptable." I said, "We'll teach it." We were getting students into the third year who couldn't read CT scans, and they didn't have a clue, I mean at the operating room table, what the structures were.

MULLINS: So what did you do?

TRUNKEY: We got together a number of surgeons, some from the specialty branches, and we offered anatomy on a clinical approach. When we studied the inguinal area, we would maybe take them through what you have to expose for a hernia repair. When you do the vasculature in the abdomen, you would show them why this is important, why when you rupture posteriorly you might survive, when you rupture anteriorly you don't survive. It made it very clinically oriented. We had CT scans all over one wall at one time.

MULLINS: How did the students like that?

TRUNKEY: The students voted us the best basic science course for eleven years in a row.

MULLINS: Were there any other consequences?

TRUNKEY: A few. They said, "Well, you can't win it more than every other year" [laughter].

MULLINS: How about the third- and fourth-year students in your tenure? Did you find them enthusiastic in some cases in terms of interest in surgery?

TRUNKEY: Yes. Initially when we started teaching gross anatomy, I guess we would get about thirty applicants that were really interested in pursuing a surgical career. Now it's dropped off a little bit, and I'm not sure if this is the Y generation phenomenon or if it's just a change in emphasis.

MULLINS: One thing that was true of the residency when you were running it is that it had a higher proportion of women as surgery residents. Is that correct?

TRUNKEY: Yes. If fifty percent of the medical students are going to be women, you damn well better pay attention to that pool, because they are bright, they make very good surgeons. It's just solving this issue of having some protected time and emphasizing that, yes, you can be a mother and you can be a surgeon and do them both very well. And, then, I recruited Karen Deveney to be the program director, and she's done a great job. Karen has—I think more than, say, myself, has been able to attract great women candidates.

MULLINS: Through the years, how have your graduates done, the people you've trained as surgery residents?

TRUNKEY: Well, that's one of the real pleasures of being a department chairman is you—number one, you can get them into either great positions within the community or, hopefully, maybe one out of three you can clone to be an academic surgeon, and I'm pretty pleased. As I look back, there are only three residents that I have any regrets about. And I know that I have a reputation of being a little bit soft. Maybe I should have just let them go early. Three residents, probably, I have some misgivings about them being surgeons.

MULLINS: You were on the Board of Surgery.

TRUNKEY: Yes.

MULLINS: And were you president of the American Board of Surgery?

TRUNKEY: Vice chairman.

MULLINS: What was that experience like in terms of understanding the training in the United States of surgery residents?

TRUNKEY: Well, it was right at that pivotal time, 1980 to 1987, where all these changes were happening in American medicine and changes in the surgical programs.

MULLINS: Do you think surgeons are better trained today than, say, forty years ago?

TRUNKEY: In some respects yes, in some respects no. In many respects, you know, with the changes in information and how we handle information through computers and things like that, I think the residents are far ahead of the curve. But going back to some of the principles that Dr. Dunphy emphasized, I think we've lost sight of some of the humanistic things that we should do in medicine.

MULLINS: Well, you've seen a lot of technology come into surgery in your lifetime. Would you want to comment on technology in surgery?

TRUNKEY: Well, I'm an old surgeon, and I haven't adapted to the technology.

MULLINS: But you were the one who put moribund patients on bypass.

TRUNKEY: Oh, yes.

MULLINS: There was a time when you were—

TRUNKEY: But minimally invasive surgery, I don't personally find that attractive. I did a few cases, and I just—it was painful. I worked with the da Vinci. I liked that much better than the laparoscopic model. But, on the other hand, it's changed surgery completely. My golly, before minimally invasive surgery, you know, you only saw patients who had raging cholecystitis or GERD that was so bad they had failed all medical management. Now these patients are being referred because it's more cost effective to do the surgery than it is to treat them with medicines for ten years.

MULLINS: Well, what do you see as the future for OHSU? We could divide it into groups. First maybe as a medical school.

TRUNKEY: As a medical school it's going to continue to be—it's going to be the state medical educational center, if you will. And we've got new towers going up now, another research building going up now, and so from that—if that's how you measure success, that's good.

Are we meeting the expectations of the Legislature? Probably not, because I think there's been a fall off in the training of family practitioners. If you look at Cooper's work—where's the need going to be in the next ten years—we're not fulfilling that need at all, because we're twenty percent behind in general surgeons, and general surgeons are so important out there in those community hospitals in the rural areas.

Now, we've started a rural training fellowship, which I think is an incredibly important thing to do, but we're a net importer of surgeons into this state. We cannot keep up with the attrition right now. So in that sense, we're failing.

Should we expand the program? I don't think so. I think it's almost too big now. I mean, we're training nine to ten residents a year, and that's a little bit unwieldy. Should we go back to having some of the private hospitals run surgery programs? Ooh. I think then

that sets up another double standard, just like we had when Dunphy came here. I don't think I'd favor that, too.

So I think we're going to have to live with the fact that some communities—Pendleton, Baker, Ontario, some of these places—may really start to hurt in having general surgeons. And those hospitals are not going to do well financially, because surgery is what drives the income to those hospitals in those rural areas, too. So it's a problem. It really is.

