

## Ronald Coy Jones, MD: a conversation with the editor

**R**on Jones (*Figure 1*) was born in Harrison, Arkansas, on August 24, 1932, and spent most of his early years there. He attended the University of Arkansas for 3 years and then entered the University of Arkansas School of Medicine, where he spent 2 years before transferring to the University of Tennessee School of Medicine. He completed a rotating internship at the Los Angeles County General Hospital. In July 1958, he began a general practice residency at the University of Oklahoma Medical Center in Oklahoma City. During that training, he became interested in surgery and did his general surgery residency at Parkland Memorial Hospital in Dallas from 1960 to 1964. Thereafter, he remained on the surgical faculty of The University of Texas Southwestern Medical School and rapidly rose in rank to full professor within 10 years (1974). From 1974 to 1976 he was acting chairman of the Department of Surgery at Southwestern. In July 1987, he moved to Baylor University Medical Center (BUMC) as chairman of the Department of Surgery and has remained in that position since.

Ron Jones has contributed continuously since 1964 to our fund of medical knowledge. His interests have been relatively broad but have focused especially on trauma, particularly that affecting the pancreas, and on surgical infections and oncology. He was the major player in establishing a modern citywide ambulance service in Dallas. His work with the American College of Surgeons in establishing standards for cancer therapy throughout the USA has brought him wide recognition. He has been a sought-after speaker, both nationally and internationally.

For his work he has received a number of awards, including ones from the mayor of Dallas (for his work involving emergency medical services), from the American College of Surgeons and the American Cancer Society (for his work on setting standards for cancer therapy throughout the USA), and from the University of Tennessee College of Medicine as Outstanding Alumnus (1996). During his chairmanship of the Department of Surgery at BUMC, Dr. Jones has expanded the residency program and made it one of the very best in the USA. His modest demeanor



**Figure 1.** Ron Jones during the interview.



**Figure 2.** As a young child.

and his loyalty to and vigorous support of his colleagues, institutions, and family make him a leader in American medicine and the community. He also is a warm and delightful person to be around.

**William Clifford Roberts, MD (hereafter, WCR):** *Ron, I appreciate your willingness to talk to me and therefore to the readers of BUMC Proceedings. We're in my home on Wednesday morning, August 1, 2001. To start, I'd like to ask you about your early life.*

**Ronald Coy Jones, MD (hereafter, RCJ):** Bill, I was born in Harrison, a small town in northwest Arkansas (*Figure 2*). I grew up on a farm about 1½ miles from the town square and off a dirt road. Early on, my dad worked for the Arkansas Power and Light Company selling electric appliances. He covered several towns in northwest Arkansas weekly, and he also sold to rural electric areas. He particularly targeted areas that were just get-

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Figure 3. At age 8.

ting electricity in their homes. When I was born, we did not have electricity.

We got electric lights when I was about 5 years old. For cooling we used an icebox. We bought the ice at the icehouse. We had milk cows, so I learned to milk at an early age and subsequently fed the cattle. My father raised both dairy and beef cattle. We started off with registered Angus and then switched to registered Hereford cattle. We always had a garden. My mother did not work outside the home in my early years. She always had a fairly large garden with lots of tomatoes, carrots, radishes, green beans, corn, lima beans, squash, and cucumbers. In the summer, she canned enough food to take us through the rest of the year. We had hogs. We killed them in the fall, salted them, and hung them in the back of the garage. We raised chickens and turkeys, and that was most of our meat. We were somewhat self-sustaining. My mother made our butter. We sold some of the milk. The house had 2 bedrooms. In the early years my dad acquired some additional land across and up the road. The property was bought relatively inexpensively compared with what it costs today. Today, that land borders the city limits. The town has grown from about 4000 to about 11,000. I still have the farm with cattle on it. I go there occasionally, but not as much as I'd like to.

**WCR:** *How many acres did you have?*

**RCJ:** I have about 300 acres now. I have about 100 cows and another 100 calves and bulls on the farm. I started in kindergarten in Harrison and went through the first grade there (Figure 3). When World War II started and a moratorium was placed on manufacturing the electric appliances my dad had sold, we moved in 1942 to Long Beach, California, where both my mother and father worked in defense plants. After about 10 months we left California, returned to Harrison briefly, and then went to Orange, Texas, where we lived until the war was over in August 1945. We then moved back to Harrison, and I resumed my junior high education, starting the last part of the seventh grade, and went on through high school, finishing in 1950.

We always had horses (Figure 4). I saved about 1700 pennies (\$17), and my dad gave me another \$10; with that, I bought a



Figure 4. On the farm with his parents.

nice shiny black Shetland pony with a spot on her forehead. I rode that pony until I was about 14 years old. My dad would never let me have a saddle because he was afraid I'd get my foot hung in the stirrup, so I always rode bareback. Initially I couldn't manage the pony by myself, and so my mother would put a bridle on her and lead me around until I was big enough to manage her by myself. Often in the afternoon, my dad and I would saddle up horses and ride in the fields. That was a favorite form of entertainment.

