James A. O’Neill, Jr., MD

Interviewed by
George W. Holcomb III, MD

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PREFACE

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

George W. Holcomb III, MD

Dr. Holcomb is the Katherine Berry Richardson Professor of Surgery and Surgeon-in-Chief at the Children’s Mercy Hospital in Kansas City, Missouri. In addition, he is also Director of the Pediatric Surgery Residency Training Program and the Center for Minimally Invasive Surgery. Dr. Holcomb is a graduate of the Vanderbilt University School of Medicine in Nashville, Tennessee. He completed his general surgery residency at Vanderbilt and his pediatric surgery residency at the Children’s Hospital of Philadelphia. Following completion of his pediatric surgery training, he was an Assistant and subsequently an Associate Professor of Surgery and Pediatrics at Vanderbilt. In 1999, he moved to Kansas City to replace Dr. Keith Ashcraft as Surgeon-in-Chief and Director of the Pediatric Surgery Residency Training Program at Children’s Mercy Hospital.

Dr. Holcomb has been a member of the AAP for almost 20 years. He has been a member and subsequently chairman of both the Section on Surgery Publications and Program Committees. He is a past member of the APSA Board of Governors. He currently serves as President of the Association of Pediatric Surgery Training Program Directors and is the President-Elect of IPEG.
Interview with Dr. James A. O’Neill, Jr., MD, FAAP

DR. HOLCOMB: This is Dr. George W. Holcomb, III from Children’s Mercy Hospital in Kansas City, Missouri. It is May 1, 2008. I’m interviewing James A. O’Neill, Jr., at Dr. O’Neill’s office in Vanderbilt Medical Center in Nashville, Tennessee. Dr. O’Neill is the 2007 recipient of the William E. Ladd Medal from the Section on Surgery of the American Academy of Pediatrics [AAP]. This is a special occasion for me, as I trained under Dr. O’Neill and his colleagues at the Children’s Hospital of Philadelphia [CHOP] from 1986 to 1988. Also, I was a colleague and partner of Dr. O’Neill’s at Vanderbilt from 1995 to 1999, before I moved to Kansas City.

Dr. O’Neill, I am delighted that we could meet today and have you share with us some of your background and thoughts about your career, and about the history of pediatric surgery. To start, tell me about where you were born, and about your parents and your siblings. Give us a little background about your family life, with any specific events in your childhood that had an influence on your career choice. What interests did you have in high school?

DR. O’NEILL: Well, those are very interesting questions. I was born in Manhattan, New York City. At the time of my birth, that was really the height of the Depression years in the United States. I came from a simple family on the Upper West Side of New York. My father had to scramble to get jobs in those years and somehow managed to stay employed during that time. But part of his difficulty early in the game was that he essentially grew up in an orphanage, The New York Foundling home. In that process, the kids finished the sixth grade, and then they were sent out to work, which is hard for us to even conceive of today.

But I go into this background because of the way he stimulated me. Anyhow, he did go to work. He was an office boy and worked for a law firm. Basically, he had selected out Wall Street-type jobs, but at the lowest level you can imagine. At night he was able to finish the eighth grade, but that was as far as he got in his formal schooling. After that, he would read in the library at night. He’d do things like that, and slowly but surely he, I would say, realized the American dream, in that he gradually got to be an executive in a grain company. Eventually he was president of the New York Produce Exchange, which doesn’t exist any longer as such. It’s now the Commodities Exchange [division of the New York Mercantile Exchange COMEX/NYMEX]. But it tells you how someone with essentially no education, and very little family support, managed. He always told me that when he was in The Foundling home, he got a wonderful education. The Foundling home was, and to this day is run by, I think, [Roman Catholic Order of the] Sisters of Charity [of St. Vincent de Paul] in New York. My
mother had a little more education background. She finished high school. So that means that I was the first person to go to college.

But as I came along in public schools, my father always stimulated me to study, and to try to achieve getting to college. Because he saw that was, particularly at that point in time, something that more or less assured an individual’s success. Now, he wanted me to go into business, because I liked things like mathematics, but I liked science even more. He actually tried to discourage me from going into medicine, and would say such things as, “Why do you want to work so hard? You can do a lot better in business.” Of course, over the years he came to realize that’s what I really wanted to do. Besides that, my younger brother was much more talented along those lines. He’s been extremely successful, and he went that route. So I think my father was happy in the end. He was very happy about my final choice. The main thing is I was stimulated.

Now, there were some other factors in this. We had lost a sister, between my brother and myself, who had congenital heart disease at a time when it was really not reparable, and I’m sure that influenced me somewhat. The other thing is that, for almost two years, my mother was very ill. She had developed carcinoma of the cervix and had lymph node metastases. She had radium treatment and was operated on, and unfortunately, developed an intestinal fistula at a time when there was no intravenous nutrition, so she lingered for almost two years. So my brother and I had to split up. I went to live with my grandparents on one side, and he went to live with grandparents on the other side. That went on for a year, and then we were able to come home, even though my mother was still hospitalized and very much an invalid. I remember seeing her frequently. My father would see her every night. For that second year, I cooked all the meals for the family, and did all of those things, obviously, while I was going to high school.

There was a fantastic teacher, an English teacher, who could see something was going on in my life. She picked me out and took me aside one afternoon, and she said, “What’s the matter with you? Your grades are falling off.” Miss Kerr, Ruth Kerr, was her name. I said, “Well, I’m having some problems at home.” So she actually said, “Well, what can we do to help you?” There really wasn’t anything except that there were some people who understood and maybe gave me a little leeway, because I was trying to play sports and trying to do academic things because I wanted to go to college. At that point in time, we had very little money, and my mother was ill. It was through Miss Kerr and connections. She said, “I want you to take certain examinations.” Which I did, and the next thing I knew I had a scholarship to Georgetown [University]. I had applied to some other places, but I had a scholarship to go to Georgetown, so I accepted that. They were extraordinarily helpful to me to go on. I entered Georgetown with an
interest in being a premed, because I had taken enough science courses to know that’s what I really wanted to do. So indeed I took premed courses, and then applied to medical school.

At that point, I still didn’t have any money. My father was able to help me a bit, because he was beginning to do a little better in his life, and digging out from a terrible illness and two years of what you can imagine. He was trying to get ready for my brother to go to school. I remember having a family discussion as to who was going to go to school first, that type of thing. Eventually, all those things took care of themselves. I got into Yale [School of Medicine], had a work-study scholarship, and was able to finish up my studies there. I think it was basically my father interesting me in studying and using my intellectual talents, whatever they were. It turned out I was a very good student. I was very fortunate. I was blessed. I was pretty well always at the top of my class.

DR. HOLCOMB: Before entering medical school, did you know you wanted to be a pediatric surgeon?

DR. O’NEILL: No, that happened in medical school. It was a sentinel event, I guess you’d call it. I liked pediatrics. Yale had a very outstanding department of pediatrics at the time. They were particularly good, both in pediatrics and in medicine, particularly good in the field of metabolism.

DR. HOLCOMB: Is that what drew you to Yale Medical School?

DR. O’NEILL: Well, it was a combination of the school being excellent, and that Yale then, as today, had something called the Yale System of Medical Education. It’s unique in American medical schools. What that system embodies is really self-teaching and continuous scholarship. There were no examinations, other than that every day there would be small group sessions with faculty in all courses. You more or less had a seminar on what was going on. Occasionally you’d skip a day, but rarely. In the clinical areas, you never skipped a day. So those were your exams. Then you had to pass the national boards at the end of the second year, and then again at the end of the fourth year before you could graduate. But they knew how you were doing, and if you weren’t doing well, people were called in. Thank goodness I never got called in. [Laughter] I mean, I knew friends of mine who did get called in.

So I think it was more that, because it appealed to me to be self-reliant. Even then, even though I was immature, I somehow had an appreciation for the fact that it was going to be good for a physician to be trained in how to continually educate him- or herself. And indeed that judgment was correct. Also, I knew it was a superb school. I knew two people who had gone there
and talked to them. Then I interviewed in the various schools that gave me interviews. There were a lot of interviews I remember, but the one at Yale was the one that impressed me the most in terms of the way I saw faculty relating to students, and the way they treated me, even though I wasn’t coming with tuition. They were going to have to supply it. It was just that it clicked with me. I always say that that probably was the lynchpin in my own career for the way I chose to do things in medicine. My own education was my own role model for what an educator should be. That probably was for me, in terms of medical education, a turning point.

DR. HOLCOMB: You were talking earlier about your interest in pediatrics and in metabolism.

DR. O’NEILL: Yes.

DR. HOLCOMB: Why don’t you expand on that a little bit?

DR. O’NEILL: Sure. I was interested in pediatrics, and I was interested in metabolic activities, things of that nature, and that was very strong at Yale. So I’d learned a lot about pyloric stenosis, and metabolic alkalosis and those things, because the basic work on that subject had been done there. Now, there were no pediatric surgeons there, and there was very little pediatric surgery going on. I had developed this interest in pediatrics, and, let’s say, new areas of pediatric care. I spent a year while I was going to school, and this included two summers, working with a wonderful woman by the name of Ruth Whittemore, who was one of the pioneering pediatric cardiologists in this country. She had come to Yale from [Johns] Hopkins [University]. She had worked with Helen [Brooke] Taussig. Interestingly, she had had some exposure to a young surgeon at Hopkins by the name of H. William Scott [Jr.], who later on appeared in my life. Anyhow, I worked with her on a project that had to do with coarctation of the aorta, and I was going to the operating room and following patients. It was a long-term study on patients with coarctation of the aorta, and what difference operation made in the course of those children. I devoured every bit of information I could about congenital heart disease, and what have you, and I followed her around. She was wonderful to me and taught me a lot.

Then because I was around, I was able to accelerate my clinical rotations. The first rotation — and this was really the sentinel event — was really before the class started in the third year of clinical years. So that summer, I did pediatrics. I was the only student on the service. One Saturday morning, a small child came in and had had what were called fainting spells. The story almost sounds amusing in today’s light. But in 1957, 1958, it was not necessarily so amusing. At any rate, this child came in and was quite ill, obviously, and had had what were called fainting spells. The child would
collapse in a playpen, and then a few minutes later wake up and seemingly be okay. Then later, the same thing would happen.

So when the child came in, the sequence was that a pediatric intern examined the patient first — like on all teaching services at that time, maybe even some today — and didn’t have a clue what was going on. Now, I had examined the patient with the intern, and I didn’t have a clue either. Well, the next person was the assistant resident, and he didn’t have a clue. So they called the chief resident in from home, who was a really brilliant guy, who later became a quite famous academic pediatrician. Well, he didn’t know either. He said, “You know, I haven’t got any idea what’s wrong with this baby. But I think there’s something wrong with this child’s belly.”

So they called a surgical consultant who did some pediatric surgery. That was more or less the model of pediatric surgery back then, where there were good general surgeons, who did whatever pediatric surgery was needed. Maybe there were a couple of people who did that. Anyhow, his name was “Stem” [James] Foster. Parenthetically, he later had a son by the name of [James H.] Jim Foster, who became the chairman of surgery at the University of Connecticut. But at any rate, Dr. Foster came in, took the history, looked at the child, put his hand on the abdomen, and said, “This child has an intussusception, needs to go to the operating room right away.” I went to the operating room. Dr. Foster was very nice to me. He showed me the operation, let me scrub in, let me handle the tissues, taught me about intussusception. And that moment I said, “That’s the kind of doctor I want to be.” That’s why I call that a sentinel event. I don’t know whether you’ve heard that story before.

DR. HOLCOMB: No.

DR. O’NEILL: But that’s what made me say, “Okay, I’m going to be a pediatric surgeon.” And from then on, that’s what I sought to do.

Now, just like my father who didn’t want me to go into medicine for nice reasons, my advisor wanted me to do well. My advisor was the chairman of surgery, Dr. Gustaf [E.] Lindskog, who was a cardio-thoracic surgeon, one of the pioneers mainly in thoracic surgery. He had offered me a residency in surgery at Yale. He ran the program. I had heard from Dr. Whittemore, who had been mentoring me, because we had been writing a paper or two while I was doing these other courses. She said they had a very good person at Vanderbilt who had done a lot of training in pediatric surgery. When I looked into it, they actually had a rotation called pediatric surgery in the internship year.

DR. HOLCOMB: And that was unusual back then.
DR. O’NEILL: It was unique. There were no other places in the United States that had that. Now, the Brigham [and Women’s Hospital] had a program, whereby after a year or two, you rotated at the Children’s Hospital Boston. But there was nothing. No residency had anything called pediatric surgery. And that was going to be my mechanism to make up my mind, finally. I’ve always felt that if you think you might do something, you can’t let it happen by osmosis. You have to actively engage it and test it, and that’s what I was going to do. I remember Dr. Lindskog said, “Well, I can’t understand why you’d want to do pediatric surgery. There’s no future in that. We do all that. Look, we do all the pediatric heart surgery. We do everything. Who needs pediatric surgeons?” He was trying to guide me. He wanted me to do something that he thought would be better for me, and I appreciated that. But I persisted, so he said okay. He said, “I’ll put in a good word for you at Vanderbilt. But you go down there, and you get it out of your system, and then you come back here.” I said, “Okay.” Actually I think I said, “Yes, sir.” We made an agreement that I would come back after a year. He said, “You have to finish up your surgery anyhow, and Yale is one of the best programs. So you should come back here.” I loved my time at Yale. So that’s how that transition occurred.

Even though I was dissuaded, by then I had read Dr. [Robert E.] Gross’s book [Surgery of Infancy and Childhood] that was published in 1953, and I had a copy of the previous book, Abdominal Surgery of Infancy and Childhood [1941] by Drs. [William E.] Ladd and Gross. Then Dr. Gross took that book, updated it, and then added cardiac, and urology and some other things. I read that book, must be ten times, and almost read it like you would a novel. Then I would follow up references and read about anomalies and some of Dr. Ladd’s original papers. All of this as a student, and I fell in love with it. So that’s more or less how that evolved over time. Despite being dissuaded, even though the people had very good intentions, I just saw a field that was a pioneering field, with not a lot of people in it, and a great need. And I thought that being able to maybe perform the ultimate role in the care of a child was the most appealing thing to me.

DR. HOLCOMB: So I guess you never came back to Yale after your first year at Vanderbilt.

DR. O’NEILL: Well, that’s kind of an interesting story, too. Because in those years, all of the surgical programs were pyramidal. You’d hear at the end of each year whether you were going to stay on and go to the next year. We started with 12 interns, and we ended up with two chief residents. So that meant that all the others had to go into specialties, or go someplace else. Admittedly, you would have gotten a job someplace else, but it was more or less by word of mouth. It wasn’t anything you did. You were told where you
were going to go. That’s the way it was everywhere. It was nice if you had a chief who would make a bed for you to lie in later. At any rate, I loved it so much at Vanderbilt, and my experience with Dr. Scott, and the things that were going on in pediatric surgery here at Vanderbilt, even though there was no card-carrying pediatric surgeon. Dr. Scott had had more training than most of the people who were recognized as pediatric surgeons, so I got all that information and experience. I made an appointment to see him, and I said, “Dr. Scott, I’ve thought about it, and I don’t want to go back to New Haven. In New Haven they have all these specialists, and they do all the work, and you don’t get to be as much of a general surgeon as you do at Vanderbilt. So I’d like to stay on.” He said, “Well, you have an obligation to go back to New Haven and Dr. Lindskog. Besides that, all the places are taken. I don’t have a spot for you, because the agreement was that you came here for a year.” I said, “Well, I really want to stay.” And he said, “Well, you have an obligation. I can’t help you.” So I left the office. Have you heard me tell this?

DR. HOLCOMB: No. [Laughs]

DR. O’NEILL: So I called Dr. Lindskog, who was a real friend of mine, and of course he knew me, and I presented the situation. I said, “I’ve not lost my love of pediatric surgery. I want to do this. This is a wonderful environment for me to do it, with people who really have a devotion to seeing that something happens, pediatric surgery-wise, in this world.” Of course I was very discreet and reverential in the way I expressed myself. But I told it like it was, in a sense. So Dr. Lindskog said, “Okay, if that’s what you really want, I really wish you well. I release you from your obligation.” So I went back to Dr. Scott, and I said, “Well, I got out of my obligation.” He said, “You did what?” Well, he started at the top of my head, and it went down to the bottom of my toes. He read me out! He called me stupid. He called me impractical. He called me dumb. I just wanted to crawl into the carpet. At the end of all that, he said, “Okay, I’ll give you one more year. You’ve obviously gotten yourself in a terrible fix. I’ll give you another year. Then we’ll have to work out what happens with you, because I just don’t have a spot for you. I hope you never do anything like this again.”

Well, I started that second year, and it turned out I had a lot of rotations. Like at the beginning of the second year, the Nashville General Hospital [at Meharry] opened up with Vanderbilt rotations. I was at the VA [United States Department of Veterans Affairs]. I mean, a whole bunch of things occurred, including a bout with polio that I had in my first week of my second year of training. In those years the PGY 1 [post graduate year] was called internship, and your first year of residency was your PGY 2 in modern terms. I was sort of off to the side. I was very careful, after being dressed down so thoroughly, to stay as far away from Dr. Scott as I possibly could. I
didn’t talk to him and didn’t go in. I was just afraid, you know, to do anything. So as the year went on, and got to the point where I knew people were being called in about the next year, I just said nothing and tried to keep a low profile. He didn’t ask me to come in. He sent a note out, and in the note it said, “Your rotations for the following year will be the following…” So I breathed a sigh of relief.

At the end of the third year, I was anxious once again. Then I got another letter that said, “Your rotations will be…” We never covered that issue again until I got called in, and I was told I was going to be one of the chief residents. Then he said, “I’ll bet you think I forgot that we were supposed to talk about where you would go at the end of your second year, and then every year thereafter. I didn’t forget. I thought that would be just a good way to make you work hard.” [Laughter] It’s sort of an amusing story, but I could tell there were times when he gave me extra rotations on services where the pediatric surgery would be done, and so forth. Behind the scenes he was actually grooming me, because he knew what I wanted to do. So that’s kind of the story that goes behind that.

DR. HOLCOMB: So during those years — this would have been the early 1960s?

DR. O’NEILL: Correct.

DR. HOLCOMB: Were there any formal pediatric surgery training programs at that time?

DR. O’NEILL: Oh, yes, there were some, but they were not formal, the training programs the 1960s. See, I finished my general surgical and thoracic surgical training in 1965, and at that time there were about 20, approximately 20 programs. I’d have to look up — I have records actually — the exact number. They were basically two-tiered. The first tier was a group of about six programs. There was Boston, there was Columbus, there was Philadelphia. I might even have some information about that here.

