Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

Kevin P. Lally, MD

Dr. Kevin P. Lally graduated from Tulane University School of Medicine in 1980. He finished a residency in general surgery at the U.S. Air Force training program in Mississippi in 1985. During his residency, he completed a research fellowship in infectious diseases at the Channing Laboratory in Boston. Following completion of his surgical residency, he went on to finish a residency in pediatric surgery at the Children’s Hospital of Los Angeles under the direction of Dr. Morton Woolley. He then served as the Chief of Pediatric Surgery at the Wilford Hall USAF Medical Center from 1987 to 1991. In 1991, he joined the faculty at the University of Texas Houston Medical School where he has remained. Dr. Lally is currently the A.G. McNeese Professor of Surgery and Chairman of the Department of Pediatric Surgery at UT Houston as well as the Surgeon in Chief at the Children’s Memorial Hermann Hospital. Dr. Lally is also the training program director for the pediatric surgery residency at UT Houston. Dr. Lally is currently the secretary of the Surgical Section of the American Academy of Pediatrics. He has been a member of the section for 20 years.

Dr. Lally met Dr. Hays while he was training in pediatric surgery in 1985. Dr. Hays was still active in clinical medicine at the time, especially in the field of pediatric oncology. During his time in Los Angeles, Dr. Hays has served as a role model for many pediatric surgeons, including Dr. Lally.
Interview of Daniel Hays, MD

DR. LALLY: My name is Kevin Lally. I’m interviewing Dr. Dan [Daniel M.] Hays, the [William E.] Ladd Medal winner. We are in East Glacier, Montana. It is July 3rd, 2007, at nine o’clock in the morning in Dr. Hays’ house. Good morning, Dan.

DR. HAYS: Good morning, Kevin.

DR. LALLY: Can you tell some of us about your background: where you were born, your parents and things like that?

DR. HAYS: I was born in Reading, Pennsylvania, on a trip, actually. My mother went back to her home in Reading because my father became ill. He was working at Yellowstone National Park, so it just happened I was born where she was raised, in Reading; but I didn’t stay there very long. I was actually raised in Montana, in Livingston, and then later in southern California. My father has always been involved in concessions in national parks. At first it was Yellowstone and Sequoia and then Glacier and so forth. So I was raised in the summertime at least in national parks.

DR. LALLY: So you got to know a lot of the national parks out west when you were growing up.

DR. HAYS: Correct.

DR. LALLY: And do you have brothers and sisters?

DR. HAYS: Yes, I have two brothers.

DR. LALLY: Where did you go to high school? Was that in California?

DR. HAYS: Yes, I went to high school in Riverside, California. I went to Stanford [University] after that, and went to Cornell Medical College in New York City after that.

DR. LALLY: At some point you decided on a career in medicine. What got you interested in that?

DR. HAYS: This was at Stanford, undoubtedly, in the latter part of my career there. I think I started out as a journalism major, and was an English major at Stanford for two or three years. There was a man by the name of Frank Taylor, a nationally prominent journalist, living in Los Altos, California at that time, and my dad sent me to him for advice on what to do to be an effective article writer, and he said, “Take all the science you can.
You don’t need to take writing.” And so, on the basis of his advice, I began
to take chemistry, physics, geology and so forth, the sciences; and then I
found myself very rapidly with almost entirely pre-med students. I found
that I’d completed a pre-med curriculum, and I said, “Well, maybe I might
as well just go ahead and go to medical school. [Laughs] I’m qualified for
admission now.”

DR. LALLY: Did you always want to be a surgeon once you decided to go into
medicine?

DR. HAYS: Frankly, the choice was really between being a surgeon or
being a pathologist. The Army made me a pathologist. The Army can do
that, you know. They just say, “You’re the pathologist in this hospital.” And
so they not only made me the pathologist at several small hospitals but they
sent me to a special pathology course that the Army had arranged in Vienna,
with the old University of Vienna. And so I had some experience with the
Army in pathology and some service training in pathology.

DR. LALLY: Dan, that was after you had done your first two years of training,
but that was during the war years.

DR. HAYS: Yes, right out of medical school I went to Boston Children’s
[Children’s Hospital Boston] for two years, in surgery, and then I went into
the Army and into the European theater. I was stationed almost entirely in
Germany for the next two years.

DR. LALLY: You were an intern at Boston Children's in 1944. Can you tell us
what that was like?