**WCR:** *How many cattle did you have back then?*

**RCJ:** I don't remember, but not as many as we have now. My dad eventually got out of the commercial business and into the Hereford business, selling some cows as registered cattle. When I was 14 or so, he got interested in Tennessee walking horses. We did some showing of the Tennessee walking horses at the county fair and at horse shows in Fayetteville, Arkansas, Springfield, Missouri, and surrounding towns and won some ribbons. We also showed cattle at the county fair and won a few ribbons.

As I got older I fed the cattle after school, which was over about 3:30 PM, and did that until I finished high school. After World War II, he did not go back to the Arkansas Power and Light Company but started his own business. Until he retired he had a store on the north side of the square, selling Hotpoint and later General Electric appliances. It became more difficult when Wal-Mart moved in. The Wal-Mart in Harrison was the second Wal-Mart store! It was a lot of competition because already 22 stores in Harrison sold electric appliances. His business was a 1- or 2-man operation, but he was very good at it and had a good reputation. People tended to come back and trade with him again. They might trade a cow, a mule, or pigs for electric appliances.

I was strongly considering going into medicine by the time I was a senior in high school. In junior high and high school I was active in the band (Figure 5). I played clarinet and saxophone, eventually playing first-chair clarinet. We had district competitions, and I was fortunate enough to get to play first chair in the district band. Our district happened to include Fayetteville where the University of Arkansas is located. The director of the district band was the director of the University of Arkansas band. (I also played in the concert band when I went to the Univer-



Figure 5. In the high school band.

sity of Arkansas.) I was on the track team and lettered a couple of years in track in high school. I ran the 440 and the 440 relay and participated in the district track meet.

**WCR:** *How fast did you run the 440?*

**RCJ:** I don't remember. You could letter if you ran it in 56 seconds, and I lettered. I don't remember how fast we ran the 440 relay. I spent more time with the band than in sports. I was the drum major of the band. I also was drum major of the ROTC military band when I went to the University of Arkansas.

**WCR:** *Drum major means what?*

**RCJ:** I led the marching band. I directed the band with the baton and the whistle. We played at all the football games and also at some basketball games. I was invited to the state band, where I played in the first clarinet section for 2 years. At the state band they had symposia or retreats in Russellville, Arkansas. We spent 3 or 4 days with other students who had been invited throughout the state to play in the concert band. We would try out and be assigned to a chair.

We had only 1 tennis court in Harrison, and that was the church tennis court. My dad would go to his store every morning, and I would go with him in the summertime and play tennis all morning. Whoever was winning got that half of the court and whoever else wanted to play challenged. I would play until noon, go home to eat lunch, come back at 1:00 PM, play until 5:00 or 6:00 PM, go home and eat, and come back and play until dark. The court was dirt and wasn't lighted. We'd play singles or if there were enough people we'd play doubles. I played a lot of tennis during the summers!

**WCR:** *You got to be a pretty good tennis player?*

**RCJ:** Locally.

**WCR:** *Did you have a tennis team in high school?*

**RCJ:** No. Around the junior/senior year I began to work more in the store with my dad and go out and call on people to sell electric appliances, particularly washers and dryers, refrigerators, and electric ranges. I began to find areas where power lines were being put in, knowing that those people didn't have any appliances. I'd load up electrical appliances in the back of a pickup truck and try to sell them. If I couldn't make the sale, I would get them to try it. I unloaded it, got it in the house, and

hooked it up. Once they got a taste of having an electric refrigerator, they'd usually buy it. If they didn't buy it, I'd go back and pick it up and bring it back to the store. This was in the late 1940s, when selling was good because of the moratorium on producing electric appliances during the war. For that 5-year period after World War II ended, many people either didn't have appliances or had to replace the ones they had. It was an interesting time. By the 1950s, that pretty much went by the wayside.

**WCR:** *Did you have siblings?*

**RCJ:** No, I was an only child.

**WCR:** *What was your mother like?*

**RCJ:** My mother was born in Piggott, Arkansas, in 1909 and died in 1975. Her mother died at an early age during a dilatation and curettage procedure. They never knew why. My mother was a great person, very supportive, an excellent seamstress, and an excellent cook. She did everything she could for me. At night she would sew things for others at minimal or no charge. She made all my shirts until I got into high school. She did great embroidery work. She would spend hours embroidering initials on sheets or pillowslips and doing fancy designs. My mother was very active in the Methodist church. She made a lot of quilts and coordinated quilting groups for the church. At Christmastime, she always was in charge of the cake and candy making. After I was married, she sent us boxes of caramel, peanut brittle, chocolate fudge, divinity, various types of nut rolls, cakes, and pies.