DR. HOLCOMB: Was there one in Seattle at that time?

DR. O’NEILL: Well, there was Gross in [Children's Hospital] Boston, [Willis (Bill)] Potts, and then Orvar Swenson in [Children's Memorial Hospital] Chicago, [C. Everett] Koop in [Children's Hospital of] Philadelphia, [H. William] Clatworthy [Jr.] in [Columbus Children's Hospital] Columbus. Seattle came, actually, a little later. It was one of the more informal ones. Then there was one in [Children's Hospital of Michigan] Detroit with Cliff [Clifford D.] Benson and Bill [William H.] Snyder [Jr.] in [Childrens Hospital of] Los Angeles. Those two had had no
pediatric surgery training. Some others came on line later. Mostly they were people who took fellows. For example, in 1966, I was still in the Army at the time, and I was invited by [E.] Ide Smith to come to Kansas City. He offered me a fellowship position with him at the Children’s Mercy Hospital, the old one, in Kansas City. He had Vic [Victor G.] McDonald [Jr.] there at the time. So that was the kind of program it was. It was that way in many, many places. Then later, it became more codified, as the so-called Clatworthy Committee came along.

DR. HOLCOMB:  Let me just take a little break. I just want to make sure everything — [Pause in recording]  Okay.

DR. O’NEILL:  I’m not sure you’d call them formal training programs. The first one was in Boston, and that was about 1937. The early training in those years was several months of observation for a residency in Boston. It was really World War II that hampered any development of pediatric surgical education. But it’s interesting, the war defined what the training needs would be. So it was, like, 1945 when Dr. Gross took over after Dr. Ladd. That’s when things became a little more codified. Then the second training program, also in 1945, was in Chicago. Then almost immediately, Philadelphia, Boston Floating Hospital [for Children at Tufts Medical Center, Boston], because Dr. Swenson had moved over there, Columbus and Montreal. So that was it. But there were no preexisting guidelines. The only thing was the experience and intuition of the small group of surgeons who decided to dedicate their careers to teaching pediatric surgery.

It’s interesting that the Surgical Section of the American Academy of Pediatrics endorsed these programs without any specific guidelines. The Surgical Section had only been established in 1948, and the endorsement came in 1952. So that pretty well left it up to the surgeons to mature their own process. But by 1963, there were 11 approved programs through this mechanism, which was more or less informal I would say. Virtually all of them had one or two years of training in Boston. It was after that that you began to see Detroit with Cliff Benson, who was a general surgeon, and Bill Snyder in Los Angeles, also a general surgeon, but one who devoted his energies entirely to pediatric surgery. So there were a lot of these people who were self-trained pediatric surgeons, if you want to say. People who had read the book, people who would go and observe, and people who would go to the Surgical Section meetings and share experiences, and wisdom, and so forth. So that’s pretty well what the early background was until the process became more formalized. That wasn’t really until 1970.

DR. HOLCOMB:  Now, following your general surgery training at Vanderbilt, you served in the [United States Army Institute of Surgical Research, originally known as] U.S. Army Surgical Research Unit at Brooke Army [Medical Center]
Hospital, Fort Sam Houston in Houston, Texas for two years, from 1965 to 1967. How did you get interested in Brooke Army Hospital, which has an emphasis on burns. Was burn treatment an interest of yours during your surgical residency?

DR. O’NEILL: Well, that’s another sort of networking story. I had done a fair amount of research during my time in the surgical residency. I was presenting a paper at a meeting, and the moderator of this session for resident papers, was a man by the name of Curtis [P.] Artz. He was one of the world’s great burn surgeons, as well as being chairman of surgery at the University of Texas Medical Branch in Galveston, where they had a really outstanding burn program under a man by the name of Truman [Graves] Blocker [Jr.]. At a reception following this resident paper session, Dr. Artz said to me, “What are you going to do when you finish your residency?” And I said, “Well, I’m going to go into the Army.” I had volunteered for something called the Berry Program [Berry Plan], which meant that you could finish your residency, but you went into the service after that, which was fine by me. He said, “Well, where are you going to go in the Army?” I said, “I didn’t know you had a choice.” So he said, “Would you have any interest in burns?” I said, “Absolutely I would, because there is an awful lot that has to do with metabolism, and fluid balance and things like that I’m interested in. All of those things relate to my real interest, which is pediatric surgery.” So he said, “Would you like to go to the Army burn unit and the Army Surgical Research Unit at Brooke?” And I said, “Well, I surely would.” He said, “Well, you will hear from me.”

But I didn’t hear from Dr. Artz, I heard from a man by the name of John [A.] Moncrief, who was the commander and director of the unit, and who was very well connected. He was on an NIH [National Institutes of Health] study section panel with Dr. Scott. They were close friends. Dr. Artz was on the same one, so these fellows networked. What they were doing was picking people out and placing them. So Dr. Moncrief said, “I’d like to interview you.” I said, “Well, I’m not slated to go to any meetings or anything like that.” He said, “Well, there’s a course in mass casualties that’s being offered to chief residents here. Go ask Dr. Scott if you can go to this course.” So I did, and Dr. Scott said, “Oh, Jack Moncrief just called me. Yeah, you can go.” So off I went. I was a chief resident at this point in time, otherwise I’d never have dared go see Dr. Scott. At any rate, I went to San Antonio, and Dr. Moncrief interviewed me and showed me around, and said, “Okay, you’ll get your orders.”

So that’s how that came about. And I went there. But that was when Vietnam started to get busy. So I had to spend a little time in Japan, which was fine, because it was all related to burn care, and I was able to continue to do research. We took care of a lot of casualties in those days that were more than burns. So I ended up doing a lot of general surgery. I ended up being
the chief of the Burn Study Division [Burn Study Branch]. I made some contacts and some lifelong friendships. For example, Basil [A.] Pruitt [Jr.], who was not there at the time I got there, but came later because he was on temporary duty in Okinawa, became the closest of friends and still is today. And many other people who came through that unit, the same way. So it was one of these providential things that I got to do a lot of surgery. I got to serve my country, and I got to do a tremendous amount of research that I was able to carry on.

Now, we worked hard. We operated seven days a week during those years, and yet you’d get to the lab in the afternoon. We spelled each other, and we did some things that were, I guess, pacesetting. It was a very good time for someone like me to be there. It helped to give me some idea I might want to be an academic surgeon down the line, because I found I liked the things that I was involved with.

DR. HOLCOMB: What was burn care like in the 1960s? What products did you have for topical therapy for burns during that time?

DR. O’NEILL: Well, first of all, there were a variety of ointments and things like that, none of which worked well. There was an entity called burn wound sepsis. This is an entity whereby if there is colonization of the burn wound above a critical level, about $10^6$ organisms per gram of tissue of particular pathogens, that it becomes invasive, and you have invasive burn wound sepsis, vasculitis, embolic phenomena and death. There was a guy by the name of Robert [B.] Lindberg, who was a PhD bacteriologist, who had developed a cream called Sulfamylon. We were involved in the first clinical studies of Sulfamylon. One of the things that happened, fortuitously when I was there, was that no one was really interested in children. We took care of soldiers, and we took care of dependents. So any dependent child would be flown into San Antonio, and I took care of all the children. They were particularly prone to burn wound sepsis.

So we did our first clinical studies on Sulfamylon during those years. Bob Lindberg was a wonderful guy to work with. We had a burn model in the lab, which I used for years afterwards in terms of burn wound healing and other types of healing. That, I think, really led to some very important advances in topical therapy. But the other interesting thing was that Sulfamylon led to metabolic changes in the patient, and I was very interested in metabolism and fluid shifts. So it became very fruitful for me. We began to study the sidelights of it, like how to take care of metabolic acidosis that is related to a topical agent. How does that affect renal function? So we had clinical studies of renal function, and so forth. How does it affect gastrointestinal secretions, particularly gastric secretions? We studied that. It was a very fruitful time in terms of that.
I would say that burn care was excellent. It wasn’t as good as it is today. We did studies with cadaver skin, pigskin. This was all before we had — We had to harvest it ourselves. There were no commercial products of any sort. There had been some studies in prior years with some prosthetic agents, but none of them were any good. Ivalon sponge was one in particular. We were involved in doing burn wound excisions, but unfortunately, the patients were not in as good a shape at that point in time. We couldn’t keep them in nutritional shape the way it’s possible to keep patients in nutritional shape today. There wasn’t quite the understanding in 1966 about how to provide super levels of nutrition. Metabolic rate had not been measured accurately yet, though it had been measured. So we were just at the beginning of a lot of advances.

But I would say we saw survivals during that period that were almost unprecedented because of the introduction of topical antibacterial therapy that was effective. Now, there were complications, but it was effective. Simultaneously, maybe with a short lag, Carl [A.] Moyer in St. Louis began to use silver nitrate. That had been used previously, but not in the way that he used it, and in the concentrations that he used it, and they had their own problems with that. But between those two advances, burn care was revolutionized, and that’s what happens today. Of course there are many changes that have occurred. Silver sulfadiazine came along, and that was a good advance, because it avoided the metabolic consequences of Sulfamylon, although, as you well know, Sulfamylon is still used for specific purposes, for resistant organisms, for soaks with donor sites, and things like that. Also during that, we had the first prototypes of donor skin expansion, and that made a big difference for us. We were able to provide skin coverage for many patients. Now, we didn’t have keratinocytes, and couldn’t grow skin and things like that, yet. But I would say, that in that period of time, burn wound care was excellent. It just wasn’t as advanced as it is today.

DR. HOLCOMB: Now, you completed your pediatric surgical residency at Columbus Children’s Hospital under Dr. William Clatworthy from 1967 through 1968. Dr. Clatworthy was certainly one of the most well-known pediatric surgeons in our field, and certainly one of the leaders of pediatric surgery during the development of pediatric surgery as a specialty. First, how did you come to obtain your training at Columbus Children’s Hospital under Dr. Clatworthy? What was training like at that time? And what was Dr. Clatworthy like?

DR. O’NEILL: That’s an interesting story, as well, because I fell through the cracks in a sense. Following, I guess, my second year, either my second or third year of training in general surgery in Nashville, I forget which it was now, I had made an appointment to see Dr. Gross in order to inquire about pediatric surgical training. Dr. Scott had told me about that.
He said he would recommend me. He didn’t say he’d let me finish my residency, but he said he’d recommend me to Dr. Gross. As a matter of fact, I thought maybe that was his way of getting rid of me at the time, which, of course, didn’t turn out to be true.

So anyhow I went up to see Dr. Gross, and Dr. Gross said, “You shouldn’t come here now. You’ll not get as much out of the training as you would when you’ve finished your residency. I would advise that you finish your residency, and then you come here.” He had a book, and he pulled out this book, and he penciled me in for that particular time. I remember saying to Dr. Gross — I probably shouldn’t have said it — but I remember saying, “Couldn’t you use a pen instead of a pencil to write my name in?” [Laughter] He laughed at that.

But in order to see him, I went up there with my wife, because she lived in Massachusetts, and it was a time when we could see the family. We waited outside his office for three hours, and then he came. He was very gracious to me. He let my wife, Susan, sit outside. But he talked to me in the office, and that’s when he went through everything. He gave me ample time, and he gave me advice, and so forth, but he said, “You know, I’ll put you in for —” whatever the date was “— 1965.” Well, 1965 came, and there was no question, I had to go into the Army. In fact, I remember calling the surgeon general’s office and saying I was supposed to come into the Army, but I had a residency in pediatric surgery now, and asking if I could have two more years. The person in the office said, “Well, what we have in mind for you, we won’t need any pediatric surgeons.” I didn’t know at the time what that was about, but of course I learned later. That was before I had any idea about getting to Brooke Army Medical Center. It was in that transition time. So I called up to Boston, and I actually got to talk to Dr. Gross. I said I had to go into the Army for two years. He said, “Not a problem. By law, I have to save a spot for you. I’d do it anyhow, because Dr. Scott had recommended you.” Dr. Scott had trained with him for three years. So I was all set.

Well, I get this page. I was at Brooke Army Medical Center. I was in the operating room, and I got a page. There were no pagers then. You got a page over the loudspeaker system, just the same way it was in any hospital. It said, “Report to Colonel Montcrief’s office as soon as you’re through.” So the nurse said I should call on the telephone to the number. So I did, and Dr. Montcrief said, “Call Dr. Scott immediately.” I called Dr. Scott, and he said, “We have a problem.” I said, “What’s that?” He said, “Dr. Gross just called me. He’s just been fired.” This is a very interesting story about how surgery worked at that time. He said, “Dr. Gross is sitting at his desk waiting for calls from various people that he has obligations to, and you should call him.”
So I called Dr. Gross, and his secretary put me through. He said, “It’s true I’m no longer the surgeon-in-chief. I’ll be here doing cardiac surgery. It’s still a wonderful place to come to train, wonderful radiology, wonderful everything. It’s still the major place. It’s just that I wouldn’t be your training director. We’re not sure now who would be. This is a great place. If you take a chance, you’ll get good training here. But if you’re not 100 percent sure, I’d advise you to go to Columbus with Dr. Clatworthy. If I were you, I would explore that. I happen to know Dr. Clatworthy is in his office.” They’d all cooked this up behind the scenes. He said, “You should call him if you have any interest. If you want to come here, the job is still yours.” So I said, “Well, Dr. Gross, I think I would like at least to explore this.” He said, “You’re prudent.”

So I called Dr. Clatworthy. Dr. Scott had already talked to him. They had had, I don’t know, a three-way conversation, or whatever. So Dr. Clatworthy said, “You’re to be here for an interview next Wednesday.” And I said, “Well, Dr. Clatworthy, I’m in the Army. I can’t do that.” He said, “Well, I’ve talked to Dr. Scott, and he’s talked to Dr. Moncrief, and you have leave to come here next Wednesday.” So I got on a plane, went to Columbus from San Antonio. I made my way to the hospital where Dr. Clatworthy was and went to his office. He had a place for me at the University Club in Columbus. He put me up nicely, took good care of me. Then he said, “We’re going home for dinner and a talk.”

So we went to his house, and his wife was there. He had a lovely home on the Olentangy River. It was really a beautiful site. Dr. Clatworthy was a great hunter and fisherman, and he had some white-winged dove that he had shot out in Colorado. His wife cooked up this fantastic game dinner. I also had a thorough tour of the hospital and met the people. I was a little antsy because one of the faculty said to me, “You’ve been at Brooke, you’ve done a lot of research. You’ve done all of these things. You don’t want to come here. This is not the place for you. You should probably go to Boston.” But I had met Dr. Clatworthy, and I had known about him, and I knew he was a superior intellect, and I knew he was a good teacher, those things, because I had done my research about him. So I could tell this was just interdepartmental tension. Although that worried me a little bit, I went further and went home with Dr. Clatworthy. We had this lovely dinner. Then he said, “Let’s have a chat.” So we went outside, out by the river. He had a motorboat there, and what have you. He said, “I think you’ll do.” By then he had reviewed my background and so forth, and he had probed me about what I thought I might want to do. He said, “We’ll take you on. But, I want you to realize one thing.” And this characterizes the man in one sense. He said, “If you don’t work out, you’ll be gone in six months.” So I said, “I assure you I will work out.”

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Later I learned that he was really tough on people. There were some people he actually almost destroyed. But I’d have to say, he was wonderful with me. Maybe he was beginning to mellow by that time. He had had some personal issues in his life. But he was fantastic to me, and then through the rest of my career he was. He was always warm with me. Later he stayed in my home. We became good friends. There was a group of young pediatric surgeons that he took a liking to and supported. So my two years with Dr. Clatworthy were wonderful. He influenced the other people there, including this individual whose name I won’t mention, so it was the place for me. I was able to do some research while I was there during my residency. We had a little lab. We interchanged with Helen Noblitt and did some of the suction biopsies of the rectum for Hirschsprung’s disease, and we worked through with the pathologist to interpret the sub-mucosal plexus of nerves. A lot of that stuff hadn’t been done. Some early work had been done with acetylcholinesterase. So it was a fantastic time. After having been there for a little bit, I saw the kinds of people who had come through there — where they had gone, and what they had become — and it told me that it was a farm for academic surgeons.

DR. HOLCOMB: Well, a number of training program directors, as well as chiefs of general surgery and pediatric surgery have come from that same training program in Columbus. Who were some of the others who rose to those ranks in academic medicine?

DR. O’NEILL: Well, Dr. Clatworthy had the abilities in education. As far as I’m concerned, there were two teachers in my life who were absolutely outstanding, and who were born teachers. One was H. William Scott, and the other was H. William Clatworthy. Dr. Clatworthy and Dr. Scott had the facility of remembering anything they read, any case they ever saw. They had wonderful intuitive analytical abilities. And more than that, they had the ability to transfer that information. We would have a teaching session every Thursday with Dr. Clatworthy. We’d make rounds, and he had a time when we’d present cases, and he would lecture. He would go into ethics, he would go into organization of surgery, he’d go into boards, he’d go into intricacies of pediatric surgery. He would ask questions like “why?” He never asked, “What, what is this?” He’d ask why. Most of the questions there was no answer to. He was as stimulating a mind as you could ever encounter. I think I benefited from that, as well as everyone else. That manner of his, and the stimulation of research ideas on his part, I think that’s why they were golden years of producing academic surgeons. If you look at the output of what happened at that time, I would have to say that Clatworthy was truly a visionary. If you look at his trainees, it ended up that eight of his graduates became chairmen of the Surgical Section, as well as president of the American Pediatric Surgical Association. Five were Ladd
Medalists, and two were chairmen of surgical departments around the country.

During his years, he also took people for a year, a number of foreign fellows, if you will. For example, he took Victor MacDonald, who was an outstanding cardiac surgeon and pediatric surgeon, who worked at the Children’s Mercy Hospital in Kansas City. I knew him very well. Michel [G.] Gilbert, although he was in private practice, worked at the University of Miami. Jim [James] Floyd, who was the chief in Detroit, Wayne State. Blanca Kent, who worked in Columbus. Jacques [C.] Ducharme, who was the chief of Montreal Children’s Hospital. Bill [William] Bailey, who was the associate chief in Denver. Peter [K.] Kottmeier, who was the chief of pediatric surgery at [SUNY] Downstate [Medical Center]. Chad Baxter, who worked in Spokane. Floyd [R.] Schultz, who was the chief of pediatric surgery at the Children’s [Hospital] at the University of Nebraska [Omaha]. Jim [James E.] Allen, the chief in Buffalo, SUNY-Buffalo [The University of Buffalo, The State University of New York]. Al [Alfred A.] de Lorimier, the chief at University of California, San Francisco. [H.] Biemann Otherson [Jr.], the chief at Medical University of South Carolina. Eric [W.] Fonkalsrud, chief at UCLA [University of California, Los Angeles]. Dick [Richard] Ellis, the chief at Fort Worth. Mark [L.] Rowe, the chief in Miami, and later the surgeon-in-chief at Pittsburgh Children’s [Children’s Hospital of Pittsburgh]. Don [Donald M.] Buckner, chief at the University of Miami. Rick Preeby, the chief at SUNY-Stony Frook [State University of New York-Stony Brook University].