DR. HAYS: That was [William E.] Ladd’s last year, really, just about the
final period, so I had the opportunity of scrubbing a lot with Ladd and
[Robert E.] Gross and [Thomas] Lanman, a range, which wouldn’t be
possible during many years. It was an interesting year. The unfortunate
problems between Dr. Ladd and Dr. Gross were developing at that time.
One had to almost take sides; it was so difficult, but you tried not to do so.

DR. LALLY: And I imagine it would be hard for an intern.

DR. HAYS: Yes. [Laughs] It surely was, very.

DR. LALLY: What was the practice of pediatric surgery like in 1944? I know
we didn’t have central venous catheters or mechanical ventilators at the time.

DR. HAYS: No, that’s right. We had nurse anesthesiologists at Boston
Children's Hospital. Betty [Elizabeth] Lank was a famous and an awfully
good anesthesiologist, I must say, but she was a nurse. They were just
introducing the first physician anesthesiologists at Children’s at that time. It was, I would say, very unique in that you’d wake up in the morning and you were going to be scrubbing with maybe Dr. Ladd or Dr. Gross or Dr. Lanman or Dr. [Donald W.] MacCollum. Do you know him?

DR. LALLY: No.

DR. HAYS: He was an excellent plastic surgeon there. But it was exciting because they were all such good surgeons. Gross was doing his early work, including his early coarctations. I scrubbed on the first two coarctations. The first one died right away. Immediately.

DR. LALLY: In the operating room?

DR. HAYS: In the operating room, yes. He took the clamps off of the aorta and the patient died, just like that. In fact, the second one died, too, not quite as suddenly. The first and second died within minutes of removing the clamp. But he went right ahead and did another one. In the third coarctation excision, he took the clamps off much more slowly, and from then on, everything was all right.

DR. LALLY: That must have been a very interesting time to be at the Children's Hospital.

DR. HAYS: Yes, I think so. As I say, you could see both those masters, i.e., Ladd and Gross, operating. Also Sidney Farber was there and going strong. He ran all the conferences, practically. I was very impressed by him. Interesting fellow, yes. Looked like a Persian rug merchant. [Laughs] Big round head and a little moustache. [Laughs] But I found him very interesting to be around. And he started the cancer programs, really. Sidney Farber was the first person that recognized that there was a future in chemotherapy. Actually, prior to that, the surgeons all said, “Did you ever see a cancer patient who was cured by chemotherapy?” The answer to that was, “No, never.” But Sidney Farber developed the idea that there could be accommodations of surgery and radiotherapy and chemotherapy, that they might augment each other. That was a new concept.

DR. LALLY: Was that what spurred your interest in cancer, or was that later?

DR. HAYS: Yes. Oh, yes. I think Sidney Farber gave you an idea that all different kinds of cancers that really were not manageable before now might be manageable with combinations of chemotherapy. Also, the idea that pathologists could take an active role in therapy. Sidney Farber did it, and then Bill [William] Newton in Columbus and several others, pathologists. Instead of the chemotherapy of solid tumors, ancillary or whatever it might
be, being carried out by hematologists, it was carried out by pathologists, which is kind of strange, but—

DR. LALLY: It is interesting.

DR. HAYS: Yes. [Laughs]

DR. LALLY: You said the Army made you do training in pathology in the theater of Europe, is that right?

DR. HAYS: The Army didn’t make me do that, but I elected to do it. At the time I got out of the Army, first-rate jobs in surgery were hard to come by, particularly the time of year I came out, which I think was in September. And so I decided that instead of taking a second-rate surgical appointment, I’d take a first-rate pathology appointment. So I got a job at the [Peter Bent] Brigham [Hospital] for a year in pathology and did something like 105 autopsies. I enjoyed it very much.

DR. LALLY: And from 1946 to 1948 you were in the Army in Europe.

DR. HAYS: Yes.

DR. LALLY: What was that experience like?

DR. HAYS: Absolutely fascinating. Germany had been a completely modern society before the war. After the war it was thrown back into an economic situation where money was worthless, i.e., everything was done by barter. Their money was worthless, and all the American currency for the U.S. Army was black marketed only; it was so valuable that everybody was fighting for it, so almost everything was done by barter. It’s amazing. Even our chefs in our mess—we had a little hospital—would take our rations out on the black market and get fresh food from the farmers.