She worked at the Methodist church into the early 1950s, when she went to work for a general surgeon, the first such specialist in Harrison. She worked for him for 20 plus years—until she died. Before I was born she was a secretary for M&M Railroad Company. Once I was born she stopped working and did not start again until I was in high school. My mother completed high school, lived in Eldorado, Arkansas, for a while and then moved to Harrison. Her father was a highway engineer who had built some roads in the Harrison area and was living there when she moved back in with him. He subsequently remarried. My mother had 2 sisters and when her father remarried, after her mother died, 2 other sisters were born. There were 5 children on her side, all girls. There are still some bridges there that her father built north of Harrison.

My dad was born in Gaither, a small town about 10 miles from Harrison. He was born in 1902 and died in 1980. His mother died abruptly when he was 4 years old from some acute illness, attributed at the time to gallstones. He was raised by his grandparents. At one point he was taken out of school for a year to work on the farm. As a youngster he worked in the hay in the summer. He was quite an athlete in high school in Harrison. He was on the basketball (beginning when he was in the eighth grade), football, and track teams. He did well at the district level in track meets. He was a stout, athletic-type individual. After high school in Harrison he enrolled briefly in a community college in Mountain Home, Arkansas, but for practical purposes he had only a high school education. After finishing high school, he worked for the railroad there and then went to work for the Arkansas Power and Light Company. He met my mother after she had moved to Harrison. They were married in 1928. My dad was very active in the Methodist church and served on the board. Along with 10 or 12 others, they gave enough money to air condition the church.

Both my grandmothers died at an early age. My dad's father was the county surveyor for a long time in Harrison and Boone County. He also at one time was a sheriff there. He died when I was 4 years old. My mother's father, who lived in Morrilton, Arkansas, died when I was in junior high school. I didn't see him many times.

**WCR:** *It sounds like your father was successful in his store. You grew up during the depression period. Did you feel the depression?*

**RCJ:** Yes. Shortly after they married in 1928, my dad acquired 5 acres of land and built a house on it. It was a small, 2-bedroom house, costing \$1300. Sometimes, they were able to make a payment of only 50¢ or \$1.00 on the house loan during the depression. He started with a few cows and gradually acquired more land close to the house. Across the road was some vacant land that he acquired by mortgaging the house. My mother criticized my dad for always buying land because she wanted some other things. By the time I started high school, he had acquired 300 acres over a 10-year period.

**WCR:** *It sounds like your mother and dad were quite busy. Your father had the store and then he'd come home and work on the farm. It sounded like your mother was doing the same thing.*

**RCJ:** We had a pretty active life. He took care of the farm by himself. Then, horses were used instead of tractors. He would mow some. We still have an old mower that is in the field outside the barn. It is an old sickle-type riding mower with a 6-foot blade that went out to the side to mow pastures. We had a rake for the hay that is still there. Often, we got others to bale it. We'd put loose hay in the loft of the barn and feed it out as loose unbaled hay. In the wintertime we'd feed and milk the cows, rain or shine. They would come up to the barn when it was time to be milked. I was always in charge of building the stools to sit on while milking the cows.

**WCR:** *When in high school, how many cows would you milk as a rule after school?*

**RCJ:** Maybe 5 or 6 were milk cows. We weren't a dairy production. The rest were beef cattle and their calves would run with them. I didn't have to milk them because the calves took all the milk from those cows. We had enough milk to put it out on the road in 10- or 20-gallon cream cans, and a driver picked it up and took it to a dairy company. We'd keep some milk to make cottage cheese or butter. We put the milk in the separator and turned the separator arm; what came off the top was the cream and what was left was the whey, which we sold.

**WCR:** *You mentioned that there was no electricity until you were about 5 years of age in your 2-bedroom house. Did you have running water?*

**RCJ:** When the house was built, a 15-foot-deep cistern was built behind it. When we had a good rain, we'd let it rain for a while, to wash the roof off, and then we would open one of the gutters to let the water drain into a sand filter and then be collected in the cistern. We'd have to clean it periodically. If it became dry, my dad would drop down in it from a rope and clean it out. The next rain would fill up the cistern. We limited the amount of water that we used for baths and dishwashing because we never knew when a long dry spell might make the cistern go dry. When I was in grade school my mother made soap, washed clothes on a wash board, and hung the clothes out on a clothes-

line. There was no city water at the time. When I was in high school, my dad and 3 others got together and paid for a small water line from town to come to our houses. They paid for the water line and then the city maintained it. We then of course had more water. The cattle got water from the ponds until we got running water, and then we installed troughs to water the cattle if the ponds went dry. When we got the city water we didn't use the cistern anymore. There were also 2 wells but we never used them.

**WCR:** *When you had the cistern, did you have to go outside and collect the water?*

**RCJ:** Early on, we pumped the water out of the cistern and brought it into the house. Once we got city water, we had water running into the house. We had an outhouse and also an indoor bathroom.