Neil [R.] Feins, the chief at Boston University, now at Boston Children’s [Hospital]. Arnold Leonard, chief at the University of Minnesota. Michael Bankole professor and chairman of the Department of Surgery at the University of Ibadan, Nigeria. Myself. Sriwongse Havananda, the chief of surgery at the [Samitivej Srinakarin] Children’s Hospital in Bangkok, at the University of Bangkok [Bangkok University] in Thailand. Carlos [M.] Antunes, the chief of pediatric surgery at the Children’s Hospital [Santa Casa de Misericordia, Belo Horizonte] in Porto Alegre in Brazil. Jay [L.] Grosfeld, professor and chairman of surgery at the Indiana University, and the head of Riley [Hospital for] Children. Madad Schiller, professor and chief of pediatric surgery at the Hebrew University-Hadassah in Jerusalem, and also later the dean. Several others in between. Burt [Burton H.] Harris, the chief most recently at Montefiore [Medical Center] in New York. Dennis King, for a time the associate chief at Columbus Children’s [Hospital], and two or three others.

I think that if you look at the output from these various programs, or output from Columbus, I should say, it’s remarkable, in that period, how many academic surgeons he produced. To this day, there isn’t another training
director, including Dr. Gross, who put out as many academic surgeons, and none who put out people who later became chairmen of major departments of surgery in the United States. I think it is his influence, his ability to transfer his talents, and his inspiration that made a difference. Plus his continuous support throughout the careers of these individuals. That’s what made Bill Clatworthy unique. He was a tough customer. But at the same time, he was giving, and kind and inspiring.

DR. HOLCOMB: You mentioned Dr. Jay Grosfeld, who’s another Ladd Medal winner. I know that you and Dr. Grosfeld were residents together in Columbus and have been friends ever since that training time. What was he like during that time? Tell me about your friendship with him.

DR. O’NEILL: Well, I was already there a year, at which point he was the next person coming in. He was coming out of the Army, as I had come out of the Army. He was stationed here in the United States and had had a general surgical slot. He was very well trained at NYU [New York University] under Dr. [John H.] Mulholland first, and then Frank [C.] Spencer, and we just hit it off. First of all, we were partners. Even though I was nominally his chief resident, there was no such thing. We were just partners. When he came in, he was in the process of having five children, so he occasionally needed a little time. We had this arrangement whereby we worked every other night covering a service, except when a newborn came in, and then we both went in and operated together. Dr. Clatworthy and the others would let us do that, because we were very well trained by that point in time. For example, when Jay Grosfeld came, he had his boards in general surgery. When I came to Columbus, I had my boards in general and cardiac and thoracic surgery. So they let me do a bunch of things, and they let him do a bunch of things, and together we had more fun.

As a matter of fact, one of our faculty staff, Dr. Tom [Thomas E.] Boles [Jr.], who was a superb surgeon in his day, used to like to be ahead of everything. He was very particular about how his patients were cared for, and so forth. He’d catch Jay and me, and he’d say, “I can’t leave you guys alone five minutes. You’re always doing something that I don’t know about.” [Laughter] And you know, fortunately, we never got ourselves in trouble. We always did things well. We all ended up friends with all of those people, because we were a bit more mature coming in. Much like the people after World War II, going into residencies were mature men who had been through the war. Well, anyhow, that’s the beginning of it. We became partners and close friends. When his wife would have a baby, I’d say, “Take off a few days,” and I’d cover constantly. There was no such thing as an 80-hour work week. But that didn’t matter, because both he and I loved what we were doing.
He, at that time, was a nice guy, a wonderful friend. At that point, if I had had to observe about him, I'd have said I saw in him a real feeling of caring for small children. He was wonderful with children. It’s good, because he had five kids of his own at that time. Our wives got to be friendly, and that has continued throughout our lifetime, because we really saw eye-to-eye. We had the same ideals. We wrote a bunch of papers together. We didn’t care whose name was first. We’d swap it back and forth. We worked equally on everything. It was, I would say, a prolific time. We did experiments together in the laboratory. If one of us had time, one of us would do work. The next time, he’d go do something. We might go in at 3:00 a.m. Whatever. Those were very, very busy years. But I have to say, Dr. Clatworthy would be there at 3:00 a.m. He expected everybody to work that way. So Jay Grosfeld was a great person to have come in and be my partner. It’s so interesting how our careers have paralleled one another in so many ways.

DR. HOLCOMB: Speaking of partners, I know that your wife Susan has had a great impact on your life, as have your three children. When and how did you meet Susan? And when were your children born, and where are they now?

DR. O’NEILL: Well, I was very lucky to get the wife I have. It was through a girl that I grew up with in New York. I had seen her vacations, things like that, and she was a friend. She wasn’t somebody that I was going to marry, we just were great friends. She was at Vassar College, and she said, “I have a friend you need to meet. She’d be perfect for you.” But I didn’t meet her for one reason or another until I got to Yale. Then I called my friend, Jean, and said, “Jean, is that girl you’ve been telling me about for a long time still available?” And she said, “Well, I’ll check.” Well, anyhow, through a series of events, I got to meet Susan, and we had a date. Although I didn’t have a date with her the first time, because she had a date with someone else. But I got to meet her through the efforts of my friend.

I made a date with her that night. We started dating, and then I met her family. Her father was a pediatrician, who was very nice to me. He’d done some training at Boston Children’s Hospital. He had trained first at Babies Hospital [Babies & Children’s Hospital of New York – in 1998 became Morgan Stanley Children’s Hospital of NewYork-Presbyterian Hospital, part of Columbia University Medical Center], and then went to Boston Children’s, and was a [Johns] Hopkins [School of Medicine]-trained individual for medical school. He took me on like a son, because he had two daughters. He said, “You know, I think pediatric surgery’s a great field.” I was developing an interest in it. He said, “Think about academic surgery.” He knew what my interests were. In fact, Susan used to get mad. She’d say, “Did you come here to see my father or me?” Because her father and I got to be such good friends.
She was the daughter of a doctor. She saw how a doctor worked during World War II. He was one of the few pediatricians left in Springfield, Massachusetts. So she understood what the obligations and responsibilities of a doctor were. In fact she said to me one time, “You know, everyone said, ‘Don’t ever marry a doctor.’ I don’t know what I saw in you, but that’s what I did.” Well, she has been supportive throughout my entire career. She, like a lot of our wives. You know, when I was starting out, I had no help. I worked hard all the time. Not that I didn’t like it, I loved it. She saw that I loved it, and she was supportive. She supported me through this, and we have had a wonderful life. We’ve had three kids, and they’ve all turned out well. We’re good friends. I’d have to say, I didn’t get to every soccer game, but I got to a number of things, and made sure I did, even if I had to go back to the hospital later. Sometimes I’d miss something, and she’d fill in. But she has been my partner, and friend and everything else. She never, ever, tried to dissuade me from doing what I wanted to do. She always supported that. And of course, I’m grateful to her for that, because she made my career possible. That’s a truthful statement.

DR. HOLCOMB: Now, following your training at Columbus —

DR. O’NEILL: Oh, by the way, I forgot about the kids.

DR. HOLCOMB: Oh, yes.

DR. O’NEILL: Because the kids are special. Our oldest is a son, Jim, and he is a basic scientist. He has a PhD in physical chemistry and works in the IBM research laboratories in Yorktown, although he’s on a temporary assignment now, setting up a new nanotechnology facility in Albany, New York. It’s a partnership between IBM and the State University of New York in Albany. So he’s a high-faluting scientist and loves what he’s doing. He’s married to a girl who’s an executive producer for Bill Moyers’ public television productions [PBS] in New York. Then I have a daughter, Elizabeth, who’s the next one in line. She’s an actress, musical theater, and has been on Broadway. She now has two girls. I forgot to say Jim has three boys, but Elizabeth has two girls. She’s teaching dance and does a little work on the side. She’s married to a fellow who does staging work on Broadway, and does that all the time. Also, I have a daughter, the youngest, who’s a nurse-practitioner, who runs a public health clinic in Austin, Texas. She speaks fluent Spanish. She’s married to an anesthesiologist in Austin, and they have a boy and a girl. The girl is new. I think our children have turned out well, and all of that is due to their mother. Maybe a skosh is due to me, but it’s really their mother’s influence. She’s taught them responsibility and dignity, and always spoke about my absence, whenever that was, by saying, “Well, that’s his responsibility.” So she never created any kind of resentment with the children. We’re all wonderful friends today, go on
vacations together, and I’m very happy with the way that turned out. Sorry I interrupted you at that point.

DR. HOLCOMB: So following your training in Columbus, you went to Charity Hospital in New Orleans and the LSU [Louisiana State University] School of Medicine for two years, from 1969 to 1971. Did you consider staying in Columbus? And how did it come about that you went to Charity Hospital in New Orleans?

DR. O’NEILL: Well, Columbus was full. There was no room for any more faculty. Now, that was a transition period. Something that influenced me was that during my last year in Columbus, one night I was operating on a newborn, and it was 3:00 or 4:00 in the morning. All of a sudden a voice behind me said something. “I would probably do this a different way.” It was Dr. Clatworthy standing behind me. So we talked about the case. I was almost through. He said, “When you’re through, come up to the office. I want to talk to you.” So I went to the office in the middle of the night. He had been in the office. He said, “I just got fired as surgeon-in-chief.” So we talked almost the rest of the night. He just wanted to talk.

What had happened was, they had had a board of trust of the hospital meeting that evening, and he had been set up. The chief of pediatrics had wanted research space, and he took the surgical research space away — the lab that Jay Grosfeld and I, and others had worked in, and surgical fellows from abroad. He just needed it. So Dr. Clatworthy, being red-headed, had a fiery temper. He said to the board, “If Dr. So-and-so is going to take space that surgery needs for development, and this board is going to allow that to happen, you can have my job.” Of course it was a setup, and they took his job. So he was talking to me. I’ll tell you a little anecdote that sort of made Dr. Clatworthy and I friends forever.

I obviously was sympathetic with him. After he told me the story — and I was aware of some of these problems — I said to Dr. Clatworthy, “Well, you know there’s a Southern story, and you got set up. The story is that Hambone was out on the beach with his friend looking out at the ocean, and he saw some whales. His friend said, ‘I’m going to swim out there and see what they are.’ And Hambone said to his friend, ‘You know, them is whales. You may think you is a whale, but if you get out there, you’d better make sure you is a whale.’” So from that point on Dr. Clatworthy kidded me about that story. When I had a birthday party in my home in Philadelphia and a number of people were invited, he gave me a present which was a carved whale that I still have in my study. I also have a photograph of Dr. Clatworthy in my office across the way, and it says, “To a whale of a friend...”
That discussion, that conversation, he said, “You know I’m not in charge anymore. They’ll appoint someone. They can’t make me stop operating and running this training program, but they’ll approve a new surgeon-in-chief.”

It was a little different from what happened to Dr. Gross. He was taken out of the general surgery piece. Dr. Clatworthy also said, “I can’t make any appointments.” There were no appointments made for several years, because they really didn’t have any spots, and they didn’t have any money at that point either. So Dr. Clatworthy said, “I’ll help you find a good job, and what have you.” But in those days there were very few jobs available, and Dr. Clatworthy had started to place people. A lot of the names I read earlier were people who went to university centers, and that was maybe Dr. Clatworthy’s greatest contribution to the field of pediatric surgery, then or ever. That was to populate the university centers in the United States with well-trained, academic surgeons, and that was the nidus for pediatric surgical research. It all came from the university centers in those days. There were a lot of clinical advances made in the children’s hospitals, but basic research, not. And of course, it was a time when collaboration with the university basic sciences, and so forth, could happen. So I had two job opportunities, one at the University of Mississippi, and one at LSU in New Orleans. I took the job in New Orleans.

And it was, like, two and a half years later that Dr. Scott called me and asked me if I would be willing to return to Vanderbilt. They were starting a new children’s hospital, actually it was a hospital within a hospital. They had offered the job to Dr. Judson [G.] Randolph, and he had not accepted the job. So Dr. Randolph called me, as well, in New Orleans and said, “I don’t want you to think that me stepping away from this job means it’s a bad job. It’s a good opportunity. I just couldn’t leave Washington.” He and his wife wanted to return to Nashville, and then they stayed in Washington because Nashville was really a step down for him. He had a marvelous position, as it was at the Children’s [National Medical Center] Hospital in Washington [D.C.]. So Dr. Scott enticed me to come back to start the first department of pediatric surgery at Vanderbilt, and to work at the [Monroe Carell Jr.] Children’s Hospital [at Vanderbilt]. But I was a one-man band. It was a long time before I had any help.

But the New Orleans years were good in this sense. I worked at Charity Hospital, and I also had private practice in other surrounding hospitals. And I learned how to establish myself in a community. That was a community where they didn’t particularly care for pediatric surgeons. The general surgeons enjoyed doing what they were doing, and they didn’t want anybody else taking their private practice away. Yet, I had enormous support from Dr. Isidore Cohn, Jr., who gave me a laboratory and gave me funds to do research until I could get a grant, which I did. I would say that Dr. Cohn, Isidore Cohn, was as influential in shaping my career, protecting my time to
do research, and so forth, as anybody I ever came across. And Dr. Cohn has been a close friend ever since. He sent me off to Vanderbilt in 1981, no, in 1971, with his blessings.

DR. HOLCOMB: You mentioned Dr. Scott was the chief of surgery at Vanderbilt, and also that he had trained with Dr. Gross at Boston Children’s Hospital. What was the department of surgery like at Vanderbilt during the seventies?

DR. O’NEILL: Well, it was small. It was an excellent department of surgery, but it was not deep with people. I would say that in every area, there was one, and occasionally two nationally-recognized, prominent individuals. But it wasn’t three or four or five or six people, so it was a relatively small department. For example, I started by myself and was by myself for, I think, seven years. Now, remember Dr. Scott could rightfully do pediatric surgery. The person that he had groomed and trained was a man by the name of Sam [Samuel Edward] Stephenson [Jr.], but he had left by that time. I had no trouble getting coverage. Then in addition, when I came back, I was treated very hospitably by George [Whitfield] Holcomb, Jr., and I became friendly with him. I admired him because he had pioneered pediatric surgery in Nashville in the community. Dr. Scott had pioneered it at Vanderbilt. But Dr. Holcomb had — Holcomb Jr., your dad — had pioneered it in the community, and he taught at Vanderbilt. He taught at the Nashville General Hospital, and I observed him when I was a resident.

Dr. Holcomb knew of my interest. He was kind to me. He was doing general surgery, as well as pediatric surgery, for quite a while. That was the status of pediatric surgery in many communities. That’s what it took to earn a living. But pretty soon, he localized his efforts to pediatric surgery. I thought that was very courageous, because it was difficult in the community, because there were many outstanding surgeons like Dr. James [A.] Kirtley [Jr.], who had done biliary surgery, and actually made some advances in pediatric surgery, and Dr. Rollin [A.] Daniel [Jr.] in the thoracic line, and Dr. Scott himself. Dr. Scott was doing general surgery and cardio-thoracic surgery, so it was tough for him. But he was kind to me, and let me do cases, and what have you, as time came along.

Then when I came back to this community, Dr. Holcomb welcomed me, and we began to cover each other. Then eventually, we become partners. And it turned out to be the first university-community surgeon partnership in the United States, where we put two practices together, and then we began to share the work. I think the reason that happened was that the Vanderbilt Children’s Hospital began to come along. Dr. [David T.] Karzon, the chief of pediatrics, recruited a lot of specialists. I was fortunate. I was getting all that work. So I had this very interesting practice, and then Dr. Holcomb
would cover for me — as I said, we were friends — and I’d cover for him. He needed an extra partner, and actually had brought somebody in who didn’t work out. So we said, you know, we should do something together and just share the work, then pediatricians won’t have to worry about referring to one or the other. Because we liked each other, and we respected one another. So that’s sort of how that developed.

Dr. Scott never lost his love for pediatric surgery, and I remember clearly him telling me one time, he had regrets that he didn’t continue on in pediatric surgery. But his life had changed in a way such that he could never go back to it. But he always loved doing it. He loved commenting on it. When he would get a special case like an adrenal tumor in a child — and he was getting these referrals from all over the world — he would let me do it. He was very, very helpful to me in developing my career, but so was Dr. Holcomb, because he gave me coverage before the two of us brought Dr. Wallace [W.] Neblett [III] in, who we called Skip Nebliitt. And then that began the development of things.

DR. HOLCOMB: Now, in the field of pediatric surgery during the decade of the 1970s, what do you remember as the advances that were made in the care of infants and children during that time?

DR. O’NEILL: Well, I think that there were several things. First of all, organizationally — and I think that was a true advance — pediatric surgery began to come of age. That was because of the fact that, as I mentioned earlier, Dr. Clatworthy had essentially populated most of the university centers. Boston put some out, etc., but by the 1970s, there were about 24 university centers that had pediatric surgeons. Now, it wasn’t easy for them, as it wasn’t easy for me when I started, but gradually, by attrition, the general surgeons kind of got out of the business, because they couldn’t keep up, and it was too small a part of their practice.

Now, there were a number of things that were going on. First of all, there were major advances in the field of pediatric trauma. That came about because of the Vietnam conflict. People coming out of the Army, and so forth, that made a big difference. So those were some of the organizational things. Another thing that came along was the marriage of pediatric surgeons and university centers. Academic surgeons otherwise, combined with major centers where you had a lot of people to collaborate with. These were, basic scientists who were eager to work with you. That’s what made the difference. It put pediatric surgery on the stage of credibility in research in American surgery. Up until that time, the advances, which had been wonderful, were all new operations or things of that nature. It was just barely the beginning of an understanding of the premature infant and things that you could do. The general surgeons in the leadership in American
surgery didn’t have a lot of respect for pediatric surgery as a field until the intellectual base, the body of knowledge, and some new advances began to get their attention. Also, pediatric surgeons were beginning to get involved in major organizations and the [American] College of Surgeons, and so forth.