DR. LALLY: [Laughs]

DR. HAYS: It was an interesting time, yes.

DR. LALLY: But after the Army, then, you came back to the States and you went back to Cornell to finish your surgical training? Residencies were structured a little differently then that they are now. Can you tell us about your experience?

DR. HAYS: Yes. I think this is a very complicated topic. For people who were interested in surgical training at the New York Hospital (Cornell Medical College), there was what was a called a seven-year program, but it wasn’t necessarily a seven-year program for everyone. Everyone had two years of internship to begin with, which I didn’t need to have because of the
Boston experience. And then they went into a pool of assistant residents, and that could go on almost indefinitely. And when you got out of that pool, you were picked for one of the three to-be chief surgical residents. In other words, out of that pool they picked three people to go on into the three senior residency years. But also many people in that pool stayed in for many years and eventually went off into orthopaedics or plastic surgery, etc. There was a beginning which was structured, and the end which was structured, both two years, but the middle part could be very long. Some people just got tired of it and left for other programs.

DR. LALLY: I guess fortunately in your case it was pretty short.

DR. HAYS: It was. They gave me quite a bit of credit for my Boston Children’s and Brigham program. The wait wasn’t very long.

DR. LALLY: So medical education has changed a fair bit since then.

DR. HAYS: Yes, I would say a lot, yes.

DR. LALLY: Do you think it’s a lot better now?

DR. HAYS: Yes, I think it’s better. We are thinking of the whole structure. I think it probably is, yes.

DR. LALLY: When you were in Cornell, did you do much pediatric surgery there, in New York?

DR. HAYS: I think it was common for the chief surgical resident, who’d been there for four or even six or seven years, to do the pediatric surgery. They didn’t let any of the juniors do it. So the fellows who had five, six years of training were doing the infant hernias, pyloric stenosis, etc. There wasn’t an awful lot. It wasn’t at all like a children’s hospital.

DR. LALLY: I know you did your early years in Boston Children’s. When was it that you decided to become a pediatric surgeon?

DR. HAYS: I think in that period. And the choice was really whether I wanted to go off into pathology. I think I always wanted to do pediatric surgery if I was going to do surgery, yes.

DR. LALLY: Somewhere in that time frame you met your wife. Can you tell us something about your marriage, children?

DR. HAYS: Yes, we met at the New York Hospital. She was an intern in internal medicine, and we met in the ER, the emergency room. [Chuckles] Yes, and we were married at Riverside Church near the Hudson River, and a
lot of the house staff came up for the wedding. We had a reception at the River Club, which was a posh place. Several of the senior staff of the New York Hospital arranged that. So we had our honeymoon in New York Hospital. [Laughs]

DR. LALLY: Well, residencies were true residencies then, in some fashion, right? Didn’t you people live in—

DR. HAYS: Yes In fact [laughs], we had a suite on the top of the New York Hospital, and they put two sections together to make a two-room, two-bath suite.

DR. LALLY: And that’s where you both lived for the early years in your marriage.

DR. HAYS: That’s right. Yes, that’s right. And it was fun.

DR. LALLY: Did the kids come later?

DR. HAYS: Let’s see. Yes, it was several years later.

DR. LALLY: When you completed your residency—

DR. HAYS: Although Esther had her first baby at the New York Hospital, that’s true, yes. We were still in New York at that time.

DR. LALLY: When you finished your residency, did you always plan to go back to Los Angeles?

DR. HAYS: No, I don’t think so. I didn’t know where I was going to go. I think I wanted to go to the West Coast. I think that was true. I came out and talked to some people who worked at L.A. Children’s [Children’s Hospital Los Angeles], and L.A. Children’s was attractive in that it had a lot of patients. It’s a big children’s hospital. I talked to some of the people who were affiliated there, and they said they thought I could affiliate there.

The question was what kind of a status was I going to have. And that really took several years to work out. I had to kind of prove myself and get a grant or two, and then I could come on as a full-time academic staff member at Children's Hospital. They didn’t have many of those. In fact, it was really dominated by part-time staff. The heads of the departments were part-time.

DR. LALLY: Who was the head of surgery at the time?

DR. HAYS: A surgeon by the name of Bill [William] Snyder, who became a friend of mine, helped me very much. But he did general surgery across the
street at Hollywood Presbyterian [Hospital], too, to make a living. He was very kind to me.