**WCR:** *Growing up on the farm and having to do many chores I suspect you got up pretty early in the morning?*

**RCJ:** Yes. I can't remember how early we got up but probably not as early as I'm getting up now. School started at 8:00 or 8:30 AM. I could get up at 6:30 and do what I needed to do. We did all the feeding in the late afternoon before it got too cold, because the temperature would drop pretty good at night in the wintertime. When the ponds froze, which they did in the wintertime, we had to break the ice with an ax so the cattle could get water.

**WCR:** *How did you get to school in Harrison?*

**RCJ:** We were 1½ miles from the square and about 1½ from the grade school. We had a car, and my parents drove me to school. They picked me up at noon and we went home for lunch, and they brought me back at 1:00 PM. When I got older I used to ride my bike to school. It was mostly downhill. I had trouble coming back. A lot of times I'd get about halfway home and call my dad and ask him to meet me or I'd go down to the store and tell him I didn't want to ride the bike back home.

**WCR:** *What was dinner or supper like at night at home? What did you talk about?*

**RCJ:** We usually talked about the affairs of the day—whatever was going on in our lives. We always had all 3 meals at home. We called it breakfast, dinner, and supper. I probably didn't eat in a café until I was 9 or 10 years old. We usually ate things that we grew on the farm. It might have been beef or ham. By upper grade school we bought more things from the grocery. At night sometimes there would be a church service. We always went to Sunday school and church on Sundays and then came home and had fried chicken, mashed potatoes, and gravy. Sunday noon was our big meal. We might also have church on Sunday evenings and often on Wednesday evenings. I became active in the Methodist Youth Foundation and eventually was president of that in high school. We occasionally sang songs after supper. If we did anything at night for activity we listened to the radio. We had one movie theater in town. Often, I went to a western on Saturday afternoon (for 10¢). I saw a lot of Roy Rogers, Hopalong Cassidy, Johnny Mac Brown, and Gene Autry. Children had to sit toward the front of the theater; the adults had the mid and back portions of the theater. If children sat in the back the usher might ask them to move closer to the front.

**WCR:** *It sounds like you and your mother and father were a very close-knit group and that you all got along very well.*

**RCJ:** That's right. I always felt that I had a say in decisions, such as to buy or sell something or go on a trip. I always felt that I had my vote and that it counted.

**WCR:** *You did very well academically in junior high and high school?*

**RCJ:** I wasn't number 1 in my class, but I was in the National Honor Society. In junior high and upper grade school it was a little difficult because I moved around a fair amount, to California and Texas.

**WCR:** *Did your mother and father encourage you a great deal scholastically?*

**RCJ:** They made it a high priority. My dad knew that spending lots of time in athletics was not good for grades. He downplayed athletics with me although he had been athletically inclined. Both my mother and father pushed me to make something of myself. Both encouraged me to go into medicine. There were 3 things they wanted me to consider: medicine, ministry, and pharmacy. As I went through high school, it became more and more obvious to me that I wanted to go into medicine.

**WCR:** *How did you get interested in medicine? Were there any physicians in your family? You mentioned that your mother worked for a general surgeon. Did that have any impact on you?*

**RCJ:** When I was growing up we had only 4 family practice physicians in town. There were no surgeons. If you had surgery, you had it in a clinic where the general practitioners practiced. Their offices were in the front, and a hospital and operating room were in the back. The nurse who worked for one of those family practice physicians (the father of the surgeon my mother eventually worked for) gave the anesthetic. My dad had an appendectomy in 1940 and was in the hospital in that little clinic for 23 days after the operation. He had pneumonia postoperatively. There was no penicillin then. One new drug that came to Harrison while he was in the hospital was sulfa. He was one of the first people in Harrison to be treated with a sulfa drug. He probably had atelectasis also because they kept you flat on your back following surgery without ambulation in those days. Medicine was relatively nonspecialized in that community for years. It was not until 1950 when I finished high school that the first general surgeon came to Harrison. My family and I went to a family practitioner; the closest specialists were in Springfield, Missouri, or Little Rock, Arkansas.

**WCR:** *How far were Little Rock and Springfield from Harrison?*

**RCJ:** Little Rock was 145 miles south and Springfield was 100 miles north of Harrison. The roads were mostly paved but crooked. The roads in the Ozark Mountains have hairpin curves.

**WCR:** *How far is Harrison from Dallas?*

**RCJ:** Right at 400 miles.

**WCR:** *How big was Harrison High School when you graduated?*

**RCJ:** There were approximately 80 students in my class, but they had just consolidated several small regional schools. The consolidation affected class standing because a lot of those students from the small schools came in with A's and the Harrison High School let them count. Earlier we probably had 50 or 60 seniors.