Now, in terms of the various aspects of things that were going on, trauma and burns would be one, and understanding of intensive care was another. Intravenous nutrition was another. Surgical critical care was another. For example, the first surgical intensive care unit for children was at the Children’s Hospital of Philadelphia. But many of the things that had to do with miniaturization of respirators, endotracheal tubes, things like this, all of that was done in childhood. Genitourinary reconstruction, the methods of reconstruction of anorectal malformations that permitted approaches to repair of rectal injuries. The reconstruction for ulcerative colitis, which was later translated to adults. All of those things came along. That’s basically a Hirschsprung’s disease spinoff.

The first clinical trial ever performed in the world was done in pediatric surgery. While I was in training in pediatric surgery with Dr. Clatworthy, there was a fledgling group of people interested in pediatric oncology, pediatric pathology, and pediatric surgery. There were very few of these people. And there was one pediatric urologist, and there were very few of those. The group was called Cancer Chemotherapy Group A, and they had a grant from the National Cancer Institute [NCI]. I’d say this group was about 20 people around the country and a handful of institutions. That started with treatment of Wilms tumor. That later became the National Wilms Tumor Study. And, of course, that evolved into Children’s Cancer Study Group [CCSG], COG [Children’s Oncology Group], CCG [NCI’s Childhood Cancer Group], etc. This became the model for clinical trials, thereafter.

When the [Report on the Manpower Subcommittee], Study on Surgical Services for the United States [(SOSSUS) 1975] was published, a piece of that report had to do with advances in surgical research. It was either number two or number three. This advance in the design of a clinical trial, productive clinical trial, and the translation — that’s the first time translational research was mentioned, that term — basically was a multidisciplinary effort. But it was spearheaded in the solid tumor category by surgeons, and Wilms tumor was number one. Then, of course, it went on to the other solid tumors of childhood.

Now, the things like gastroschisis, abdominal wall defects, prosthetic use, the application of nutrition to that, the advancement in the field of enteral nutrition, now a lot of these were multidisciplinary. That’s appropriate, but those collaborations, many of which, perhaps most of which were led by surgeons, came about in that period. And of course many have come since
that time. I’ve only skimmed the surface of many of those things, as you are probably aware.

DR. HOLCOMB: Now, in 1981, you were named surgeon-in-chief at the Children’s Hospital of Philadelphia, and held that same position until 1995. Dr. C. Everett Koop had just retired, and you were selected to follow him. What factors were involved in your decision to follow Dr. Koop at CHOP?

DR. O’NEILL: Well, my tenure, my first tenure, at Vanderbilt was from 1971 to 1981. Beginning about 1978 or so, the chief position in a variety of the major children’s hospitals began to open up. Maybe there had been a few before that, but I’m —

DR. HOLCOMB: This is when the first generation of pediatric surgeons was beginning to retire?

DR. O’NEILL: Yes, so I was one of a group that was asked to look at a number of these positions. A large number of that group were Clatworthy people. We’d all done research, and we’d all gotten into positions in American surgery beyond pediatric surgery for whatever reason. Probably our own interest. So I got asked to look at a number of things. Some things I didn’t get asked to take, some things I turned down, and I was happy. But then I got asked to give surgical grand rounds at the Children’s Hospital of Philadelphia in 1980 sometime. Dr. Koop was still there. I went up to give grand rounds. After grand rounds, I was surprised because Dr. Koop said, “I’d like to see you in my office.” There was also a member of the board of managers. That’s what they called the board of trust at the Children’s Hospital of Philadelphia. It was a little unusual process, but they said, “We’d like you to come back for a visit as a candidate.” They had done this, I guess, with some other people. I know Marc [L.] Rowe was one of them, and Jay Grosfeld was one of them. The same group of people.

So I went back and had my visit, and didn’t think anything more of it. The next thing you know, I got a call from this member of the board of managers, who said, “We’d like you to consider coming here. We want you to come back with your wife.” My wife hadn’t even seen it yet. So I did. It turned out my wife was very happy here in Nashville. The kids were well established. Everything was great. Yet, this was a very good opportunity. Dr. Scott had said, “You should look into this. You’ve probably done what’s possible to do here at Vanderbilt. You should consider this if they’ve asked you to take this job.” He’d never said that about any of the other jobs.

So I talked to my family. My son Jim was in college, two girls were home. So I had him come home, and we had a weekend together. We talked about it around the dining-room table. They said, “Well, Dad, if that’s best for you,
you should do it. We’re not going to stand in your way.” But I wanted their approval. One daughter was very interested in dance. She’s the one who later became the actress. And one daughter loved sports, gymnastics and stuff that she was doing, and she didn’t want to leave. So I said, “Okay, we’re going to go to Philadelphia and won’t let them know we’re coming.” So we went to Philadelphia, and we visited schools, and we looked into ballet, the Pennsylvania Ballet School, and so forth and so on. And they said, “We can move. We could go to Philadelphia.”

So I called back, and I said, “Okay, my wife and I will come up for a visit.” And I got the formal job offer. The chairman of the board said, “I don’t care about the arrangements. It’ll be up to you and the president of the hospital what arrangements you make, and with Chick.” Meaning Dr. [C. Everett] Koop, because Dr. Koop was just leaving to go become surgeon general at that time. He hadn’t been confirmed, so he was still around at lot.

DR. HOLCOMB: Is that what prompted his retirement from CHOP?

DR. O’NEILL: Well, he got to be 65. He had to retire. Those were the rules. But he was still around, and everybody loved him there. Anyhow, I talked to him, and he gave me a lot of pointers, and so forth. In fact, I still have a dictation tape that he gave me. It goes on for an hour with advice, and the ins and outs and information about people. He was wonderful. I made my deal, and so forth. Basically, it was getting support for the department. By then I had done an assessment of what everybody needed, and that helped us advance things. So I went in 1981, and it was a very good time. I loved that hospital, and loved the people. I go back on occasion, not often because an old chief shouldn’t be interfering with one who’s there. But I have gone back by invitation. One of my grandchildren was operated on there about a year and a half ago.

DR. HOLCOMB: How hard was it, or was it, to replace such a legendary figure in our field as Dr. Koop?

DR. O’NEILL: Well, nobody could be more different from Dr. Koop than I. But it was not easy. For example, this is anecdotal, when I went there — and Dr. Koop had warned me — all the other surgical faculty had a partnership. And the questions was, would I be a partner? They begrudgingly said, well, okay, because, see, I was the only person ever who had not come through the University of Pennsylvania program in the entire history of the hospital. No one had ever come from outside. So I was more or less resented, because they had a fair-haired boy, who was not in Philadelphia at the time, that they wanted to have come back, who would have been an excellent choice, by the way. But be that as it may, they chose me. But the people there didn’t like it. So I remember one of the faculty
coming into see me, one of the senior faculty, and saying, “We’re not sure what you’re going to have to do, because we do all the work.” Well, we solved that problem very quickly. Then gradually I was fortunate to be able to win them over, and we became good friends and good partners. But it was not easy at first. The specialists were a little bit antsy about me until they saw we could work collaboratively. I was not interested in taking anything away from them, but adding something to them. To this day, we’re close friends, fortunately. I think it was a very productive time for us. I would’ve been there today if things hadn’t changed at Vanderbilt.

DR. HOLCOMB: Now, during your time there, you gained a worldwide reputation for your work with a number of pediatric surgical conditions, including conjoined twins. Was that an interest you developed at Vanderbilt, or earlier in your training?

DR. O’NEILL: Well, actually, I think I told you that when I was a student, I had been ravenous in terms of reading about pediatric surgery and learning about it, and so forth. And along the way I read about conjoined twins. It was a fascinating story to me, but mostly fascinating because conjoined twins had a lot of anomalies. When I was in New Orleans, I did a set of conjoined twins. So that was my first case. Then at Vanderbilt, we had a couple of twins. Then when I went to CHOP, Dr. Koop and his colleagues had done two or three sets. So having had experience in it before and understanding it, and still having several members of the team there — Dr. [Louise] Schnaufer, Dr. [John M.] Templeton [Jr.] were the main ones involved, superbly knowledgeable about the subject — I was able to step in. Then we developed a large referral practice. Even to this day, I get consultations and work with surgeons in other children’s hospitals to assist them in setting their programs up and cases that they do, and so forth. So we had a very fortunate time. We had the cases, we had the team, and I think we made some advances in that field that were really a matter of opportunity more than anything else.

DR. HOLCOMB: Now, I’d previously mentioned that I was one of your trainees from 1986 to 1988 at CHOP, and look back extremely fondly on my time during that training period. One of the things I remember most about the training is the preoperative preparation for the separation of cervical conjoined twins, and the numerous conferences and radiographic studies, and even models, that were developed. Could you describe the evolution of this progress, and how you came to learn how to evaluate these babies?

DR. O’NEILL: Well, the idea of having a planning conference goes back way, way earlier than me, or I think even some of the people before Dr. Koop. Everyone who ever undertook separation of conjoined twins realized very quickly that you really had to plan things ahead of time. That no one
individual could do this, you really needed a team of people. So there would be a planning conference. Well, this led to the development of, or let’s say the application of, imaging techniques, as imaging techniques were developed. It led to the modification of imaging techniques to tailor-make them to this situation. That then meant you would bring specialists together, because this was a time when pediatric urology was beginning to develop, even though pediatric surgeons did it. Pediatric urology was developing because pediatric surgery and pediatric surgeons were stimulating their development. They wanted people to focus on urology and cardiac surgery, and so forth.

So, we would gather these people together, and we would develop a plan of how you’d go about it. There were some things internally that you couldn’t get from imaging, at least early, and you had to create a model, for example a model of a heart, from a cardiac catheterization. Of course we don’t do that anymore. Actually while I was at CHOP, we developed the technique of gated [magnetic resonance] MR [imaging], dynamic MR [imaging], in order to have three-dimensional images of the heart you could look at in different ways. So we no longer had to use children’s play clay models to do that. We had a wonderful museum of congenital heart problems, including conjoined twin hearts. So that led to study, and other members of the team would help with that.

We also developed a catalog of gastrointestinal and biliary anomalies collected from the literature, as well as the experience that we had. That gave us information about how to decide how to fix things, and so forth, if they were fixable. It also gave us a great deal of information that could be used for prognostication and counseling of families, because prenatal ultrasound began to come into its own, and it became gradually more and more possible to distinguish anomalies. Then you could use this information to say, well, this is fixable, or it isn’t, or this is what you might expect to see later. It was more or less as we had the experience as a team, we’d ask questions, and we’d seek answers that would help all of us in our chores. So that’s sort of how that came about. But I don’t think the planning conference was unique with us. That was done from time immemorial. It just got to be more refined and better.

Also, how did you and Dr. Dean come to write a book on this relatively uncommon spectrum of conditions?

DR. O’NEILL: Well, I’d say that this has been part of my personality through the years. When I came out of the Army, nobody wanted to take care of children’s burns. I found it interesting and rewarding, so I got interested in burns. Then there were not a lot of people interested in complicated pediatric surgery like conjoined twins. Okay, so I got interested in that. I more or less gravitated that way. There was nobody, only adult surgeons, interested in vascular surgery of childhood. Now, I was stimulated by a man by the name of John [H.] Foster, who was the first vascular surgeon at Vanderbilt, a really brilliant man. He was one of the very first people who had an interest in portal hypertension in childhood. He was one of the very first people who had an interest in renal artery stenosis in childhood. Dr. Scott had some interest in that, although not a big interest. His interest was more coarctation of the abdominal aorta, and he had accumulated two or three cases, I remember. In fact, I helped him operate on one of what, at that time, was called coarctation of the abdominal aorta. That actually was a single constriction, that particular variety. Anyhow, I began to get interested.

Now, one time when I was chief resident in general surgery at Vanderbilt, Dr. Foster had a case of a four-year-old child with — three- or four-year-old child — with left-sided renal artery stenosis. Now, nobody was repairing renal arteries at that time, so I was to do a nephrectomy. The other side was okay. We actually had an arteriogram. Of course that was being done at that time, for quite some time. I remember the child had a cardiac arrest on the table because blood pressure control wasn’t as refined as it is now. The child wasn’t quite as well prepared as one would be able to do today. But resuscitation was done, and the child was fine. Interestingly, that child came back a number of years later, like 1972, or something like that, with renal artery stenosis on the other side. So here I was back again with my same patient. So Dr. Foster was still here then, and we teamed up. But he had a young protégé, who was finished up as chief resident, by the name of Dick Dean, Richard Dean. He was grooming him to be a vascular surgeon. So anyhow, we scrubbed together, and I fixed this renal artery. I just gradually became more and more interested in it. Then I did two or three more cases. And we’ve always collaborated.

Then I worked with Bob Richie, Robert [E.] Richie. He was the first transplant, really the first transplant surgeon who stayed a while and established the program in a big way at Vanderbilt, although there had been some people pioneering a bit ahead of him. We worked together, particularly on the children. So I just got into all of that. Then Dr. Foster retired, and Dick Dean came on the staff, and we worked together. He’d ask
my help with the children, and we’d work together on that. He was doing a lot of renal artery work at that time, because it was a specialized center for research, and I participated in that. This was before I went to CHOP. So we put this book together just before I moved to Philadelphia. In fact, I remember working on the index in Philadelphia when I was first there. But Dick and I were friends as surgeons. We worked together. We also worked independently. But be that as it may, we put this little book out, and I think it’s the first book of vascular surgery that came out in childhood. Then of course, we established a program at CHOP and developed a broad series.

DR. HOLCOMB: Well, Dr. Dean moved on and became chief of surgery at Wake Forest [Wake Forest University School of Medicine at the Bowman Gray Campus], and eventually president and CEO of the hospital.

DR. O’NEILL: That’s correct. He recently retired from that. When he went to Bowman Gray Wake Forest Medical School, he did predominantly vascular surgery. He became internationally known in that field because of his work in renal vascular hypertension, but he did everything. Along the way at Vanderbilt, we’d also worked together on some vascular anomalies, and I developed an interest in hemangiomas, and AV malformations, and things like that, again because nobody else was interested. So that’s how that came about. Then when I went to CHOP, we established the first multidisciplinary vascular clinic for children with plastic surgery, dermatology, interventional radiology, pediatric surgery, and so forth. That model, I think there’s now one in Boston, as well.

DR. HOLCOMB: Right, there’s one in Boston, and I think there’s one in Cincinnati, too. During your time in Philadelphia, I like to tell our current residents, was the time that the giants in pediatric surgery walked the face of the earth. [Laughter] It seemed to me that everyone on staff was a giant in pediatric surgery. What was it like to be at CHOP during these 15 years?

DR. O’NEILL: Well, as I mentioned earlier, they were wonderful years. I might say, amusingly, when you say that was the time when giants roamed the earth, you may mean dinosaurs, I don’t know. But be that as it may, we had a wonderful staff, people who were doing things. For example, Harry [C.] Bishop, who had developed the Roux-en-Y exteriorization procedure for meconium ileus and intestinal atresias. He also had worked on plicating the diaphragm for eventration. He had an interest in tumors and was involved in the early National Wilms Tumor Study. He was a stimulating person who had an interest in ethics, as well. So when we developed our teaching conference, which was a Thursday conference they hadn’t had before for management of cases, and so forth, he was the great sage to have.
Then there was Louise Schnaufer, who I would say was a gifted surgeon and teacher, and probably a good example of women surgeons of her day. She’s probably one of the great women surgeons of her generation, or maybe several generations, and certainly she’s been recognized for that. But she, too, was a storehouse of information. She was a colleague in the management of conjoined twins and other things. Her office was next to mine, and we used to chat all the time. She was the one the residents would love to see in the evening, particularly the chief residents. She’d open her drawer, and peanuts would be there, and they’d all share that. They called her “Aunt Louise.” She was just this lovable character that we all loved.

Then there was Moritz [M.] Ziegler, Mory Ziegler, who headed the laboratory effort. A brilliant man, whom we were able to groom administratively, and he went on to be chief at the Cincinnati Children’s Hospital [Medical Center], and then later at Boston Children’s, and now he’s the chief at The Children’s Hospital in Denver, University of Colorado. So he’s had an effect on a number of institutions. He was probably the go-to person for many of the faculty in pediatrics, tumor-wise, although Louise would get tough cases, and obviously, I would get some cases, as well. But I would say he was sort of the person who would be innovative. It was nice to have a mind like that. For example, I remember a case of absence of the sternum with ecopia cordis, and how he thought through that. We all worked together on many of these things in management. But that’s the way he was. He also started the transplantation effort, mainly kidneys, but later liver.

Then there was Jack Templeton, who focused his efforts on anal-rectal malformations. He also worked on conjoined twins. I give Jack credit. I remember one day we were doing a separation of conjoined twins that were ischiopagus. Up until that time, the standard was to do a colostomy, and then close that later. I didn’t like that. I remember he was on one side, and I was on the other, and I said, “You know it’s a shame.” This was fairly early on. “We shouldn’t do a colostomy, you know. Maybe it’s a little risky, but we’ve got the pelvis open, and what have you.” And he said, “You know, I think we should.” He encouraged me, and I give him credit for that. He said, “I’ve seen too many complications from this. I know it has to happen. But, I’d like to see us do that.” So we started doing that. I probably wouldn’t have had the courage to go against the dictum of before. See, he was a thinker, too, and he was a great detail person in terms of planning, and he was very much a helper to me in setting things up and getting things going.

We later brought in some other people. Henry [T.] Lau, who is now at Johns Hopkins [Medicine], and working in transplantation. But I think it was the friendship, the sense of community, and the relationships we had with world-
class people in oncology, and gastroenterology, and pulmonology, and so forth. I made mention of the fact that in our early efforts at Vanderbilt, we had one, or maybe two world-class people. At CHOP, they were six deep everywhere, the same way. That meant that the level of work you could do was outstanding. It was because you had the people. If you had a question you wanted to ask — For example, we wanted to ask the question as to why fibromuscular hyperplasia occurs. Well, we had people in immunology who helped us look into this in measuring anti-nuclear antibodies and some other things. We never did eventually get the answer, but we had more answers than most anybody else has gotten on this subject. We had an individual in rheumatology who helped me enormously with the vasospastic disorders of childhood, who taught me a tremendous amount. But he had spent his life doing that, Dr. [Balu H.] Athreya. We had good friends everywhere, and I think it’s that sense of community that made that such a wonderful time for me. Even though I might say, I had kind of a rocky start, because I wasn’t accepted at first, being an outsider, but it didn’t take long before I was one of them. And I loved it for that.

DR. HOLCOMB: Now, I know that you were very good friends with Dr. John [W.] Duckett and collaborated on a number of patients with him, especially the conjoined twins and other complicated patients. What was it like to work with him, and how do you view his influence in the world of pediatric urology?