DR. LALLY: Were you able to do pure pediatric surgery when you first finished?

DR. HAYS: Very quickly, yes. I actually had an interest in the patients with bladder extrophy. Dr. Tracy Powell and I had thirty patients in this group. Some of that was general surgery, believe it or not, because we had decided that if you were going to take care of these special patients, you had to sign on for their entire lives—no adult urologists would help them later. That was a special group.

DR. LALLY: Your CV [curriculum vita] said you were on faculty at UCLA [University of California, Los Angeles] around this time period as well.

DR. HAYS: Yes, that’s right. I had a job with a salary. I was called the surgical consultant to the student health service of UCLA. That meant that I helped the house staff at UCLA do appendectomies and hernias on the undergraduate students, and there were a lot of them. And I was on salary for that.

DR. LALLY: Around mid fifties to late fifties you became full time at the Children's Hospital?

DR. HAYS: Yes, yes.

DR. LALLY: What was the practice of pediatric surgery like then, in the late fifties at the Childrens Hospital Los Angeles?

DR. HAYS: You waited for the big case, the tracheoesophageal fistula or the diaphragmatic hernia. And then you had to decide whether you were going to let the resident do it or not, and that was tough, particularly if you weren’t sure how good the resident was. [Laughs] I tried to be pretty generous, but—

DR. LALLY: And pediatric anesthesia was still in its infancy, even then, in Los Angeles.

DR. HAYS: Yes. I went through the phase of nurse anesthesiologist, i.e., when there were no physician anesthesiologists at Boston Children’s. And at L.A. Children’s there were physician anesthesiologists, as I recall, from almost the time I got there.

DR. LALLY: What kind of anesthesia were they giving? Do you remember? Was it ether?
DR. HAYS: I think for an appendectomy it could be a mask with ether, yes. I’d say the cases that always should be intubated were largely intubated.

DR. LALLY: Who were some of the people who helped you most in your career? You talked about Dr. Snyder.

DR. HAYS: Yes, Dr. Snyder had the concepts: 1) that research was very important in pediatric surgery, and 2) that there should be a specialist who did nothing but pediatric surgery. He was the first one that really accepted both of those things completely and himself dropped out of doing general surgery. I think I admired him and helped him as much as I could. Prior to him, there had been three chiefs of general surgery at Children’s, each of whom took a third of the year. In other words, they had responsibility for a third of the year. All three did general surgery.

DR. LALLY: Were there some other folks who helped you in your career along the way, from Cornell or afterwards?

DR. HAYS: Oh, yes, Dr. [Charles] Gardner Child [III] at Cornell. He was kind of a model of an academic surgeon, as far as I’m concerned. I don’t know whether you ever heard of him, but he published a lot on portal hypertension and its problems. He was clearly a model of mine. He promoted me, too, I’m sure.

DR. LALLY: Is he the Child for the Child [Turcotte-Pugh] Classification of cirrhosis?

DR. HAYS: Yes. Some faculty, some people really did not get along with him well, but I got along very well with him, yes.

DR. LALLY: So he helped you later as well?

DR. HAYS: Yes, he did.

DR. LALLY: Sometime in the early sixties, then, you were joining the Surgical Section [Section on Surgery] of the Academy, 1963.

DR. HAYS: That sounds right.

DR. LALLY: Was that something you were active in early on?

DR. HAYS: Yes, because this preceded APSA [American Pediatric Surgical Association] by quite a few years. I mean, the Academy and its surgical section were functioning for a long time before APSA appeared and it was very helpful to me, I think. I attended every year, participated whenever I
could. It was good and I introduced a review of pediatric oncology into the program each year.

DR. LALLY: One of the reasons the Surgical Section was useful was because there was a lot of resistance in general surgery to the specialization. Did you see a lot of that when you were in Los Angeles?

DR. HAYS: Yes, there were a lot of surgeons who wanted to do some pediatric surgery but did not have any special training or much experience. Yes, there were some who felt they had a right to do pediatric surgery, although they had no special contact with it. It was their belief that quite a bit of what we call pediatric surgery was really general surgery.

DR. LALLY: Were the pediatricians useful, then, in helping direct patients?

DR. HAYS: Yes, through the American Academy of Pediatrics and otherwise—the pediatricians did. They picked me out, so to speak, for programs or committees, etc., of the Academy. The pediatricians were immensely helpful.