**WCR:** *Did anybody in junior high or high school have a major impact on you?*

**RCJ:** I don't recall any teachers who did. The association with some of the family practitioners had some impact. During

high school and college, one general practitioner let me make rounds with him. (Harrison got a true and larger hospital after I graduated from high school.) In Harrison the physicians did well financially and that had some impact. In high school my great aunt taught several courses (science, journalism, and Latin), and I took courses from her. The building I went to high school in was the same one my dad had gone to high school in. It's now a museum. There weren't a large number of teachers. I had 1 teacher in chemistry, 1 in science, 1 in civics (the coach), 1 in history, and 2 in math and English. The English teachers also taught speech. They taught more than one course. Each class used a separate room. The old grade school had been pulled down, and we had classes during the second grade on the stage in the old armory building. The army trucks were parked inside the armory. When I was in the second grade I had scarlet fever, and for 2 or 3 weeks I had a high temperature and eventually my skin peeled. Penicillin had not been made available.

Most of what we did when I was growing up didn't cost much money. I collected stamps from grade school on. I saved all the stamps I could acquire and still have a lot of 1¢, 2¢, and 3¢ stamps. Eventually, I got stamps from other countries. I also collected coins from grade school through high school. I still have a pretty good collection of old dimes, liberty-head nickels, Indian-head pennies, silver coins, and silver dollars. When I was in high school my mother worked for the church and took care of the Sunday collection on Monday morning. She would go through the collection plate and find the coins I wanted. She would put in the money to replace them before the deposit was made in the bank. I still have those coins in a safety deposit box in Dallas.

**WCR:** *There wasn't much money when you were growing up to travel much?*

**RCJ:** Generally, the only places we went were Little Rock or Springfield. When I was 5 and 8 years old, we went to Canada. (My father's sister had married a Canadian and lived in Toronto.) We drove in our car to Toronto, often camping out on the way. We saw Niagara Falls. When I was in junior high and high school, we took Sunday afternoon trips to Branson, then a small resort area in southern Missouri. Silver Dollar City and Eureka Springs are near there. Some motels there let visitors swim in the pool for 50¢. (In Harrison the only place we had to swim, until I was in high school, was the creek. Often there were snakes in the creek.)

**WCR:** *How did you choose the University of Arkansas for college? Was that a financial decision? Was that the only college you thought much about?*

**RCJ:** I'm sure part of the decision was financial. I don't think I ever considered going out of state to college because the tuition was cheaper in state. I looked at 2 colleges—Hendrix, in Conway, Arkansas, and the University of Arkansas. Conway was 110 miles south; Fayetteville was about 90 miles west but hard to get to. At that time you had to drive up through Eureka Springs on a really crooked road to Gateway (the state line between Arkansas and Missouri), back down through Rogers, Springdale, and into Fayetteville. The university was a larger school than Hendrix, a well-thought-of Methodist college. Hendrix had only about 400 students in 1950. When I started at the University of Arkansas, there were about 3200 students. The ratio of men to

women was at least 4:1, because the guys were coming to college after coming out of the service. There were only about 800 women in the entire university.

The first year I pledged a fraternity and lived with a professor, who was chairman of the department of chemistry, and his wife. I didn't like that fraternity and in the sophomore year went through rush week again and pledged Sigma Chi. We were required to live either in the house or in an adjacent property that Sigma Chi owned. Between the first and second year I went to summer school and took the equivalent of 21 hours, which was pretty hard. I took algebra II, trigonometry, qualitative chemistry, and quantitative chemistry that summer. I got accepted to medical school at the end of the third year. Tuition was modest. It cost \$800 that first year of college, and that included meals, room, laundry, and spending money.

**WCR:** *How did the University of Arkansas hit you? Three thousand students was probably as many as you had encountered in your entire precollege years.*

**RCJ:** That was almost as big as my hometown. The students who came from the larger cities—Little Rock, Pine Bluff, Fort Smith, Eldorado, and Fayetteville—seemed to have the jump on me because they had come from larger high schools and had had more opportunity to have courses that I might not have had before college. There was a little junior college at Harrison, and during the summer before I went to college, I took freshman English from the husband of a woman who had been my speech and English teacher in high school.

**WCR:** *You studied hard at college?*

**RCJ:** I studied hard, perhaps too much the first year, every day and night and weekends. I rarely went to a football game because of studying. (You can get burned out that way by not having some relaxation.) I went home occasionally on weekends by bus or by hitchhiking. I eased up studying a little my sophomore and junior years. My primary emphasis in college was study, study, study to get into medical school.

**WCR:** *What was your major in college?*

**RCJ:** I majored in zoology with a minor in chemistry.

**WCR:** *Did you feel comfortable in the science courses? Did you have a natural instinct for them, or did you have to work very hard in them?*

**RCJ:** I worked hard in them. Premed at that time was very science oriented. I also took some English and history courses, and a few courses for which I was sure I could make good grades (maybe philosophy or anthropology). I spent 2 or 3 afternoons each week in a laboratory for a science course.