MULLINS: Do you feel that the Department of Surgery should have research as a low, medium, or high priority in the next decade?

TRUNKEY: Ninety-two percent of all NIH dollars now go to PhDs; MDs are only successful in obtaining grants in about eight percent of the cases. So I would say that clinicians—it's going to be increasingly difficult for them to maintain the "triple-threat concept" in doing bench research, education, and clinical care. In fact, if anything, some of the departments have almost abandoned the concept of research. I think it's increasingly hard. And maybe that's the way it should be. The only problem with that is, if you have a clinical problem, who's the one who's going to point out how we apply this research or to develop new research to solve problems? And everybody talks about having the marriage between the basic scientist and the clinician, and in some institutions that works pretty well. I'm not sure it does as well as it could here.

The bottom line is that if I was in the State Legislature and I was from a rural district, I would be a little bit upset, quite frankly, if they were putting a lot of the taxpayers' dollars into research when I can't get a surgeon out in his/her community.

MULLINS: Well, you've been an academic leader for a long time. Could you give us a few examples from your own perspective of where American surgery has changed in your lifetime, and how did that change come about?

TRUNKEY: Well, there's been a tremendous change since I started my training in 1966 and the reason is, is because we've gone away from big, open cases, and sometimes mutilative cases, particularly like in cancer surgery, to more restrained, minimally invasive surgery. You stop to think about it, you're really at two ends of the bell-shaped curve.

If Dr. Dunphy were alive and well today, I think he would really be very happy in regards to the way cancer surgery is going. We don't do mutilating mastectomies anymore, we don't do mutilating—you know, take off somebody's entire pelvis and limb, and we've done away with these Andy Gump procedures. We don't do that anymore, and that's been a real plus.

On the other hand, I think general surgery per se is really suffering right now, because we don't have general surgeons, we have specialty surgeons. We have foregut surgeons, we have hepatobiliary surgeons, we have colorectal surgeons, and nobody is putting this all together, and we're not training the surgeon that can go out and do most of the surgery that needs to be done in a rural community. If I got called today from somebody at Three Rivers

Hospital in Grants Pass, I would be hard-pressed to find somebody that could go out there and be a partner with those people in Grants Pass, because, quite frankly, they don't do non-cardiac thoracic, they may not even do vascular surgery.

MULLINS: Are you talking your trainees?

TRUNKEY: Yes, our trainees. That's what they want in Pendleton, that's what they want in La Grande, and we're not training that surgeon anymore.

MULLINS: In terms of changes in trauma surgery, for instance, was it research that brought about the important changes in your lifetime, or was it something else that brought about the academic achievement of making things better?

TRUNKEY: I think what really changed trauma, in my opinion, was approaching trauma from a system standpoint, and it was a process. And recognizing that, you use components of the healthcare system—we share with cardiology the EMS system. Getting the patient to the hospital rapidly, in a safe manner, and, hopefully, intubated, if necessary—that's EMS. Well, that's a shared system. But once the patient gets to the hospital, all of the nursing and physician components having to work as a team has been a huge change since, say, prior to 1966. A huge change.

The area that we're weak on is rehabilitation. Only one out of every eight patients who has traumatic brain injury gets into appropriate rehab. Part of that's finances and part of it's, quite frankly, we don't have a countrywide rehab program that focuses on putting injured people back into productivity. You contrast this with, say, Germany or Israel, where they have superb rehabilitation, then we're not doing that well.

MULLINS: But you've been involved in the debate regarding trauma systems. Was it a research-driven endeavor or was there something else that brought about the change?

TRUNKEY: Politics. But that was where the research came in. Doing clinical comparisons of communities without trauma systems with those that did have some of the components or all of the components, and then going public with this information made a difference.

I'll never forget, in San Francisco I really felt very strongly we needed a trauma center in San Jose, we needed a trauma center in Marin County, we needed a trauma center in the East Bay. And trying to get that through? It was like trying to pull teeth. So I went back to the old faithful autopsy study, and I looked at the nine counties. It showed that they—all the counties had seven to ten preventable deaths every year from trauma because patients didn't get into appropriate care or a surgeon wasn't available. When we went public with that, I was a little bit strident, I guess, on TV, but the bottom line, we now have those centers.

MULLINS: And that, I think, brings us to this issue of publicity and dealing with the press and perhaps influencing politics. Do you have some observations on your personal

experiences, successes and failures, Dr. Trunkey, about dealing with the press and public relations?

TRUNKEY: Well, I guess my best success was in dealing with the hospital administrator at San Francisco General. One of the things that Blaisdell did when I first got back, I went to him and I said, "We need a burn center here." And he said, "Go ahead." So I went down to the hospital administrator, and the hospital administrator said, "Over my dead body." He said, "That's just going to take nurses and money that I don't have, and you're not going to do it."