DR. O’NEILL: Well, John Duckett became my best friend. It was one of the great sorrows in my life to lose him to a leukemia crisis from lymphoma. I had lived through that with him for a few years before he died. But he was probably my best friend for a number of reasons. First of all, I admired him enormously. He was the most innovative, creative surgeon I have ever met or worked with. He had a brilliance about him that, I think, is unprecedented in my mind. First of all, he was beautifully trained in general surgery, so he was an excellent general surgeon. He knew about the field of surgery broadly, not just urology. He knew about transfer flaps. He knew about vascularization of flaps. He knew about evaluation of flaps. Things we might call plastic surgery. He knew about what you could do with the GI [gastrointestinal] tract, and what you couldn’t. He knew how to use the GI tract for urinary reconstruction. He knew how to sort out what part of the GI tract you should use when you were going to need it for anorectal reconstruction. He was conversant across the board. He was collaborative. He didn’t have a small bone in his body. If you did a urology case, let’s say he wasn’t available, or whatever, he didn’t resent that. He was delighted you would be able to work with him, and we would scrub frequently. He was a wonderful host, he was a wonderful friend. He was a warm friend. He was really liked by the board of managers. When I came there, he smoothed the way for me with a lot of people, particularly with the group called Surgical Associates. He made sure that I was a full-fledged member.
The other thing was that, I hadn’t decided whether I was going to take the job there. I was at a(n) [American Academy of Pediatrics] Surgical Section meeting, and he called me ahead of time and said, “Could I meet you at the Surgical Section?” We had dinner together, and he said, “You’ve got to come to CHOP. We need you there for a variety of reasons.” I’d say he was partly influential. His wife helped my wife get introduced to Philadelphia. They made us feel at home. They showed us around the city, they helped us find a place to live. They did everything they possibly could to be hospitable. As I said, he became my best friend. And, of course, it was one of my greatest sorrows. I have some really, really close friends because of things we’ve been through. John Duckett would have to be categorized as one of those. We were both supportive of one another. I don’t think there’s any question in my mind that in his day, he was the greatest pediatric urologist in the world. He was generous with our pediatric surgical trainees, as well. So he was a special person in the world of surgery, not just pediatric urology. If anybody established it here in the United States, he did. But he was internationally recognized and known for this.

DR. HOLCOMB: Yes, he was a wonderful man. I remember scrubbing on a number of cases with him, and he was always warm and friendly, and a wonderful mentor. Do you want to take a break?

DR. O’NEILL: I’m okay.

DR. HOLCOMB: So in 1995, you returned to Nashville as the John Clinton Foshee Distinguished Professor of Surgery at Vanderbilt University Medical Center, and chairman of the Section of Surgical Sciences. At that time you were one of only two or three pediatric surgeons to hold a chief of surgery position in a general surgery training program as a pediatric surgeon. Interesting that Dr. Grosfeld was another one to hold similar positions. What factors led you to return to Nashville at that time, and how did your recruitment come about?

DR. O’NEILL: Well, the one thing I hadn’t done in my life was chair a major department of surgery. Not that I actually sought that out, but what happened was that I had gotten involved. I was a director of the American Board of Surgery, and I had gotten into leadership positions in a number of organizations. In other words, I was working in an arena of American surgery that was basically controlled by the general surgeons. I was becoming one of them, even though I was doing pediatric surgery. But I had a major post in a children’s hospital, and they allowed that. Well, then, I guess about 1991 or 1992, I began to be asked if I would look at chairs of surgery beyond pediatric surgery. I declined to follow up on any of those because I loved where I was, I was being productive. They were good years. But it made me think. Then finally I got asked to look at the chair at Cornell
New York Hospital [NewYork-Presbyterian Hospital/Weill Cornell Medical Center]. The president of the hospital had been a classmate of mine at Yale Medical School, and we had been close friends.

DR. HOLCOMB: That was Dr. Skinner?

DR. O’NEILL: Dr. Skinner, David [B.] Skinner. We also had one of his daughters as one of our Penn [University of Pennsylvania] residents, Linda Skinner [Callans]. I have known the girls since they were little girls. So I don’t know, he may have put my name into Cornell, because the hospital was separate from the university, although they work together closely of course. So I was asked if I would be willing to look. Actually, he asked me if I would be willing for him to put my name in while we were giving American Board of Surgery exams together, I don’t know, Chicago or someplace. I said I was pretty happy where I was. He said, “Well, let me tell you more about it.” So he convinced me to come take the train down there. I looked at it, and got all the way down to the wire, and turned the job down, because New York Hospital really didn’t have the facilities or resources to permit me to do pediatric surgery like I was accustomed to. Now, they hadn’t yet formed the partnership with Presbyterian Hospital. So it might have been possible to put the whole thing together. They haven’t done it yet, but it might have been. Anyhow, I turned the job down at the last minute. In fact, everybody at CHOP thought I was leaving. I turned down the job, and I remember the president of the hospital said, “You’re crazy! I happen to know how much money you’ve turned down.” And I said, “Well, pediatric surgery is more important to me than that. Any job I would take, I’d have to be able to do pediatric surgery like I’m accustomed to.”

Then I got asked to look at Duke [University Hospital], and I turned that one down, and so forth. I said, “I’m just going to stay.” Susan had been through the mill. She was tired. So I said, “Okay. I’m not going to look at anything else.” So one evening — and I don’t know whether you know this story — one evening a pediatric surgeon in Nashville by the name of George Holcomb, Jr., called me in Philadelphia, and he said, “Vanderbilt is up in arms. They’ve offered the chair to Edward [M.] Copeland [III], Ted Copeland, and he’s fooled around for a long time. Finally the vice chancellor, Dr. “Ike” [Roscoe R.] Robinson, has terminated discussions with him. Would you be willing to have your name thrown in the pot?” I said, “I’m not sure that I would.” And I told him my story, and so forth. I said, “It’s wonderful for you, you’re a good friend to do that, but I don’t think that would be in the cards for me.”

So that’s all I thought. But what he did was, he talked to the vice chancellor, and the next thing you know the vice chancellor called me. He said, “Would you be willing to talk to a couple of us?” So I said, “It would be difficult for
me, you know, not to talk with you. That wouldn’t be polite — an institution that I love. Besides that, I was on the search committee that selected you, Dr. Robinson, when I was at Vanderbilt. So how could I do that? But I’m going to be on vacation with my family on the Outer Banks [of North Carolina], so I can’t come to Vanderbilt.” He said, “I don’t want you to come to Vanderbilt, anyhow. We’ve had a hard enough time. I don’t want you to come. People will think you might be coming back, and then I’m embarrassed again.” He was really upset about the way things had worked before. They had also had this episode with Dr. [John L.] Cameron from Hopkins, accepting, and then not taking the job. So Dr. Robinson was very upset. He said, “No, I want to come see you. Would you ask your wife —” I was at home when he called me, because he’d called me at night. He said, “Would you ask your wife if I could be permitted to come see you?” So he did, and he brought another individual with him from the administration of Vanderbilt University.

Anyhow, to make a long story short, they came to visit. And they lobbied Susan. They were well prepared. So the two of them talked to me, and so forth. Then Dr. Robinson said, “Now, you know we have a search committee. Would you be willing to come down to Vanderbilt to talk to the search committee?” Even though we had talked for several hours, acquainting me with Vanderbilt, and so forth, he said, “But I don’t want you to come to talk to the search committee right away. I’ll pay your way for all this. I want you to come on the earliest Sunday possible and spend Sunday with me. Come in the morning, go home in the evening. Then you ask me any questions you want.” So we did that. And then he said, “Alright, are you willing to consider this?” He wanted to make sure I was serious. Well, by then I had seen a lot of things, and I’d loved Vanderbilt for reasons that you already know. So I met with the search committee, and they happened to be very enthusiastic. But they had seen all these other people, too, and I don’t know how many other people they saw. But this was the way this process worked. So, I guess, in the end, I was kind of the last hope for them, and it seemed like an enticing opportunity. So I came back. But there was a huge job to be done here, as you can imagine, as you know.

DR. HOLCOMB: Well, when you returned in 1995, how different was Vanderbilt in the department of surgery than when you had left 15 years earlier? And what advances did you feel needed to be made?

DR. O’NEILL: Well, the first thing was that Dr. [John L.] Sawyers had been the chairman in between and had done a wonderful job developing the specialties and enlarging general surgery. So it was a much bigger department by several times larger. The practices of the surgeons had developed. There was more money in the department. The vice chancellor was willing to give me anything I wanted to develop surgery more. They
already had a nidus of good faculty, but they had huge holes — people who were retiring, or people who had left. When Dr. Sawyers retired, there was an interim chairman, who was understandably not interested in general surgery or the department, and never intended to be a candidate for the chair.

I also saw that Vanderbilt itself had matured wonderfully. There were more buildings, more facilities. The basic sciences had developed tremendously. Vanderbilt was clearly, in my view at that time, in a phase of very rapid development. It was transforming itself, so it was exciting. Now remember, when I came here for these visits, and also when I came on, I had experience. When I had been here at Vanderbilt, I was a vice chair for Dr. Scott, and he groomed me administratively. I then had almost 15 years of being the chief at the Children’s Hospital [of Pennsylvania] and running a department. And I was a vice chairman at Penn, and I had duties with regard to the main department at Penn. So I had a lot of experience by that time, 25 years of experience running a department, and admittedly coming along. But I was also mentored in this process. For example, while I was at Penn, Jonathan [E.] Rhoads was a great mentor for me. He saw to it that I was mentored by him. So all of that was good, and I was able to come in and understand what the problems were. I didn’t have to learn the ropes. I could learn quickly, by talking to people, what the problem was. I could look at a balance sheet, a budget, and understand that.

At that time, I had already gotten my MBA [Master of Business Administration], so to speak, through on-the-job training, so to speak. While I was at CHOP, I had learned how to develop outreach practices in other hospitals. I had learned how to fund a foundation. You know, a lot of things like that that are important. I learned how to help people get grants and things like that. Because CHOP had no research to speak of, we had to develop that. Fortunately, I had Mory Ziegler to help me with that process.

But Vanderbilt had holes in surgery. While they had fantastic medicine, excellent pediatrics, all of these things, the big problems in surgery were that the residency program was in a shambles. Morale was terrible. There was a $6 million deficit in the department, in what’s called the Section on Surgical Sciences, which encompasses everything but ophthalmology and orthopedics. It needed somebody to lead. It needed somebody to bring the faculty together. It needed somebody to recruit. We needed renewal in cardiothoracic surgery. Retirements were coming up. We needed a complete division of surgical oncology, because Vanderbilt was developing a cancer center. We had very little surgical presence. And on and on. We needed a new chief of vascular surgery. We needed rejuvenation in transplantation. We weren’t doing some of the things that were being done outside, like pancreas transplantation. Fortunately, I had good partners in many of these
I was lucky, I was able to pretty quickly size-up who I could work with, and so forth. Probably the only thing I couldn’t do, because there was so much to do — building new facilities, building new labs, bringing new people in — I couldn’t concentrate on pediatric surgery very much. It was just impossible for me to do that. While I did pediatric surgery, I couldn’t concentrate on its organization or anything else. But that was running reasonably smoothly.

But the section really needed a lot of work, and I found that fun. I didn’t mind doing administrative work, and actually we were successful. For example, our deficit we turned around in a year. Because their systems were not good — they didn’t have an accountant — they didn’t know what their budget was. They didn’t know what the expenses were for the upcoming month. They didn’t know how much cash flow they had. You can hardly believe this was the case. So anyhow, that’s what that was. And we needed to build some endowment. We needed to bring in all kinds of money to do development, and to get some more endowed chairs. And actually, we did all of that. That’s what the job took.

DR. HOLCOMB: In the early 1990’s, minimally invasive surgery came to be developed. What are your recollections of the early part of the training for minimally invasive surgery, both at CHOP and at Vanderbilt? I know that a number of advances were made at Vanderbilt in laparoscopy during your time there.

DR. O’NEILL: Well, actually the beginning advances in laparoscopic cholecystectomy started before I came here. It was one of the first efforts in the nation, as a matter of fact. It was interesting. I think it happened in the community, because the surgeons at Vanderbilt pooh-poohed the idea. I think that happened in a lot of places. At CHOP, we were fortunate to recruit Perry [W.] Stafford, who had had some experience in the Navy. He began to develop a program there, and then some of the others did, as well. None of us had that background, but the Nashville background began to percolate throughout the nation. But I think Vanderbilt came up on board fairly soon thereafter. Now, of course, it’s a thriving enterprise. Bill [William O.] Richards got into it early, and Kenneth [W.] Sharp, and people like that. We had very little equipment, by the way, that we had to buy. In pediatrics, it was slow to come, because pediatric surgery was a little more, I would say, regimented and traditional, as opposed to being innovative. So that came about slowly. Of course, now it’s pretty well established.

DR. HOLCOMB: Is there anything else you’d like to share with us about your time at Vanderbilt?
DR. O’NEILL: Well, I think the time at Vanderbilt has been good, because if I think of — and I’m thinking of pediatric surgery now — if I think of my ten years first from 1971 to 1981, and then my time thereafter up to the present day, I think you can look around the country today and see a number of pediatric surgeons who came through the general surgical residency program at Vanderbilt. In the early years, we were able to place essentially everyone. In those days it was a little more informal. I’m not sure when the matching program started in pediatric surgery, but it could not have been until, like, 1980, or something like that, so it was still somewhat informal. But we were able to place everybody in the field. And, of course, that pleases me a great deal, because I think it has helped us build pediatric surgery.

The thing that is distinctive about the Vanderbilt residency program in surgery is that, traditionally and to this day, it has been extremely strong in general surgery. There have been a minimum number of fellowships. In each instance where there has been a fellowship, we’ve never allowed it to interfere with general surgical training. So that means that we’ve put out a product that has been well-known as being capable. So pediatric surgery program directors have liked that, because in pediatric surgery we don’t train surgeons. They learn that in general surgery. But we train people in the intricacies and nuances and special areas of pediatric surgery. Vanderbilt has, and continues to be able to put people into the circulation of pediatric surgery with that. I would say that — and I’m quite familiar with a number of training programs — I think we do it almost better than anywhere. Not that we’re exclusive in that regard, but I think it’s because of the breadth of the training, and the excellence of the training, and the depth, the volume, and the scope of surgery that happens here. For a person to develop an academic career, I can’t think of a better place. I mean I had wonderful mentors. I like to think that continues today. Although, I have to admit that many of those people were special individuals in the world of surgery, and came along at a time when the work ethic was a bit different, and your exposure to them was much, much more extensive than perhaps is the case today. For all of these people, their life was their work. You could say they were unusual perhaps in today’s world. You could say they were peculiar even, that what they cared about was their work. As I say, their life was their work. But that meant their trainees were like their children, and they concentrated on them. So it was wonderful. I think we saw the same kind of spirit at CHOP. But of course those are my individual experiences.

DR. HOLCOMB: Over the more than 30 years of your career as a surgeon, what changes have you noticed in the training of residents, and do you think these changes have always been for the benefit of the training? Or are there some changes that might not have been done, or should not have been done?
DR. O’NEILL: Well, I think that surgical training today, whether it’s general surgical training or pediatric surgery, or you name it in surgery, I think that it has been affected by the changes that have occurred in medicine, pediatrics, radiology, etc, where the work ethics are somewhat different from the traditionally known surgical work ethics. Now, I think that this 80-hour work week, whatever that arbitrary figure might be, probably was a necessary thing, because it recognized for the first time legitimate personal interests, and the need to take care of family needs, and so forth. Although, I would hasten to add that many of us, most of us, have very successful marriages, my own of 49 years. Most everybody I know of my generation has stable marriages. But be that as it may, I think it is probably a good trend.

But what is not good is that it came about without flexibility. So that people who want to stay longer, just like Jay Grosfeld and I would work every night if there was a newborn coming in. I think for people who want to develop their careers, and develop a discipline that has to do with a profession of surgery, I wish things were a little more flexible, so that it wasn’t a matter of keeping attendance, which is what it’s gotten to be, a compliance issue. Now, I think that education is also a reflection of society at large. I think, whereas many of us came out of the Depression, and that was the norm at that time, and for a generation afterward, people getting ahead in a field, now the field is well established. There is much more in society of lifestyle and me-first. I don’t mean to be cynical, but that is a reflection of our world. So lifestyle issues — and I’m not talking about legitimate personal interests, which I ascribe to — but lifestyle issues, to a certain extent, are beginning to be reflected in people’s career choices, as opposed to where they think they might be most useful to society. So I think some values, not all because people are still very idealistic, but some values or attitudes have been changed. So this is why we have a looming shortage of general surgeons, and why we may in the future have a shortage of pediatric surgeons, because that’s the well that pediatric surgery comes from. So some of the training issues are because attitudes have changed. You see, I think if you have a trainee who wants to learn how to be an excellent surgeon and a fine professional, and who wants to achieve in research at the same time, he or she will devote energies to that, as opposed to wanting more time for recreation, and so forth. I think some of these attitudes have become a little distorted.

Now, I say this at the risk of being an old head, but I also say it from the perspective of having a feel for the value of the profession of medicine and surgery, and what it takes to prepare yourself for a life of service. What I include in service is developing new knowledge, contributing to the profession, making it better than you found it, as well as taking care of individual patients and following them through their entire illness, and
having a feel for that. Taking full responsibility for it. I think that may affect quality. Now, I know there are a lot of advances. I think that there may be a little bit too much emphasis on technology, and imaging and laboratory studies, because I find that people are not as good at physical examination. They don’t worry about feeling a pyloric olive, which by the way, is the time to talk to parents, because they see you there at the bedside. You bond with them. There’s value to that. There’s gratification to that. I think that some of the dissatisfaction that has come has been in missing some of the pieces that were the most gratifying part of a physician’s life.

Now, are our teachers conveying those values today? Do people read as much as they should? Are they making themselves the best professionals they could? I’ve seen a little deviation from that as I’ve come along. I’m not cynical, because there still are those stars, people who know how to do it and have those natural talents. So it’s a perspective. I would like to see a little more emphasis on the values of the profession, and the attitude that needs to have a little bit more of your life than comes second. That has been something of a trend today. It is not universal by any means, but it has affected people going into surgery, I’m sure. I talk to a lot of young people, and it’s not just something that I say off the cuff. Whether everybody would agree with that, I don’t know.