**WCR:** *Did you run track in college?*

**RCJ:** No. I played some intramural sports.

**WCR:** *You played in the band in college?*

**RCJ:** I played in the concert band and in the ROTC band, but not in the marching band, which I had directed in high school, because it was too time consuming. It required playing in all home and out-of-town basketball and football games. I was in a choral group in medical school for a while. After that I stopped playing musical instruments and never went back to them.

**WCR:** *Who encouraged you to play a musical instrument? Were your parents musically inclined? You said that you 3 sang together occasionally.*

**RCJ:** My dad had a natural talent for playing the piano. Although he never had a piano lesson in his life, he could listen to a tune and then play it. We didn't have a piano, so he could play only when we visited his sister, which we did often on Sunday afternoons. I had a first cousin (my father's brother's son) who played in the band and was at one time band director in Harrison. He encouraged me to start playing a musical instrument. He had played the clarinet and encouraged me to play that instrument. When I was in the seventh grade, my dad bought me a metal clarinet. Before that he bought me a tonette, which was a little short black finger instrument, to get me started. When in kindergarten I was in a little drum and tambourine band. (I still have my little tambourine hat.) Practicing a musical instrument in a small house was probably more irritating to my parents than to me. I got a wooden clarinet in high school and then a nice saxophone. I started with the saxophone when I was a junior. I played both during my junior and senior years in the concert band in high school.

**WCR:** *You mentioned you loosened up a bit your sophomore and junior years. Were you dating much during that period?*

**RCJ:** Not a lot but I did date. There were some formal dances sponsored by the fraternity, and I had a date for those. Because the ratio of men to women was 4:1, not all boys could get a date for each affair. I also dated for some church functions. Most of the activities either centered on football or basketball games or fraternity functions. We wore suits to football games, and the girls might have corsages.

**WCR:** *Did you apply to medical schools other than the University of Arkansas? What were your thought processes at the time?*

**RCJ:** I thought all along that I would try to get into the University of Arkansas. I also applied to Baylor at Houston because they were going to conduct interviews at Arkadelphia, Arkansas, not far from college. My dad and mother drove me there early one morning. That is where Quachita College is located. I don't remember if I was offered a position at Baylor or not. I had decided that I was going to go to Little Rock because it was in state and less expensive than an out-of-state school. Houston also seemed like a long way from Harrison.

**WCR:** *Do you have any idea where you stood in your class after 3 years in college?*

**RCJ:** We didn't have class standings. Most students were freshmen and sophomores with fewer juniors and seniors. The University of Arkansas medical school selected students according to districts of the state. My region included a portion of north Arkansas. Thus, I did not compete with students from the region that included Little Rock. The medical school accepted 120 students, knowing that all of them couldn't be accommodated through the entire 4 years. It was a pyramid. You competed only with students within your district. The college grade-point average was important. A student might have been accepted from one district and not from another.

**WCR:** *Back in 1951 and 1952, grades meant something. Not many students in my college class had 3.8 or 3.9 grade-point averages. It seems to be pretty common today.*

**RCJ:** We were on a 6-point scale then. An A was 6 points; B, 4 points, and C, 2.

**WCR:** *How did you end up? Do you remember?*



Figure 6. Ron and Jane Jones leaving their wedding reception.

**RCJ:** I don't remember my overall grade-point average, but probably overall I was a B student.

**WCR:** Do you recall your first impressions when you started medical school? How did medical school strike you? Was that a good experience?

**RCJ:** I was overwhelmed. The thing that struck me most when I first started was the vocabulary. The names of the muscles (anatomy) amazed me. In the first semester, we took only 2 courses—*anatomy and biochemistry*. We spent a lot more time on *anatomy* than on *biochemistry*. I had some Latin in high school and Greek word roots in college, but that didn't help much. The second thing was the amount of study necessary to keep up with those courses. We had *anatomy* every morning, *biochemistry lab* every afternoon, and 2 hours of lectures. The time spent studying was much greater than in college. There were 32 classroom hours per semester that first year.

**WCR:** Were there classes that you really took to or that you enjoyed very much or any teachers who had a considerable influence on you?

**RCJ:** I don't recall having any significant or close relationships with any teachers in medical school. During the first 2 years I looked forward to the next 2 patient-contact years. I was so enthusiastic about trying to have patient contact during my sophomore year that, although I didn't need to work, I worked in a lab at the Veterans Affairs (VA) hospital at night. The return for working every other night was free room and board in the VA hospital. The VA lab work took an inordinate amount of time away from studying. The laboratory work was from 5:00

PM on and included doing blood counts—hemoglobins and hematocrits—and also collecting blood from all blood donors. If there was emergency surgery at night I had to type and cross-match the blood. There was no one in the lab but me. That meant being up most of the night, every other night, going to school the next day and then trying to study. It was almost impossible. I did that for only one semester.