DR. LALLY: So early in your career, when you were starting in Los Angeles, were you able to do a lot of research?

DR. HAYS: Yes, I got a federal grant pretty early. I got an NIH [National Institutes of Health] grant, which I held for thirty years, believe it or not, regarding the factors influencing hepatic regeneration: types, speeds, etc. I don’t know how I kept getting it, but I got it over and over again. [Laughs] I got on the programs of the College with this—you know, the American College of Surgeons’ programs. I had my abstracts accepted. I guess that’s why I was funded. But it went on for 30 years.

DR. LALLY: Was that funding through the government?

DR. HAYS: Yes, NIH. I adopted a policy of going to Washington at least once a year, talking to all those people at the NIH.

DR. LALLY: To the people at the NIH.

DR. HAYS: Yes, yes, about what the prospects were for the next year and what they were looking for. Have you ever done that?

DR. LALLY: Once or twice, but not every year.

DR. HAYS: You should go every year, I think.

DR. LALLY: That may be why you got repetitively funded.
DR. HAYS: I got to know them.

DR. LALLY: So I wanted to see if we could focus on a few of the obvious major areas in your career. One of them was in this whole area of liver disease. Did this start with your interest in biliary atresia?

DR. HAYS: Yes, I believe it did. I think they were connected, yes, because biliary atresia is about as bad a liver disease as you can get.

DR. LALLY: There really wasn’t much of a surgical cure when you finished training.

DR. HAYS: No. The Japanese did try things, and some of them occasionally worked; but often they didn’t work, too. They really went right down into where the hepatic artery and vein split, and they were dissecting into that part of the liver. The so-called Japanese approach to biliary atresia had different results. Sometimes it worked, and sometimes it didn’t. You know what I’m talking about?

DR. LALLY: I do. Back in 1962 you were actually on an AAP committee on biliary atresia, so this has been a long-term interest of yours.

DR. HAYS: That’s right, yes.

DR. LALLY: But this was not accepted in the United States early, the Japanese approach.

DR. HAYS: No, it wasn’t. There was no real approach in the United States. You were supposed to dissect down there, and if you found a little bud sticking out of the liver with bile in it, while you made an anastomosis to the intestinal tract, but you hardly ever did find it. I mean, “correctable” atresia was a rare bird. Much more frequently, you found what looked like white threads at the porta hepatic.

DR. LALLY: How did you then go about learning the Japanese approach?

DR. HAYS: Well, the Japanese surgeons were reporting some success, and Dr. [Keijiro] Suruga attributed this to employing a microscope during surgery. I have forgotten what they call it, i.e., surgery using a dissecting microscope. But I think actually the microscope had very little to do the success the Japanese were reporting. Most of the surgeons and pediatricians in the United States and Europe involved in the therapy of biliary atresia were very skeptical. There hadn’t been any major surgical contributions to pediatric surgery originating in Japan. There was really no reason to believe that they had anything special to contribute. Consequently, most of the
western surgeons and pediatricians discounted the early Japanese reports. However, I knew the people in Japan. I had been to Japan. I knew they were intellectually honest. I knew they weren’t making up these stories or exaggerating too much.

END OF TAPE 1, SIDE A

DR. LALLY: Okay, we were talking about going to Japan?

DR. HAYS: Yes, I was in Japan, actually, for two periods, each three or four months long. I went to every major center in Japan where they were doing surgery for biliary atresia; I tried to make a record of all the Japanese cases by a study of their hospital records and watched the surgeons operate in the OR. Then I wrote the book.

DR. LALLY: Was this in the early seventies that you did that, or before?

[Recording interruption]

DR. LALLY: You were talking about your fellowship in Japan and the book you wrote.

DR. HAYS: Yes.

DR. LALLY: And that book was written with?

DR. HAYS: Ken Kimura. Why did I work with him? It was because I would say two-thirds of the references on this subject are in Japanese, written in Japan, and Ken Kimura translated all those for me. Actually, some of the Japanese resented that. They thought that he was just a translator rather than a pediatric surgical investigator, but I think he was much more than a translator. Do you know Ken?

DR. LALLY: I do. I do.

DR. HAYS: Some Japanese surgeons stated that he shouldn’t have been an author, but I thought this was quite justified. So it was quite an experience, I must say. There was no question that there are some cases that are surgically correctable, but there aren’t too many.