DR. HOLCOMB: Speaking of reading, I’d like to move on and talk a little bit about your publications and interest in dissemination of information, and some of the leadership positions which you’ve held in surgery. First, you became involved with a two-volume textbook entitled *Pediatric Surgery* [Chicago: Year Book Med Pub 1979] during your time in Philadelphia. I believe your first edition was the fourth edition with Drs. [Kenneth J.] Welch and Randolph and [Mark M.] Ravitch and [Marc I.] Rowe. Is that correct?

DR. O’NEILL: Yes. That was in 1980. Dr. Ravitch called me one day. He was really the person in charge of the whole thing. He said, “I want you and Marc Rowe —” He was calling him, because he was in Pittsburgh, and Marc Rowe was on his way to Pittsburgh at that point. He said, “I want you and Marc Rowe to come on the board. Judson Randolph is retiring, so I’d like you to — and Cliff Benson is retired — I’d like you to come on. Our first meeting is such-and-such.” He didn’t say “Would you like to do this?” He just told me that’s what I was going to do. He became mentor, taught me how to edit, taught me how to write a chapter, how to revise someone’s chapter. He was a wonderful mentor in terms of that. He was a hard taskmaster, but he was a wonderful friend, as well. So I remember going up to Martha’s Vineyard to his home, and we would edit manuscripts up there, the whole group of us. He was a great guy. He just told me that’s what I was going to do. Of course then he retired from it, I eventually did my turn.
Everybody on the masthead would rotate. But somehow, although they’d rotate, he was in charge. Well, everybody knew he was the most capable.

DR. HOLCOMB: Did that book follow on one of Dr. Gross’ books? Or is that how it developed?

DR. O’NEILL: No, it was a parallel book. Dr. Gross had his book, The Surgery of Infancy and Childhood, came out in 1953. He never put out another edition. In 1949 or 1950, somewhere in there, Dr. Ravitch, Dr. Welch, Dr. [William T.] Mustard, Dr. Benson — I’m forgetting the fifth one [William H. Snyder, Jr.], there were five — put out this two-volume book called Pediatric Surgery. That was the first edition of that. And of course, it came through a couple more revisions, and then I came on.

DR. HOLCOMB: You were an associate editor for the Journal of Pediatric Surgery. Were you involved in the development of the Journal of Pediatric Surgery?

DR. O’NEILL: No, that was the brainchild of Stephen [L.] Gans. He and Chick Koop were friends, and Chick Koop became the first editor-in-chief. But that was in 1966. I was just finishing my residency and going into the Army. It was later, I guess while I was at Vanderbilt, that Dr. Koop tapped me and said, “How would you like to —?” By then, I was involved in the [American] Pediatric Surgical Association and had gotten to know him. So he said, “How would you like to join the editorial board?” And so I did.

DR. HOLCOMB: How important was the development of this journal for the field of pediatric surgery?

DR. O’NEILL: I think it was the final lynchpin. Beginning in 1955, people had begun to look for certification in pediatric surgery, and it was turned down repeatedly. But pediatric surgery had not developed far enough. This is where I think Bill Clatworthy made a contribution, by getting pediatric surgeons out to university centers. All of a sudden all these contributions came in. Then there was an organization, the Surgical Section. Then came the American Pediatric Surgical Association [APSA]. Before that, of course, there was the Journal of Pediatric Surgery. The Journal of Pediatric Surgery’s establishment, that then made people begin to listen. The Residency Review Committee, which was basically the American Board of Surgery at that time, opened up the door. But it still was a while before it got established.

DR. HOLCOMB: Tell me about pediatric surgery being recognized as an entity by the American Board of Surgery, and the creation of a certificate of
special competency for pediatric surgeons. Were you part of that process? And were you one of the ones who took the first exam for the special certificate?

DR. O’NEILL: I was not one of the people who did that. That was a group of senior surgeons, people I call my fathers, Dr. Koop and people like that. There was a large group, though, of people who tried to do that. A lot of them were the people who founded the Surgical Section of the American Academy of Pediatrics, that first group of people, Bill [William B.] Kiesewetter and people like that. They were influential. Bill Clatworthy was a very prominent one in this. And since he and Bill Scott were good friends — Bill Scott was his chief resident at Boston Children’s Hospital. They’d trained together.

DR. HOLCOMB: He and Dr. Clatworthy?

DR. O’NEILL: Yes.

DR. HOLCOMB: Okay.

DR. O’NEILL: So that’s why when Dr. Scott called Dr. Clatworthy, and said my boy needs a job, I got a job. That’s why he told me if I don’t work out, there was only reason he was taking me — because Dr. Scott was his chief resident. Anyhow, those were the people who got it started. But it was really Harvey [E.] Beardmore, a Canadian, who did this in 1974. But it took that long. It took 20 years for that to occur. But, I was one of the first ones to take the exam. There was a committee of Beardmore, Randolph, and Rowe who wrote the exam, and we got to take it. Everybody had to take this exam. Dr. Ravitch was grandfathered. He didn’t have boards in general surgery, but they allowed him to sit for this exam in pediatric surgery.

DR. HOLCOMB: So did you take the first exam?

DR. O’NEILL: I did, in Puerto Rico.

DR. HOLCOMB: And that was done in Puerto Rico?

DR. O’NEILL: Yes, it was.

DR. HOLCOMB: How did that come —

DR. O’NEILL: It was a meeting of APSA, and the American Board of Surgery said they would set up this certifying exam that had been approved by the various avenues. It was a written exam. It was a three-hour exam to be given in the morning the day before the meeting. So we went in, and there was only one thing that would be different from today. In the front row,
there was Dr. Ravitch, and I don’t know who else. Dr. Gross didn’t take the exam. But they were all the, I mean, the real higher-ups in pediatric surgery. Well, I was about three or four rows back. The people from the board were there proctoring the exam. Within five minutes of the exam starting, Dr. Ravitch pulls out this big cigar and starts to smoke this cigar, with smoke everywhere. People were coughing, and so forth. I moved to the back of the room. I remember this exam. It was really something. Anyhow, we took the exam. I don’t know what the pass rate was, but I know not everybody passed. But I passed. That was all I cared about at that time.

DR. HOLCOMB: And that exam was written by Drs. Beardmore, Randolph, and Rowe?

DR. O’NEILL: Yes, yes. They were the first ones that were selected by the American Board of Surgery to do that. There was a committee that the American Board of Surgery had put together. It turned out that Dr. Beardmore and Dr. Randolph, if I’m remembering this story correctly — maybe we can get some more history later — they had been examiners for the American Board of Surgery. I think they were guest examiners, but it may have been more formal than that. Then they got Mark Rowe involved. That’s the way I remember the story. Anyhow, they wrote this exam, and the rest has been history.

DR. HOLCOMB: You’ve been involved in almost every leadership position possible, not only in pediatric surgery, but in general surgery, as well. You’ve been involved with the [Residency Review Committee] RRC for Surgery. You’ve been president of the American Pediatric Surgical Association, chair of the Section on Surgery of the AAP, and are currently president of the Southern Surgical Association, to name just a few of these positions. First, regarding APSA, were you involved in the creation of APSA, and how did that come about?

DR. O’NEILL: Well, there were a couple of people who really had — APSA was their brainchild. It was Lucian Leape and Tom Boles. Tom Boles was one of my teachers in Columbus. They had talked to a lot of people, and they got a group of people together, about 25 people, and they had an organizational meeting. Now, I was not one of those people, because their organizational meeting was held the year I was out of training. I was just finishing my pediatric surgical training, and I was on my way to New Orleans when they were having their organizational meeting. So it was a group of about 25 people. It’s the ones you’d expect — Lester [W.] Martin, and Dr. Gross, and Tom Boles, and de Lorimier, and Koop, and a number of his senior trainees, and people like that. Hugh [B.] Lynn, Bill Kiesewetter, all great names. Ide Smith, Judson Randolph, [John G.] Raffensberger, [Lawrence K.] Pickett [Sr.] — great names in pediatric surgery, the great early contributors to the field. They were the wise old heads, so they would
be called the founding members. But that wasn’t enough, they needed to bring people together. They had what were called charter members, of which I was one of those. But the work had been done for two years, maybe three, putting this stuff together by these people. I have a list of all of them, and every one of those names is recognizable as someone who did something important in the field.

DR. HOLCOMB: How would you characterize APSA and the Surgical Section? How are they similar, and how are they different?

DR. O’NEILL: The Surgical Section was the first forum for presenting scientific information, and slowly but surely pediatric surgeons, like myself, got involved in the American College of Surgeons. We presented papers and panels there, and so forth. Then with all of these academic pediatric surgeons coming out and going to university centers, we had so much work to present, that it was a natural thing to develop APSA. Also, people really felt — Boles, and Leape and some others — that we needed a pure surgical organization. On the other hand, the best avenue for affecting child care was through the Academy of Pediatrics. It’s probably still true today. So APSA was formulated. Then we developed a presence at the American College of Surgeons, as well. There were a number of people who contributed to that. I was fortunate to be part of that effort. It may be that because there were relatively few of us involved at that time, I had opportunities. But maybe I can just say lucky, I guess. I got into these things, and people, like Scott and Clatworthy, would promote their trainees, and I was very fortunate. I was promoted and helped by these individuals very much.

DR. HOLCOMB: What do you feel the role of APSA is currently?

DR. O’NEILL: Well, APSA is the place that is the forum for developing standards for the field. What is the scope of pediatric surgery? Making statements about that. Not that it doesn’t do it in partnership with the Surgical Section in the Academy of Pediatrics, because it’s been effective in that role, but it really sets standards for the field. It’s the spokesperson for pediatric surgery to American surgery generally, through its representatives, because that organization now has representatives in virtually every surgical organization that means anything, the American Board of Surgery, and so forth. The Surgical Section has some, but not to the extent that APSA does. It’s the organization where the standards for training and the program directors have their home. Probably the best work is presented there. It is now the avenue for international pediatric surgery. Of course, it’s developed that role over time. It’s the place where the Journal of Pediatric Surgery has its annual meeting. It’s the main pediatric surgical meeting. So it’s matured in that sense.
DR. HOLCOMB: You were very involved in a manpower analysis for pediatric surgery in the 1980s and 1990s. How did the thought of doing these analyses come about, and how were the data generated?

DR. O’NEILL: Well, first of all, I mentioned some time back in our interview the SOSSUS, Study on Surgical Services of the United States. That was undertaken in partnership by the American Surgical Association and the American College of Surgeons. They wanted to survey the status of surgery in the United States — academic surgery. It had a number of counterparts, but they had what, in that time, was called a manpower study. Dr. Clatworthy, at that time, was the president of APSA. He was invited by Dr. Francis [D.] Moore, who was the chairman of that study, to be the APSA representative for pediatric surgery. Dr. Clatworthy turned around and assigned me to that job. Well, the reason he did was that at the time I was the secretary of APSA.

DR. HOLCOMB: This is in the late 1970s?

DR. O’NEILL: This was in the 1970s, yes. Not late.

DR. HOLCOMB: Mid part of it then?

DR. O’NEILL: Maybe mid-1970s.

DR. HOLCOMB: Okay.

DR. O’NEILL: Anyhow, at that time I was the secretary of APSA. Tom [Thomas M.] Holder was the first one. Dale Johnson may have been the second, and then I was the third. Anyhow, I was the secretary of APSA. While I was secretary, I would get these letters from people looking for a partner, and asking if I knew of anyone. It was really that that lead to my development of a clearinghouse, the one that exists today. So I developed this clearinghouse for people, and it was where people — and I advertised it — where people could send me their names. We could do it confidentially, if they didn’t want to have their name in public. Then gradually, if somebody was looking for somebody, we’d get that, too.

So I had this list that we started. Dr. Clatworthy liked that idea, so he said, “I’m going to make you the representative.” So I started going to these meetings, and I learned the methodology of the SOSSUS study from the statisticians at the Brigham, today Brigham and Women’s Hospital. I went to a number of meetings with Dr. Moore. That’s how I learned the methodology. I learned the various methods of studying workforce, of which there are four or five. I got involved in the studies that were done by the National Academy of Sciences and the Bureau of Health Manpower, which is
part of HRSA. So I learned a lot from these things. We used those methodologies that combined population-based studies, need-based studies, and disease-based studies. That’s a jargon that perhaps is beyond this interview. But that complicated methodology in the uses of census tracks, and area surveys, and death-and-retirement rates, and integration of all of that by sophisticated statistical means became my hobby. We did it for the next 25 years.

DR. HOLCOMB: Do you have any feel for the current manpower situation? Do we have too many, or too few pediatric surgeons now?

DR. O’NEILL: It’s a very interesting thing. Because, as you know, the idea of workforce need can be defined in various ways, so I don’t believe that a definitive answer can be made. If you took some information, like a number of places looking for pediatric surgeons, you have to say, “Well, what kind of jobs are there? Should there be pediatric surgeons in those places? Is there a need for that? Etcetera.” I don’t have an answer for that, obviously. If you take other surveys, including one I just saw which was published in the Journal of Pediatric Surgery this past month, the indication is that there are enough, except in certain areas. So, in terms of geography, pediatric surgeons are well distributed. My own view is that a few more pediatric surgeons are needed. But I believe that with the increase in the number of training programs, that need is going to be met.

Now, if you take the demographics of the United States — and this is why it’s such a complicated issue and why it must be surveyed frequently, why we did this every five years, and why I think it should continue to be done every five years — is that things change. We have immigration. Now, immigration has increased the number of children, but not the number of insured children. So unless we have universal health care, it’ll be difficult for pediatric surgeons to earn a living, and for departments to support them. So certain things have to happen globally for that picture to stabilize. Having said all that, I think from what I know — and I still keep up with this very much, including the economics of it — I believe there’s a need for a few more. But that the increase in the training programs will probably take care of most of that. Remember, we can train pediatric surgeons in two years, so we can catch up pretty quickly. If we did produce a big excess, then predictably the cost of care would rise, and there are going to be governmental strictures against that. So I do not feel that we have a huge shortage by any means. Some people believe that, and they’re entitled to their opinion, but that’s my educated guess from this. And if certain trends change, then I think we could see that there might be a need for a few more. But we can get there easily, and we’re having it happen now.
DR. HOLCOMB: At this time I’d like to talk about your involvement with the Surgical Section of the AAP. I understand you became a member of the Surgical Section in 1969.

DR. O’NEILL: That’s right.

DR. HOLCOMB: And were program chair from 1973 to 1974, during the time Dr. Judson Randolph was chairman of the Surgical Section.

DR. O’NEILL: Yes. He asked me to do that, and at that time, it was three years. The Academy was good to do this, because they wanted specialty input since the Surgical Section was the first and the largest of the sections that the American Academy of Pediatrics had. They had the rule that the program chairman of the Surgical Section was also an automatic member of the Committee on the Scientific Program [Scientific Program Committee] of the Academy. Which, by the way, meant an extra weekend meeting, but be that as it may. So therefore, the wise old heads of the Surgical Section had said that job should be a three-year job. Dr. Randolph — I was here at Vanderbilt at the time — called me from Washington. He was the chairman of the section, and he said, “Would you be willing to do this? It’s a three-year job...” He’s a very persuasive man, so I agreed. I did it for that three-year period, and also participated in the Academy. That’s how we got a lot of surgical stuff on the general Academy program.

DR. HOLCOMB: How did you come to know Dr. Randolph?

DR. O’NEILL: I met Dr. Randolph first when I went up to Boston Children’s Hospital to interview with Dr. Gross. One of the things Dr. Gross did was he picked up the phone, and he called Dr. Randolph. Dr. Randolph was there for an extra year after his training in a fellowship at the Jimmy Fund [Clinic] building with the Sidney Farber Cancer Institute [Dana-Farber Cancer Institute, originally established in 1947 by Sidney Farber, M.D. as the Children’s Cancer Research Foundation,], because he was waiting for his job to open up in Washington. So Dr. Gross gave him a job for a year. I was coming in from Nashville, so he called Dr. Randolph on the phone and said, “I want you to show this boy around. He’s from Nashville.”

I’ll tell you a thing about Dr. Randolph. About a year later, I saw a paper in the journal, Surgery. That was something that Dr. Ravitch had started. He had a pediatric surgery section there. That was the Journal of Pediatric Surgery at the time. Dr. Randolph had a paper, he and Dr. Gross, on Mikulicz exteriorization for intestinal atresia. Big series, and so forth. Since nothing was online at that time, I sent a postcard for a reprint. I got the reprint back with a nice note on top, “It was wonderful to see you here in Boston. I hope you continue your interest in pediatric surgery.” Now, how
he remembered a resident after a year, but he had toured me around. That
tells you something about Dr. Randolph. He toured me around, and I got to
know him well. He would come back to Nashville every so often because he
was a Vanderbilt person, and I would see him at meetings when I actually got
established, and we became friends. He was nice to me. He said, “Well, how
about doing this job for me?”

DR. HOLCOMB: I understand that the Resident Competition Session at the
AAP meeting was initiated during the time you were program chairman, as well.
It’s now known as the Rosenkrantz Resident [Research] Awards.

DR. O’NEILL: Right.

DR. HOLCOMB: How did this come about?

DR. O’NEILL: Well, we were looking for innovative things to do, like
any program chairman does, and I talked to Dr. Randolph, and then the
other chairmen along the way. I don’t remember which year we did it, but
we brought this idea up, because I was interested in having a little bit more
science in the program. Not that clinical papers weren’t good, but I didn’t
feel it was as well-balanced a program as it could be. Maybe I was a little
forward for a young person, but that’s what my feeling was. So I made the
suggestion, and it was accepted. They said, “That’s a good idea. You run it.”
[Laughter] So I did, and it was successful, because it encouraged people to
— People were bringing their residents who were interested in pediatric
surgery, anyhow, and I thought this was a way to broaden it. So that’s how
that came about.

DR. HOLCOMB: In the Surgical Section in 1977, I understand there was a
revision in the section bylaws to upgrade the practice requirements needed for
eligibility for membership in the Surgical Section. Do you remember the
previous practice requirements, and what were the new practice requirements?

DR. O’NEILL: That was Dr. Clatworthy who did that. He thought the
standards weren’t high enough. Up to that time it was 50 percent, as I recall
it. He wanted 100 percent, but we got 90 percent. The Academy executive
committee was a little chary about doing this, because they didn’t want to
alienate some of the other specialists in communities who took care of
children. So they got away with 90 percent, and then some years later it
became 100 percent. Once APSA came along, it had to be 100 percent,
because APSA was 100 percent. So it was basically Bill Clatworthy’s view
that the standards could be better, if the admission requirements were a little
stricter.
HOLCOMB: Now during your early membership in the section, I understand there was the Clatworthy Committee on Postgraduate Education and Residency Training of the Surgical Section.