Drawing blood was how I met my future wife, Jane. I was in charge of the blood bank and she was a dietitian at the VA hospital. She had done her dietetic internship at Charity Hospital in New Orleans and worked on the staff for another year before she came to the VA Hospital in Little Rock as a dietitian. We had a doctor's dining room, and the dietitians ate in the same room as the physicians. I also got to eat in the doctor's dining room. I met her at noon a time or two. One afternoon, after I'd been up most of the night before, I was awakened about 5:00 PM by a phone call from the operator, who told me there was someone in the blood bank who wanted to give a pint of blood. I walked down there and there was Jane. She was straightforward with no motive as far as I could tell. I talked to her a few minutes, taking her history, and drew the pint of blood. Then I asked if she wanted to go out and have a cup of coffee. That started our relationship. She always said that she gave blood to get me! We dated for a year before we were married.

**WCR:** When did you get married?

**RCJ:** For my junior and senior years I had transferred from Little Rock to the University of Tennessee at Memphis. Jane and I were dating at the time, and that created an inconvenience in terms of being able to see each other. I occasionally drove the 140 miles from Memphis to Little Rock on the weekend and back, and sometimes she would drive from Little Rock to Memphis and back. I transferred to Tennessee in October 1955 and we married February 4, 1956 (Figure 6).

**WCR:** You were at the University of Arkansas medical school for 2 years and at the University of Tennessee medical school for 2 years. Why did you transfer?

**RCJ:** To be eligible to transfer, you had to be in the upper half of the class. I had no idea where I was in my class until I went in to find out. Three of us wanted to go to Memphis. At the time, the University of Arkansas medical school used an old building in MacArthur Park and an old hospital with relatively low patient volume. (Later, the University of Arkansas School of Medicine moved to a new area in Little Rock and built a new medical school and new hospital.) The University of Tennessee School of Medicine was on a quarter system; Arkansas medical school was on a semester system. Tennessee medical school had a transition quarter which included July, August, and September, and a test was given in October. If you passed that test then you could go into the junior year at the University of Tennessee. (I still finished in June 1957, even after taking that additional quarter.) I did all of my clinical work at Memphis.

In my opinion, the University of Tennessee Medical School was bigger and better than the University of Arkansas Medical School at the time. It may have even been the largest medical school in the USA: it finished close to 200 students a year. My quarter finished about 45 students. The Tennessee school was well recognized. It had Gaston Hospital, Baptist Hospital (the largest private hospital in the USA at the time, and the admin-



**Figure 7.** As an intern at Los Angeles County Hospital in 1957.

istrator for a long time was a brother of Boone Powell, Sr.), a VA hospital, the Le Bonheur Children's Hospital, a cancer hospital, and another smaller hospital. It was a large campus with lots of trauma and lots of newborn babies.

**WCR:** *When did you decide to become a surgeon? Was that an easy or difficult decision for you? After you rotated through those services as a junior, which specialties attracted you?*

**RCJ:** When I first rotated on surgery, I thought it was one of the physically hardest things I had done. I thought, "I don't know why anybody would want to be a surgeon, stand here, and hold a retractor in the middle of the night, operate all night, and be tired like this." I decided that the one thing I was not going to do was go into surgery! Never in medical school did I consider going into surgery. I thought I would go into family practice (and go back to practice in my hometown) or maybe go into internal medicine or pediatrics. I also liked obstetrics.

In those days you didn't have to visit an institution to apply for internship. You could apply by mail, send your transcript, and get accepted or rejected. I decided I wanted to intern at the Los Angeles County Hospital (*Figure 7*). I had lived in Long Beach, just south of Los Angeles, during the war when my parents were working in the defense plant there, and I liked that area. There was a lot to do and see in Southern California. Los Angeles County Hospital was the only internship I applied to. At the time, that was a combination of the University of Southern California and the College of Medical Evangelists. I had a rotating internship.

At the time, Los Angeles County Hospital had >3000 beds and was one of the 5 largest hospitals in the USA. (The others were Charity in New Orleans, Philadelphia General, Bellevue in New York City, and Cook County in Chicago.) The workload there was the heaviest that I've ever seen anywhere I've been, including Parkland. It was unbelievable. We would admit as many as 20 patients in a 24-hour period. When I was a medical student, I was responsible for doing all the lab work. I thought I'd get out of that as an intern, but the interns did the lab work at Los Angeles County (the students didn't have to do it). We



**Figure 8.** Jane as a dietitian in the mid 1950s teaching medical students.

had to do all the white counts and differentials. If a spinal tap was needed, we did it, and we did all the lab tests on the spinal fluid. If there was an lupus erythematosus prep, we did it. All lab work was expected to be on the chart by 8:00 AM the next day. Admitting that many patients required being up all night. Many times I would be up 40 hours in a row, maybe more, without any sleep. There were not many places to sleep—mainly an empty bed on the ward. You couldn't get away long enough to walk to the Los Angeles County's residence for the residents and interns. When sleeping in a bed in the hospital I told the nurse where I was because I didn't have a pager. During the internship I decided that I wanted to do general practice.