DR. LALLY: When this was published, this was right as people were starting to take on the Japanese approach for biliary atresia.

DR. HAYS: Yes, that’s right.
DR. LALLY: You were also involved, I notice, in the Pacific Association of Pediatric Surgeons [PAPS] early on and helped foster relations with the Japanese pediatric surgeons.

DR. HAYS: I think that’s true. I think I was the treasurer of PAPS early.

DR. LALLY: Yes, you were. And you were also the president. But the Japanese pediatric surgeons were not very involved in international meetings before that. Clearly, though, after biliary atresia or simultaneously with biliary atresia was a broad interest in children’s cancer; so you had kind of two kind of simultaneous interests?

DR. HAYS: That’s right, I did, yes. And then I got into a cancer cooperative group. I was the head of surgery in one of the two major cancer cooperative groups, Children’s Cancer Study Group.

DR. LALLY: You were at the very, very beginnings of the Children’s Cancer Study Group. Can you tell us how that all came together?

DR. HAYS: Yes. Amazingly enough, as you know, it was the pathologists who pushed the cooperative group movement. Bill Newton, for example, at Columbus, was a pathologist; but he took over the clinical management of the cooperative group patients, and so did Farber at Boston Children's. He was a pathologist, but he became the head of what was called Eastern [Cooperative] Oncology Group or something or other. That’s an interesting phenomenon. That happened all over in the country somehow. The pathologists began to run the clinical programs in oncology.

DR. LALLY: And did that happen in Los Angeles as well?

DR. HAYS: Let me think. Yes, it did. It’s funny, but the hematologists who were treating leukemia and quite willing to treat the new leukemias, did not want to take over the treatment of metastatic solid tumors, for example. I heard that repeatedly. Because of this, I had established a little clinic of my own at L. A. Children’s to give the simpler forms of chemotherapy to the solid tumor patients with disseminated disease.

DR. LALLY: So you started the chemotherapy clinic in Los Angeles.

DR. HAYS: Yes, for metastatic solid tumors, disseminated solid tumors. The hematologists didn’t want to treat them, so I started a clinic to give chemotherapy, really. We didn’t give complicated chemotherapy. Somebody had to do it, but they just thought it was too dull, you know, just giving a shot of vincristine or actinomycin every week and that sort of stuff.
DR. LALLY: Somehow we’ve evolved from when you were seeing these children, giving chemotherapy in the surgery clinic, to the big group practice treatment. How did that come around?

DR. HAYS: How it came around? Because of the refusal of the medical department to take them on. It was just because it had to be done, and we were the only ones to do it. In other words, if somebody with a solid tumor patient, disseminated, say, were given vincristine and actinomycin-D in fairly standard dose, our oncology department didn’t want to manage them. They would refer them to the county hospital if we didn’t want to do it or something like that.

DR. LALLY: How did the surgeons get involved in the Children’s Cancer Study Group?

DR. HAYS: Well, they had to have protocols. In other words, these were studies that were worked out by statisticians to make sure they were going to be sufficiently valid when the results came out. And so to do that, they had to be comparable groups of patients, comparable in number and type, in every way, to make a logical study. So who was going to determine, for example, whether they were the same type? The pathologists, one, but the surgeon also. That committee had to say, “This patient had an adequate operation for a certain tumor” or didn’t have an adequate standard or comparable operation, and why. Otherwise, any randomization would be fallacious.

DR. LALLY: The studies drove the standardization of the surgery.

DR. HAYS: Yes, they did. Exactly. In other words, if a patient did not have an adequate initial operation, in the opinion of the surgeon on the committee, this placed him in a special category that required separate statistical analysis or possibly exclusion from the study entirely.

DR. LALLY: That must have taken up a fair amount of time, reviewing all those.

DR. HAYS: That’s right. What you reviewed was the operating notes and the path [pathology] reports. The path reports would tell you a lot about the surgery too, of course. Every case that went into the Intergroup Rhabdomyosarcoma Study would be ticked off by a surgeon: Yes, surgery was adequately done. And also a radiotherapist reviewed the radiotherapy, to ensure that both in regard to field size and amount of radiation, it was adequate, and so forth.