DR. O’NEILL: Yes. Mmmm hmmm.

DR. HOLCOMB: That was formed in 1970 for the purpose of judging residency programs in general and pediatric surgery according to criteria that they developed in 1967.

DR. O’NEILL: Yes.

DR. HOLCOMB: Do you remember the members of this Postgraduate Education Committee? And how did this committee come about?

DR. O’NEILL: Well, let me see if I can. Well, first of all, because of seeking certification in pediatric surgery, there was a need to establish appropriate standards for training. As I had mentioned to you, it was pretty loose. Not that it wasn’t pretty good, but it was loose. So that meant that they needed to have something better. Dr. Clatworthy, in 1967, wrote the first standards for training in pediatric surgery [“Special Requirements for Training in General Pediatric Surgery”]. I have a copy of that in my file that he gave me. In 1970, these forces that were trying to get certification became stronger, and Dr. Clatworthy was asked, because he had written the standards. He had modeled them somewhat after the American Board of Surgery, but particularized them for pediatric surgery. In 1970, the Clatworthy Committee was established, and that included several people. It was called the Committee on Postgraduate Education. Bill Clatworthy was the chairman.

Then there was Bill Kiesewetter. He was the chairman of the section at the time. The other chairmen were consulted. Tague Chisholm, who represented the community, but also served the University of Minnesota in Minneapolis. Colin Ferguson in Canada. Eric Fonkalsrud in Los Angeles. Alex [J.] Haller [Jr.] who was at Hopkins. Harvey Beardmore, whom I mentioned, became prominent later, of course. Larry [Laurence M.] Linkner in Phoenix was the secretary of the section at the time. People who participated, they were the main ones. Some of the people who participated in some of the site visits were Swenson, Koop, Sandy [Alexander H.] Bill, Hugh Lynn, Larry Pickett, Mark Ravitch. Those were people who participated in that. But there’s no question who did all the work, whose brainchild it was, and that was Bill Clatworthy. They did this until 1975, when the ACGME [American Council for Graduate Medical Education] took over. So they did it for five years. But they were strict. In the first
inspection there were 24 programs inspected, and 11 were approved. So it was pretty strict, but it was necessary.

So when you asked me before how we got to the boards, I think the journal was the final lynchpin. But it was these pieces, and they were all constructed deliberately by people, but mainly Bill Clatworthy, because he knew what it would take to be successful. Now remember, he had talked to people. One of the people who would have been in the process of decision making was H. William Scott, and so he consulted with him. There was a lot of this, you might call it politicking, I call it constructive activity, because of what it represented. Bill Clatworthy was never looking for power or recognition. He did this for the good of the field. Maybe, I would say, he had the right attitude. I referred to attitude and values before. He epitomized that, in my view.

DR. HOLCOMB: This is off record, but if I could just sometime get a copy of those standards? Because I think it’d be interesting for the Program Directors Association.

DR. O’NEILL: I’d be happy to.

DR. HOLCOMB: To understand the — You may, or may not know, but I’m the president of that group now.

DR. O’NEILL: I did know that.

DR. HOLCOMB: I thought it might be good to put in our history. We’ve actually had a website, or part of a spot on the APSA website to put those.

DR. O’NEILL: Let me see if I have it in here. If I don’t have it here, I’ll get it to you, because I saved so much of this stuff.

DR. HOLCOMB: Anything you have about those standards or training or resident education, I’d love to have.

DR. O’NEILL: Yes, I have it here. And when it was approved, and everything. I’ll get copies of this for you and send it to you.

DR. HOLCOMB: That’d be great.

DR. O’NEILL: Yes. Plus the first programs and stuff like that if you’d like.

DR. HOLCOMB: That’d be great.
DR. O’NEILL: Yes.

DR. HOLCOMB: Do you remember — I think you mentioned this earlier — but do you remember when the Association of Pediatric Surgery Training Program Directors [APSTPD] was started, and were you involved in that creation?

DR. O’NEILL: Goodness! That began to come out of the annual resident meeting that Judson Randolph established. Then the training directors began to talk, because they thought, well, this would be a good thing for all of us to do. So I don’t think any one person — If you had to say anybody, it would be Jud Randolph. But it was a consensus thing that came about, and I was involved in that. But it was every one of the training directors.

DR. HOLCOMB: Regarding the first Pediatric Surgery [Annual] Residents’ Conference, which Dr. Randolph started in 1980 in Washington, the Surgical Section executive committee — and I think you were a part of that committee — voted to support this conference on an ongoing basis. And this support continues today. What do you remember about the development of this Pediatric Surgery Residents’ Conference?

DR. O’NEILL: Well, I remember Dr. Randolph had the first one, and then people were signed up to do others. The dues of the members of the Surgical Section far outweighed the cost, so the Academy was very good and reasonable in saying, okay, you can spend money on certain things from your dues. This was one of them. Because we felt — and the Resident’s Prize was another, and things like that for the papers — we felt this was a valid thing to do. I don’t know whether that still goes on today. But the Academy was very flexible on that.

DR. HOLCOMB: But it still goes on.

DR. O’NEILL: Well, I think it’s good.

DR. HOLCOMB: It’s a $3,000 stipend, I believe, from the AAP.

DR. O’NEILL: Well, it helps a training program to do this.

DR. HOLCOMB: During your time as chair of the Section on Surgery at the AAP in 1980 and 1981, I understand there was a proposal that the Surgical Section meet at the time of the annual meeting of the American College of Surgeons, rather than at the annual AAP meeting. Can you expand on this issue?
DR. O’NEILL: Well, I was the chairman of the session at the time. It was, I think, a disappointment to me to come into this. Several people who were leaders in pediatric surgery felt we shouldn’t bother with the Academy anymore. That we had the College, we had APSA, and we ought to stick with the surgeons, and not worry about being with the Academy. Now that, of course, was an unfortunate, very unfortunate thing, because APSA and the College had very little ability to influence the broader aspects of childcare in this nation. Whereas, the Academy of Pediatrics is right there with the government, and the children’s agencies, and so forth and so on. And they do today. And the education of pediatricians, even though that’s been difficult through the Academy, some education has always occurred. Pediatricians in communities have looked to surgeons of the Surgical Section to help them.

So because of that, the Academy has been a very, very important venue throughout. There were several people involved, who honestly felt — I actually have my notes from that time because I had to chair all of this, and I have the opinions, letters from a number of people. He was well-meaning, Harry Bishop and a couple of his people, including one of the younger people who was interested in separating from the section. Too many meetings, and, you know, I respect that. But they sent a letter to several leading people who were in the Surgical Section and APSA. I was at CHOP at the time, and Bishop being one of my faculty, it was something that led to tension between us, because I didn’t believe that the process was right for him to do this. Now, that was his right, you know. He was well-meaning, and so forth, but he didn’t really get everybody’s views. So I convened an evening session at the Surgical Section and brought in everyone who was a leader in pediatric — senior leader in pediatric surgery. I have some letters, handwritten and typed, and others in this file of mine. Overwhelmingly, the old heads said APSA and the College of Surgeons were appropriate extensions of our function, but organizationally, we would lose our ability to influence pediatrics in a way that we should — meaning pediatric care.

So they were opposed to it, but they gave their reasons. We had a fair distribution of opinions. Dr. Bishop and his constituency were able to express themselves first, then we had Mark Ravitch and Dr. Gross. I can’t tell you how many off the cuff, but I have the records of it here, as well as my handwritten minutes of this. We made up a list of pros and a list of cons. Anyhow, the consensus ended up that we had plenty of material for our scientific programs. The Academy had given us our first home when no surgical organization would. This was before my time, but I appreciated that tradition, and that there was a very real purpose in doing it.

So we were able to get through that crisis, and it was indeed a crisis at that time. We were lucky. Maybe I was lucky. I didn’t want to preside over the
death of an organization that had done so much good. But where I was lucky was that I got the right people together to talk it over. And that saved the day. I’ve saved that file.

DR. HOLCOMB: I’ll bet.

DR. O’NEILL: Well, I mean it’s an interesting bit of history.

DR. HOLCOMB: Now, in 1978, I think something happened that I think the younger readers of this oral history will enjoy hearing about. I understand that in 1978, the executive committee of the Surgical Section approved the concept or a manuscript about primary anal anastomosis as a surgical option for Hirschsprung’s disease.

DR. O’NEILL: Mmmm hmmm. Mmmm hmmm.

DR. HOLCOMB: I understand this was controversial. Can you explain this controversy, as it is a well-accepted concept now?

DR. O’NEILL: Well, that’s an interesting story. It was very controversial. I made some reference to the fact that pediatric surgeons sort of were rigid. The way that the early ones had been trained by Dr. Gross, was the way it was done. There was no room for innovation, although he was innovative. But there was none, you know. Nothing could come out otherwise. So all of his trainees all did things the same way. This proposal came up for a section survey on Hirschsprung’s disease and endorectal pull through. Dr. [Franco] Soave had developed the operation leaving the pull through colon outside, and then a week later would go back and amputate it when there had been good adherence to the cuff. Scott [J.] Boley in New York at Downstate, was more a general surgeon than he was a pediatric surgeon, but he had devoted his energies to pediatric surgery. He was a well-trained colorectal surgeon. He’d worked with Clarence Dennis, and he’d worked with some other people in New York. Dr. Boley said you should do a primary anastomosis. He was not in the mainstream of pediatric surgical leaders, so he wasn’t accepted. Of course he was right. But the person who made the difference — because I was present at this discussion and the approval of this protocol — the person who made the difference was Mark Ravitch. Mark Ravitch went through the history of when he and David [C.] Sabiston did that endorectal pull through operation, and why he thought that this was a brilliant idea, and why he felt that the Soave method was not necessary. His logic and his background knowledge of all the various things that had been done before broke the argument.

So it came out you could do it either way. But the people who were putting it together, and most of the others, were dead-set against this, because they felt
it was dangerous. Dr. Ravitch pointed out the error of their ways, as he could so well do, and immediately turned the tide. It was Dr. Ravitch and his brilliance. Remember he was a superb editor, had probably read everything ever written in every language. So he was savvy about all this. And he had done the first operation really.

DR. HOLCOMB: Board re-certification in surgery began to be discussed in the early 1980’s. What do you remember about these early conversations about re-certification, in general, in pediatric surgery?

DR. O’NEILL: Well, the establishment of the certificate in pediatric surgery by the American Board of Surgery, when that was approved by the main Accreditation Council for Graduate Medical Education, demanded that there be re-certification in ten years. So pediatric surgery, when its certificate was approved, was approved with that proviso. What had not been worked out was what the exam would be, and so forth. That came up over time. The first exam that was given was given from a pool of questions, and I was involved in that.

DR. HOLCOMB: In the 1980s also, I understand there was controversy with emergency medicine physicians about who was best equipped to take care of pediatric trauma patients. I also understand there was an effort to require critical care training in order to take care of surgical patients in the ICUs [intensive care unit]. These similar discussions — or similar discussions — have continued today. What do you remember about these early discussions?

DR. O’NEILL: Well, it turns out I was in the middle of it. There was a thing called the [American Academy of Pediatrics] Committee on Pediatric Emergency Medicine, so-called COPEM. They have it today. But there was no section of emergency medicine, or anything like that, in those days. We’re going back to the mid-1980s, or so. Now, while I had been the chairman of the section — was it 1980, 1981, something like that — I had been doing trauma and burns, and so forth, and had gotten involved at the [American] College [of Surgeons] level and with the American Association for the Surgery of Trauma in the field of pediatric trauma, and the organization of it. So I got asked, if I would serve on this committee. It was the next crisis that came along after the first crisis having to do with separation. Because they said, “Well, if they’re going to treat us this way, we’re out of here.” It was foolish, because it obviously should have been a collaborative effort. It was unfortunate. There was an individual involved at the time, who I guess was trying to make her way in the world. She was really a nice person, and her motivation was to develop pediatric emergency medicine as a field, but I don’t think she appreciated the contribution of pediatric surgeons. She had to learn that over time.
So it took several years. I served on that committee, I think, six years, and went to the meetings, and interfaced with them, and put in reports on a regular basis, because I was made liaison. When we had this disagreement, there were the various chairmen of the Surgical Section. One of them actually went to the president of the Academy, and said, “We need to have a liaison member.” And that’s how I got appointed. So I did that for a good while, and things quieted down. We began to do productive things like develop courses in EMSC [Emergency Medical Services for Children], develop modules for the PALS [Pediatric Advanced Life Support] course, and so forth. A lot of stuff that Alex Haller was involved in, I got involved in. Oh, he led that effort, but it started because of controversy and ended up being a contribution, I think, with some recognition. But there is always going to be a little tension. Intensive care units? We didn’t have trouble with that. It was emergency rooms and stuff like that.

DR. HOLCOMB: How do you feel the Surgical Section has changed — or has it changed — from the time that you were initially involved to the 1990s, and even to 2008?

DR. O’NEILL: Well, I think it’s much, much larger. It’s not the small thing that it was. It no longer has to be the main standard-setter in the field, which it was. No longer has to establish training standards, which it did. I mean, a lot of the work, pioneering work that needed to be done was done by them. Well, that’s over. Now it’s a triumvirate of organizations that take their place in the organization of surgery. So the Surgical Section has taken its place as a way to influence childcare in America, because they’re now even better liaisons with the leadership of the Academy. That may be its most important thing — a way to help set standards for surgical care in children’s hospitals. Because pediatricians control a lot of that. Pediatric surgeons are involved in, booklets, committees, things like that. That’s changed, and it’s important. And of course it’s a very vibrant, scientific meeting. So I think it’s just matured. It’s coming into its own.

DR. HOLCOMB: Who would you say were the three most influential people in the development of your career?

DR. O’NEILL: Oh, my goodness! Well, certainly H. William Scott, without any question. H. William Clatworthy, without any question. Then I would have to honestly say my father, who from a base of no education, no opportunity, no family, had the insight to cultivate my talents, and to inspire me to work and to contribute. Throughout his life he talked about, well, children need this, and people need this. Maybe it was because of his own experience. He inspired me, even though he didn’t mean to, to follow science and medicine, and he encouraged me thereafter. There are a lot of people
who influenced my career. But those are probably the three key figures I would focus on, who made a difference and who mentored me.

DR. HOLCOMB: If you had to advise or mentor a young pediatric surgeon in an academic position, who wanted to advance up the academic ladder, what advice would you give that young surgeon?

DR. O’NEILL: Well, first of all to get the best possible background of general surgical training you can, as broad as possible. While you’re there, do something other than do a residency. Contribute to the field. Do some research, or take a special fellowship in transplantation, or whatever. Develop a special interest, then you get your pediatric surgical training. Maybe after that, if you’re interested in research, do some more training, because research is more sophisticated today. Then get a job in an institution where you can spend enough time doing research. But have a work ethic that lets you develop your career in clinical pediatric surgery. Be collaborative. Work with other people. Be productive. Don’t worry if you have to work nights and weekends. Do all of those things. Because I don’t see being an elite pediatric surgeon without that effort. If I look at elite pianists or elite anything, they work all the time at that. An elite athlete. I think if you’re going to be an elite surgeon, and do the important things, and push back some frontiers, you’ve got to do that. You can’t lead without that. And then develop our administrative talents, Join and get involved in national organizations, and show that pediatric surgery has a place in the surgical world. I’m talking about a lifetime continuum. If a young person follows those steps, and has the talents, and has the right mentors and connections — you can get them if you seek them out, because people will respond. Then an individual will be successful, and will have the gratification when they’re all through that they’ve made that field better and added something. And there is a lot of gratification and satisfaction to that.

DR. HOLCOMB: Where do you think, looking forward, where do you think the practice of pediatric surgery will go in the next 10 to 20 years or so? What do you think we might be doing then that we’re not doing now?

DR. O’NEILL: Well, I think that things will be more tailored to the individual patient. I think we will probably be doing some additional operations, but I think also we’ll be doing more multi-modal things. Surgeons are going to have to think more scientifically. They’re going to have to know genetics. They’re going to have to know basic science concepts, and use new pharmaceutical and technological developments, new bio-imaging techniques, new robotic or minimally invasive techniques, new interventional techniques that may not involve incisions in order to bring more advances to children. But if you don’t know a child’s genetic makeup, it may not be possible to treat them appropriately. I’m talking about
oncology now. And you’re going to have to be able to teach these things. We’re going beyond. We’re going to have to continue to do the technical things and advance technically, but all of these other advances in medicine, I think hopefully, will give us opportunities to make things better surgically.

When I talk about bio-imaging, I’m talking about better imaging to plan things. Better imaging and genetics to know whether you should use radiation first, or surgery first, or whatever. I think we will do more clinical trials. I think we will see that some people, some places with good people, will do things better than others, and they will set the standards. And others will either come along and advance, or will wither on the vine.

I think that surgery will get, surgical care, will eventually get cheaper, because the better your work is, the fewer complications and the better opportunities for you to have less expense. Anyhow, those are some of the things I see. I have a very, very optimistic view of where surgery will go, because you’ll be able to do so much more that people are going to like that. That’s what attracted me to the field. I could do more than a pediatrician could, and that’s what I think is going to be even more so. Why do you think people like pediatric surgery? It’s a neat field. And the people who are in it usually like it.

DR. HOLCOMB: Who informed you about receiving the Ladd Medal, and tell us about the ceremony.

DR. O’NEILL: Well, the chairman of the section, Kurt [D.] Newman, called me on the phone one afternoon. He had tried to call me earlier, and we played tag for a little bit. He called me and said, “I have something to tell you.” I didn’t know what he was calling about. He said, “The executive committee has unanimously voted to award you the Ladd Medal, but don’t get your hopes up yet. It has to be approved by the Academy executive committee.” So I said, “Well, I won’t get my hopes up.” But I was speechless. I never expected anybody to call me about that, quite honestly.

Anyhow, the ceremony was wonderful. The president of the Academy came and awarded it. I had a couple of my kids there, which was wonderful for me. Unfortunately, Susan was sick so she couldn’t be there. She was very ill at the time. Fortunately, she’s well now. But since her sister was able to take care of her, I was able to go to get the Medal. Otherwise I couldn’t have. But I went for just a short time. It was very nice. The Advisory Council dinner was nice for me, because they mentioned me and made a fuss over me. Then I had to give a little talk, which I enjoyed giving. That’s one of the requirements of the ceremony, that the awardee give a little talk, which I did. It was a wonderful, warm occasion. And for me, a highlight, obviously, in my career, because the thing I value most in my life is my pediatric surgical
career, and what it has meant to me over the years, and what I’ve seen in the enormous advances in 40 years. This field has come of age and blossomed, and it’s even more wonderful than it was when I started.