So I went scrounging around the hospital, and I found an empty ward, and I got an old claw bathtub out of the basement and put it up there, and I went over to St. Francis Hospital, which was the private burn center, and I recruited two nurses as emergency room nurses, and brought them over. Then I called the mayor's office and I talked to his administrative assistant, and I said, "We are going to dedicate the Mayor Alioto Burn Center on Friday afternoon. Could the mayor be there?" "Oh, yes, he'll be there." I said, "Can you arrange for the press to be there?" "Oh, yes, we'll take care of that."

So Friday morning I told Blaisdell what I was doing, and I said, "You should have the hospital administrator up there." And so the mayor shows up and he dedicated the burn center, and the hospital administrator absolutely was livid. It was a fait accompli, because it had been done by the mayor. I'll never forget this as long as I live. He went to Blaisdell's office afterwards and he said, "Fire him now." And Blaisdell said, "I can't. He's on the university faculty." So, again, Blaisdell bailed me out.

I guess the worst times I've had with the press are when—my approach to the press is to be totally candid. If you make a mistake, if you screw up, you say so. Well, that didn't wash—that's not the way people like to do things, as you know.

MULLINS: Well, I recall an incident when, in your department, a mismatched heart was inserted.

TRUNKEY: Yes.

MULLINS: How did that go?

TRUNKEY: Well, again, I thought the best way to handle it was to say yes, it was a mistake. In fact, I got up—NBC was there, CNN was there. I can't remember if CBS and ABC were there, but there were a lot of TV cameras in that auditorium that day, and I basically said, a mistake was made. I'm department chairman; I take full responsibility.

And, of course, the press wanted the name of the individual, and I absolutely was not going to give them the name of the individual. I mean, she—there was no way—it was an honest human error, and you don't crucify somebody or pillory them in the media. You deal with the problem, you change the system, and after that we did change the system. You had

to have a double check. We put in checks and balances so that that would never happen again.

MULLINS: So would you recommend chairmen of the future work on their public relations skills as well as their surgical, research, and educational skills?

TRUNKEY: I think that they—a strong statement could be made that chairmen probably should be a little bit more political than I was, and maybe a little bit more—less confrontational.

MULLINS: Well, in closing, do you want to give some final thoughts about the status of OHSU's Department of Surgery here today, 2005?

TRUNKEY: Oh, I think the department is healthy. I think John Hunter has come in and taken over from me and in some ways is a better chairman than I am, because I think he is a little bit more politically suave. And he clearly pays attention more than I did to some of the administrative—particularly committee meetings, the dean and the hospital and stuff. I hated those things. I'd rather go to a laundromat and watch it roll around than some of those things.

I guess the other thing I would say is if I had to do it over again, I'd do it the same way. I think—surgery, to me, has been incredible. I think I was in surgery in the best of times, because we were truly able to be a general surgeon, and that's been a real plus. I really think it's a noble profession.

MULLINS: I'd like to ask one more question. Grace Rozycki was our visiting professor, and she reported on a survey of American women who are surgeons, and she reported—I think this is correct—twenty percent of senior surgeons who are women, asked, Would you do it again?, said no. And she concedes there's a major flaw, she hasn't interviewed men, but she—do you think men would have the same proportion that would say the same thing? And, more importantly, what do we learn from people who do this and they say at the end of it they wouldn't do it again?

TRUNKEY: I've thought about Grace's lecture. As I go around the country and I talk to people there's a lot of male general surgeons who are retiring early. They're unhappy, and they feel that they have been abused by the system for all kinds of reasons. People are unhappy with HMOs, they're unhappy with the way surgical education and research is going.

I don't know if there's a male-female difference here or not. My guess is there might be a little bit, because the glass ceiling was epitomized in many ways, from a professional standpoint, by surgery. The neurosurgeon at Stanford who wrote about it highlighted a lot of the problems in being a woman in a profession where it was difficult to get treated in an unbiased way. So I think there is an element of that, I really do. I think that we as surgeons, though, are partly to blame in regards to not providing women an educational experience during their residencies where they do have protected time. Or you might even extend the program a little bit longer so that they could have family time.

MULLINS: I'm sorry, I was more interested in—I asked the question poorly. I'm interested in the fact that some surgeons at the end of their career, all that work, all of those people that they've helped, say they would not do it again.

You find that an anathema. You can't understand how you wouldn't want to do it again.

TRUNKEY: No, I can't.

MULLINS: Why is it that some—

RUNKEY: I think it's basic personalities. Some people look at the glass half full and others look at it as half empty. I think no matter what profession they might have gone into they might have been unhappy at the end. Maybe they didn't put full effort into it. I don't know. It's just the way you approach life in general, I think.

The most rewarding experiences I get are from patients who write me at Christmastime. They send me Christmas cards, still to this day, or they come back, and the mother and father are so pleased that their son or daughter didn't die in that automobile accident. What more can you get out of a profession than having that kind of instant gratification. It's incredible.

MULLINS: Well, thank you very much, Dr. Trunkey.

TRUNKEY: My pleasure.

MULLINS: This was an interview with Dr. Donald D. Trunkey, and it took place June 21, 2005, at the Oregon Medical Association in Portland Oregon. My name is Richard Mullins.

[End of interview]

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