DR. LALLY: Moving from that to rhabdomyosarcoma, obviously there had been major advances in the last thirty years. It seems like you’ve been integrally involved in most of them.
DR. HAYS: I think basically that was recognition that there are various sites and histologic types of rhabdomyosarcoma, each with a distinct influence on survival, and that you can divide all rhabdomyosarcoma into about twenty-five categories, if you will, and that the prognosis in those categories was vastly different, entirely different. The prognoses for patients with a prostatic rhabdomyosarcoma and an extremity rhabdomyosarcoma were just a “mile” apart, i.e., they were so much better for the patient with prostatic primary, for example.

DR. LALLY: When you first started with the IRS, the Intergroup study, was all rhabdomyosarcoma considered to be the same?

DR. HAYS: It wasn’t recognized how different the prognosis was by histologic type and site. It was quite remarkable, yes. First we established if these differences existed, and then we modified all the therapy to compensate or take advantage of these different prognoses. As I say, the prognosis for rhabdomyosarcoma of the prostate and rhabdomyosarcoma of a major muscle in an extremity was just incredible—one could be twice as lethal as the other. It often was, yes.

DR. LALLY: Also in this time frame, besides writing a book on biliary atresia, you edited the first book on pediatric surgical oncology.

DR. HAYS: That’s right, I guess I did.

DR. LALLY: Yes, you did. Since you got involved in oncology, what do you think some of the major advances have been?

DR. HAYS: Well, of course, the combination therapy, employing radiotherapy, either implants or external beam, and the chemotherapy and the radiotherapy and the surgery—when they can be combined in different ways, in different stages of the disease—I think that is a major advance. That concept is a major advance. Often you can achieve results—I’m thinking in terms of bringing in the surgery sometimes well after the chemotherapy started for example. It started out with the chemotherapy, in an attempt to reduce the tumor tremendously in size; then perhaps have surgery, and then radiotherapy after that, or some combination but not necessarily any traditional sequence.

DR. LALLY: But certainly in your involvement, some of the tumors have achieved cure without surgery at all.

DR. HAYS: That’s right. Yes, I agree with that, too. But sometimes a final little cleanup surgery at the end, for residual tumor, might be a good idea, and sometimes not. You’re right.
DR. LALLY: Through the late seventies and eighties, you were practicing at Los Angeles Childrens. When did you kind of transition past that? When did you stop surgery?


DR. LALLY: You still remain pretty actively involved in the rhabdomyosarcoma work.

DR. HAYS: In the studies, yes, that’s right. [Chuckles] We were a very congenial group, the Intergroup Rhabdo Study, yes. And we get along very well. Hal [Harold] Mauer was the chairman for years. He was a great mediator. [Laughs softly]

DR. LALLY: I’m sure he needed to be with all the specialists.

DR. HAYS: Yes, with all the specialists. And I guess my best friend was Bill Newton, pathologist on the committee, yes. I enjoyed working with him.

DR. LALLY: What do you think the next decade or longer holds for children’s cancer?

DR. HAYS: Oh, I think probably chemotherapy will get better. Surgery can’t get much better. [Laughs] And radiotherapy might evolve in different ways. Different forms of implants and so forth might be advances. But I think the advances will be in better chemotherapy, more effective chemotherapy.

DR. LALLY: Well, Dan, that’s all the questions I had. Are there some other things you wanted to tell us?

DR. HAYS: Not at all.

DR. LALLY: Well, good. Thank you very much.

DR. HAYS: That’s okay.

[End of interview]
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DANIEL M. HAYS, MD

Dr. Hays is a graduate of Cornell Medical College (New York City) and received his surgical training at Cornell and at Children’s Hospital Boston. He has been associated with the medical faculties of Harvard Medical School; Cornell; University of California, San Francisco; University of California, Los Angeles; and University of Southern California; and has served extensively on committees of the National Institutes of Health (rhabdomyosarcoma, Hodgkin’s Disease, etc.). He was awarded NIH grants through his career relative to such diverse subjects as hepatic regeneration and the economic problems of cancer survivors. Throughout his leadership of cancer study groups and national and international organizations he has actively encouraged surgeons to participate, with other pediatric specialists, in the formation and conduct of the group trials associated with pediatric oncology.

Journal Articles


102. Hays DM, Woolley MM, Snyder WH, Jr., Reed GGJ, Landing BH. Diagnosis of biliary atresia: relative accuracy of percutaneous liver