DR. HOLCOMB: Dr. O’Neill, I want to congratulate you on being awarded the 2007 William E. Ladd Medal. It is certainly one of the highlights of one’s career to be recognized as the Ladd Medal winner. This concludes the interview with Dr. James A. O’Neill, Jr., the 2007 William E. Ladd Medal winner. Well, thank you.

DR. O’NEILL: It was fun.

DR. HOLCOMB: That was a blast for me.

DR. O’NEILL: You heard things you never heard before.

[End of Interview]
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CURRICULUM VITAE

Name: James A. O'Neill, Jr., M. D.

Place of Birth: New York, New York

Date of Birth: December 7, 1933

Married: Susan P. O'Neill

Children: James A. O'Neill, III, M. Elizabeth O'Neill Griffin, and Kathryn O'Neill Miller

Academic Degrees: B. S., Georgetown University 09/51-06/55

M. D., Yale University 09/55-06/59

M.A., honorary, University of Pennsylvania 1982

Licensed by States of: Ohio, Louisiana, Tennessee, Pennsylvania

Internship: Vanderbilt University Hospital, Vanderbilt University School of Medicine 07/59-06/60

Assistant Residency: Vanderbilt University Hospital 07/60-06/64

Residency: Vanderbilt University Hospital 07/64-06/65

Columbus Children's Hospital, Ohio State University School of Medicine (General and Thoracic Pediatric Surgery) 07/67-06/69

Teaching and Research Appointments Previously Held:

Instructor in Surgery, Vanderbilt University School of Medicine 1964-1965

Chief, Burn Study Division, USA Surgical Research Unit, Brooke Army Medical Center 1965-1967

Instructor in Pediatric Surgery, Ohio State University College of Medicine 1967-1969

U.S.P.H.S. Fellow (Pediatric Oncology), Columbus Children's Hospital 1967-1969

Assistant Professor of Surgery and Pediatrics; Chief, Pediatric Surgical Service; Louisiana State University School of Medicine 1969-1970
Teaching and Research Appointments Previously Held (Cont'd):

Associate Professor of Surgery and Pediatrics; Chief, Section of Pediatric Surgery, Louisiana State University School of Medicine 1970-1971

Professor of Surgery and Chairman, Department of Pediatric Surgery, Vanderbilt University School of Medicine 1971-1981

Chief of Medical Staff, Vanderbilt University Medical Center 1976-1977


Professor of Pediatric Surgery, University of Pennsylvania School of Medicine 1981-1995

C. E. Koop Professor of Pediatric Surgery University of Pennsylvania School of Medicine 1988-1995

Present Position:

Professor of Surgery Vanderbilt University Medical Center 1995-Present

Surgeon-in-Chief, Vanderbilt University Medical Center 1995-2002

Chairman, Section of Surgical Sciences Vanderbilt University School of Medicine Emeritus 1995-2002 2002

John Clinton Foshee Distinguished Professor of Surgery Vanderbilt University School of Medicine Emeritus 1995-2002 2002

Director of Clinical Program Development and Education, Meharry-Vanderbilt Alliance 2002-Present

Board Certification:

American Board of Surgery -1966
American Board of Thoracic Surgery -1966
Certificate of Special Competence in Pediatric Surgery -1975
Recertification in Pediatric Surgery -1999
Certificate of Special Competence in Surgical Critical Care -1986
Advanced Trauma Life Support, Instructor -1986
Recertified, Advanced Trauma Life Support -1991

Society Memberships:

Alpha Omega Alpha
American College of Surgeons
American College of Surgeons, Metropolitan Philadelphia Chapter (founding member)
Society Memberships (Cont'd):
American Academy of Pediatrics, Section on Oncology-Hematology
American Academy of Pediatrics, Surgical Fellow
American Association for the Surgery of Trauma
American Burn Association
American Pediatric Surgical Association, Charter Member
American Surgical Association
Association for Academic Surgery
British Association of Pediatric Surgeons
Davidson County Medical Association
Halsted Society
International Society for Burn Injuries
International Society of Parenteral Nutrition
International Surgical Group
James D. Rives Surgical Society
New Orleans Surgical Society
Pennsylvania Chapter, American Academy of Pediatrics
Philadelphia Academy of Surgery
Philadelphia Pediatric Society
Societe International De Chirurgie
Tennessee Chapter of the American Academy of Pediatrics
Tennessee Medical Association, Delegate 1976, 1977
Tennessee Pediatric Society
The College of Physicians of Philadelphia
The Nashville Surgical Society
The Society for Surgery of the Alimentary Tract
The Society of University Surgeons
The Southeastern Surgical Congress
The Southern Gut Club
The Southern Society for Pediatric Research
The Southern Surgical Association

National Committees, Appointments:
American Academy of Pediatrics, Surgical Section, Program Committee (1975-77, Chairman)
American Academy of Pediatrics, Advisory Committee for Postgraduate Education, 1979-81
American Academy of Pediatrics, Surgical Section, Executive Committee 1977-80, Chairman 1980-81
American Academy of Pediatrics, Pennsylvania Chapter, Pediatric Trauma Care Coordinator
American Board of Surgery, Director, 1981-87, Senior Member 1988-99
American College of Surgeons, Committee on Trauma, 1972-77
American College of Surgeons, Committee on Trauma, Executive Committee, 1975-77
American College of Surgeons, Subcommittee on Burns, 1975-77
American College of Surgeons, Nominating Committee, 1986
American College of Surgeons, Committee on Postgraduate Education 1979-82
American College of Surgeons, Committee on Continuing Education, 1981-88
National Committees, Appointments: (Cont'd)

American College of Surgeons, Cancer Liaison Physician, 1971-81
American College of Surgeons, Regental Ad Hoc Committee on Legislative
Issues in Trauma and Emergency Medical Services, 1987-95
American College of Surgeons, Board of Governors, 1990-95
American College of Surgeons, Board of Governors' Committee to Study
the Fiscal Affairs of the College, 1992-95
American College of Surgeons, Philadelphia Chapter, Vice President 1993-94
President-Elect 1994-1995
American Medical Association, Site Visitor, Residency Review Committee
for Surgery
American Pediatric Surgical Association, Secretary 1976-79
American Pediatric Surgical Association, Chairman, Education Committee,
1984-87
American Pediatric Surgical Association, Manpower Committee, Trauma
Committee, Committee on Issues and Ethics; Chairman, Manpower Taskforce
American Pediatric Surgical Association, President-elect, 1987-88
American Pediatric Surgical Association, President, 1988-89
American Pediatric Surgical Association Foundation, Board of Directors,
1994-1997
American Surgical Association, Council on Academic Surgery, 1993-97
American Surgical Association, First Vice-President, 1997-98
American Trauma Society, Board of Directors, 1974-78
Association for Academic Surgery, Membership Committee, 1973-74
Association of Program Directors in Pediatric Surgery 1989-95
Association of Program Directors in Surgery, Steering Committee,
1990-94
College of Physicians of Philadelphia, Council 1988-91
Georgetown University, Dean’s Advisory Board, 1999-2003
Georgetown University, Woodstock Theological Center for the Study of Ethics
and Public Policy, Board of Directors, 2005-
Halsted Society, Board of Governors, 1986-89
International Association for the Surgery of Trauma and Surgical Intensive
Care, Active Member, 1989-
Nashville Surgical Society, President, 1998
N.I.H., Children's Cancer Study Group, Surgical Steering Committee
1975-92
Philadelphia Emergency Medical Services Council-1981-95
Trauma Care Subcommittee of the Medical Advisory Committee
Project Hope - Hope Foundation Medical Advisory Board
James Whitcomb Riley Research Foundation, Indianapolis, Ind., Advisory
Board, 1986-89
Society of University Surgeons, Education Committee, 1974-75
SOSSUS, Manpower Evaluation Committee, Pediatric Representative,
1974-76
Southeastern Surgical Congress - Program Committee 1979-82
Southeastern Surgical Congress - First Vice-President, 1998-1999
Southeastern Surgical Congress - President 2000 – 2001
Southern Surgical Association – President 2007 - 2008
St. Mary Villa Children’s Care Center, Nashville, TN Board of Trust 2004-
State of Pennsylvania Foundation for Trauma Care, Standards Committee
Chairman; Pediatric Trauma Center Standards Committee
U. S. Army Institute of Surgical Research, Fort Sam; Houston, Texas
Surgical Consultant
Editorial Board, JOURNAL OF BURN CARE AND REHABILITATION 1978-91
Editorial Board, JOURNAL OF ENTERAL AND PARENTERAL NUTRITION, 1980-90
Editorial Board, JOURNAL OF SURGICAL RESEARCH, 1974-80
Editorial Board, JOURNAL OF TRAUMA, 1983-
Subeditor for PEDIATRICS 1994-2003
Editorial Board, PEDIATRICS, 1984-90; Editorial Consultant 1990-
Editorial Board, PEDIATRIC EMERGENCY CARE, 1984-
Editorial Board, PEDIATRIC SURGERY, 4th edition; Lead Editor, 5th edition; 6TH Edition
Editorial Board, ESSENTIALS OF PEDIATRIC SURGERY, 1st edition
Editorial Board, PRINCIPLES OF PEDIATRIC SURGERY, 2ND edition; Lead Editor
Editorial Board, PEDIATRIC SURGERY INTERNATIONAL, 1988-
Editorial Board Reviewer, EMIRATES MEDICAL JOURNAL 1996-
Associate Editorial Board, JOURNAL OF PEDIATRIC SURGERY, 1992-
Referee, JOURNAL OF MEDICAL PRINCIPLES AND PRACTICE, 1994-
Editorial Consultant, JOURNAL OF VASCULAR SURGERY, 1992-

Honorary Memberships and Awards:
U.S. Army Commendation Medal
Canadian Association of Paediatric Surgeons, Honorary
Dominican Society of Pediatric Surgery, Honorary
Pediatric Association of Guatemala, Honorary
Portland Surgical Society, Honorary
Society of Black Academic Surgeons, Honorary
South African Association of Pediatric Surgeons, Honorary
Surgical Association of Guatemala, Honorary
Seoul Children's Hospital (Korea) – Award Medal
University of Tokyo Children's Hospital – Gold Medal Award
Taiwan Association of Pediatric Surgeons – Association Award
Japanese Association of Pediatric Surgeons – Association Award
Vanderbilt University Gold Medal Award
Yale University School of Medicine – Distinguished Alumnus Award
Castle Connolly’s America’s Top Doctors
University of Nagoya, Japan – Institutional Gold Medal
American Academy of Pediatrics – Ladd Medal

Endowed Lectureships:
1971 Univ. of Cal., SF - Edward P. Carlson Lecture on Trauma
1984 Gary Wratten Lecture, USUHS
Warner L. LeBlanc Memorial Lecture, Lafayette, La. General Hospital
1985 Carpenter-Noone Lecture, Lankanau Hospital, Philadelphia
1986 Loren Chandler Lecture, Stanford University
Ronald Cook Lecture, University of Ct.
1987 AOA Lecture, Albany Medical College
1988 Towsley Lecture, Univ. of Michigan
1990 Robert Garrett Lecture, Johns Hopkins University
1991  Distinguished Professor Lecture, Walter Reed Army Medical Ctr.

Thomas G. Edison Lecture, Georgetown University, Holy Cross Hospital, Silver Spring, Md.
Ballantine Lecture, Penn State University
Merrill Davis Lecture, Indiana University
GW Holcomb Lecture, Vanderbilt University
1993  Japanese Assn. of Pediatric Surgeons Visiting Lecture
1994  J. Aitkin Meigs Lecture, Phila. Ped. Society
      Phila. Academy of Surgery Lecture
1996  1st Edward Free Lecture, Children’s Hospital, Oakland Children’s Hospital, Oakland, Ca.
      Children’s Hospital Lectureship, Omaha, Neb.
1998  J. Louw Lecture, S.A. Assn. of Pediatric Surgery
      W.T.S. Wang Lecture, Chinese Univ. of Hong Kong
1999  Emmett B. Frazier Lecture, Univ. of S. Ala.
2000  Longmire Lecture, UCLA
      Whitehead Lecture, Emory Univ.
      Fred MacLeod Lecture, Canadian Assn. of Pediatric Surgeons
2001  1st Ray Amoury Lecture, Univ. of Mo., Kansas City
      James D. Rives Lecture, LSU School of Medicine
      Frederick Stubbs Lecture, National Medical Assn.
      1st E.W. Fonkalsrud Lecture, UCLA School of Med.
      Taiwan Assn. of Pediatric Surgeons Lecture
2002  C.E. Koop Distinguished Lecture, USUHS
      Osaka Univ. Research Foundation Lecture
      Peter Canizaro Lecture, Cornell Univ.
2004  Louis R. Del Guercio Lecture, New York Medical College
      International Pediatric Trauma Conference Keynote Speaker
2006  1st J Grosfeld Lecture, Indiana University School of Medicine
      John Lilly Lecture, Univ. of Colorado School of Medicine
2007  Colodny Lecture, Univ. of Vermont School of Medicine

Visiting Professorships:
1971  Univ. of California, San Francisco
1972  Children’s Hospital, Univ. of Mexico City
      Louisiana State Univ. School of Medicine
1973  King’s Daughter’s Children’s Hospital, Norfolk, Va.
1974  Univ. of Louisville, Ky.
      Indiana Univ. School of Medicine
1975  Charlotte Memorial Hospital, N.C.
      Med. Coll. of Wisconsin, Milwaukee, Wi.
      Univ. of Taiwan, Veteran’s Gen. Hospital
      Penn State Med. College, Hershey, Pa.
      Children’s Hospital, Univ. of Mexico City
      Univ. of Chicago School of Medicine
1977  Variety Children’s Hospital, Miami, Fl.
      Yale Univ. School of Medicine
      Univ. of Mo., Kansas City; Mercy Children’s Hospital
      Indiana Univ. School of Medicine
1978  Tulane Univ. School of Medicine
1979
Hadassah Univ. Med. Center, Jerusalem
Washington, DC, Children’s Hospital
Denver Children’s Hospital, Univ. of Colorado

1980
Children’s Hospital of Philadelphia

1981
Univ. of Oklahoma School of Medicine
Letterman Army Hospital, San Francisco

1982
Albany Medical College
Medical College of GA
Univ. of Medicine and Dentistry, New Jersey
Variety Children’s Hospital, Miami, Fl.
Johns Hopkins School of Medicine

1983
Indiana University School of Medicine
Scottish Rite Children’s Hospital, Atlanta, Ga.
Ohio State Univ., Columbus Children’s Hospital
Oregon Health Sciences Univ.
Brown Univ. School of Medicine
Baylor Univ. Coll. of Medicine

1984
NY Medical College
Mayo Clinic
Walter Reed Army Med. Center
Yale Univ. School of Medicine
Univ. of New Mexico School of Medicine
Univ. of Dublin School of Medicine
Lafayette, La. General Hospital
Children’s Orthopedic Hospital, Seattle

1985
Rutger’s Med. Center, UMDNJ
Hadassah Univ. School of Med., Jerusalem
Univ. of Texas, SW, Dallas
Univ. of Colorado, Denver Children’s Hospital
Case Western Reserve School of Medicine
Univ. of Fl. School of Medicine

1986
Geisinger Medical Center, PA
Stanford Univ. School of Med.
Univ. of W. Va. School of Med.
SUNY Downstate
Children’s Hospital of San Diego

1987
Univ. of Melbourne, Australia
Albany Medical College

1988
Tufts Univ., NE Medical Center
Case Western Reserve School of Medicine
Penn State Univ. Coll. of Med., Hershey, PA
Uniformed Services Univ. for the Health Services (USUHS)
Univ. of Michigan College of Medicine
Univ. of Guatemala, San Carlos
SUNY, Stony Brook

1989
Indiana Univ., Riley Children’s Hospital

1990
Johns Hopkins Univ., Garrett Visiting Professor
Univ. of Ala. School of Medicine

1991
St. Barnabas Medical Center
Penn State College of Medicine, Hershey, PA
Univ. of Pecs, Pecs, Hungary
Univ. of Helsinki, Finland
Univ. of Uppsala, Sweden
Univ. of Leningrad, USSR
Vanderbilt Univ. School of Medicine
Ohio State Univ., Columbus Children’s Hospital
Univ. of Cincinnati, Cincinnati Children’s Hospital
1992 Cook Children’s Hospital, Ft. Worth, TX
Tulane Univ. School of Medicine
1993 Mt. Sinai School of Medicine
Univ. of Osaka
Univ. of Tokyo
Univ. of Nagoya
Juntendo Univ. School of Medicine, Tokyo
1994 Bowman Gray School of Medicine
Dartmouth Medical College
Albany Medical College
1995 Univ. of Tn., Knoxville Medical Center
1996 Children’s Hospital, Oakland, Ca.
Univ. of Nebraska School of Medicine
Univ. of Tn., Memphis School of Medicine
1997 Jefferson Medical College
Albany Medical College
Univ. of Cal., San Diego
North Shore Hospital, Cornell Medical College
1998 Muhimbili Univ. College of Health Sciences, Dar Es Salaam, Tanzania
Univ. of Cape Town, Red Cross Children’s Hospital
Univ. of Miami School of Medicine
1999 Univ. of S. Alabama School of Medicine
Univ. of Pennsylvania School of Medicine
2000 Memorial Health Univ. Medical Center, Mercer Univ., Savanna, GA
UCLA School of Medicine
Emory University School of Medicine
Univ. of Wisconsin, Madison
2001 East Carolina Univ. School of Medicine
Univ. of London Twin Congress
Hospital for Sick Children, London, England
Univ. of Kuwait Children’s Hospital
Univ. of Mo., Kansas City
Louisiana State Univ. School of Medicine
Univ. of Taiwan
2002 William Soler Children’s Hospital, Havana, Cuba
SUNY, Stony Brook
Uniformed Services Univ. of the Health Sciences, Children’s Nat’l Med. Ctr
Osaka Univ. School of Medicine
2003 Cedars-Sinai Medical Center, Los Angeles
2005 Indiana University School of Medicine
University of Michigan School of Medicine
Columbia University College of Physicians and Surgeons
2006 University of Minnesota School of Medicine
Indiana University School of Medicine
Albany Medical College
University of Colorado School of Medicine
Other Outside Presentations and Invited Lectures, Grand Rounds Presentations, National and International:

1971 – 2007 Over 425
BIBLIOGRAPHY
James A. O'Neill, Jr., M.D.


320. O’Neill JA Jr: Will reduced work hours improve the state of the art of healing? Virtual Mentor, JAMA, 2006; 8:466-468.