Jane and I had a good time there with lots to do and see. We did not have any children then. Cheap entertainment was to go to a live television show. They'd be recording in the afternoon and you might see Jack Benny, Fred Allen, Dean Martin, Spike Jones, Giselle Mackenzie, Eddie Fisher. That was good entertainment. I would go to the beach after 24 hours on call and sleep there. When on obstetrics, I'd be on 24 hours and off 24 hours. Jane was a dietitian at Los Angeles County and brought with her the diabetic diet, which they didn't have (*Figure 8*). That was a good year for us.

**WCR:** *Going to Los Angeles was a very gutsy thing for both of you to do.*

**RCJ:** Traffic was heavy. You'd get off the freeway at the wrong exit and be in deep trouble. I drove a 1949 Plymouth. (It was 1957 and 1958.) After the internship, I thought I wanted to do general practice. I had looked at general practice residencies in California, but Oklahoma City was the closest place to Harrison (200 miles) with a general practice residency. I wanted to be closer to family. Also, Jane's family was from south Arkansas. Jane had a brother in Fort Worth and 3 sisters and her mother and dad in Arkansas. My parents were in Arkansas. It seemed like a logical place to come, plus it was a university setting and it provided good training.

When driving from Los Angeles to Oklahoma City to do the general practice residency, everything we owned was in the car except for one large box that we shipped. I had copies of *The New England Journal of Medicine* stuck under the seats. We drove to Oklahoma City via Las Vegas. The general practice residency included 1 year of internal medicine with subspecialties (hematology, gastroenterology, and cardiology) and 1 year of surgery with surgical subspecialties. John Shilling in surgery encouraged me to go into surgery. He was the first major influence that I had for going into surgery.

By then, I had had an opportunity to actually do some operations and not be a first or second assistant, and I liked it. Raney Williams, who had trained with Mark Ravich and Alfred Blalock in Baltimore, indicated to me that he could probably get me a position with Mark Ravich at the Baltimore City Hospital. John Shillings had been married to the daughter of Whipple, of Whipple's disease fame, but she had died. He had married again but his second wife died too (of leukemia) right after he moved to Seattle.

In Dallas at Parkland Hospital was Tom Shires, who was acting chairman of surgery. At that time nobody gave salt during operations, and Shillings thought Shires may have been wrong in giving salt during operations. Shillings didn't know too much about Parkland, but he encouraged me to look at it. Jane and I went to Dallas, and I interviewed with Dr. Shires. By then it was August 1960. He just had a resident drafted the morning before I went to Dallas. He said, "If you want the job, you can have it." I was the first resident he selected himself. The first year I was there he was still acting chairman, and the second year he became chairman of the Department of Surgery.

Before coming to Parkland, Raney Williams encouraged me to train with Mark Ravich, and I called Ravich. They had a pretty steep pyramid program. They took in 7 residents each year but finished only 4. I'd already had 3 years of postmedical school training including internship and 2 years of general practice residency. I didn't want to do 3 more years and then get cut before the beginning of the fourth year. He said, "I'll take you." I said, "I would hate to be cut at the end of 3 years." He said, "I wouldn't take you into the second year if I didn't think you'd finish." But he never guaranteed me a fourth-year slot. Finally, after a couple of phone calls and much discussion, he said, "I'll tell you what. Why don't we just forget about it?" That made my decision much easier. I went to Dallas with Shires, which was probably the right thing to have done in the first place. My starting salary was \$125 per month plus meals.

After 4 years of training at Parkland I finished and stayed on as probably the fifth person to join its general surgery staff. When Shires was the acting chairman he was the only full-time gen-



**Figure 9.** As chief resident at Parkland. Front row: Drs. Malcolm Perry, Don Jackson (senior resident), Robert Jones, Tom Shires, Ronald Jones (senior resident), Robert McClelland, Charles Baxter, Wayne Delaney (senior resident), and Jim Garvey (senior resident).

eral surgeon on the staff. Ronald Garvey was there for 1 year, and then he left and went into private practice. I stayed on the full-time staff there for 23 years. When Shires went to Seattle in 1973, I was appointed acting chairman of the Department of Surgery (on January 1, 1974) and remained in that position almost 2½ years (until April 1, 1976). I'm probably the only one to be acting chairman of the Department of Surgery at Southwestern, chief of surgery and program director at Parkland Hospital, and also program director and chief of surgery at Baylor.

**WCR:** *It sounds like you owe a debt to John Shillings. Do you know what he noticed in you to encourage you to go into surgery?*

**RCJ:** I think he thought that I worked hard. Jane was a research dietitian at the research center at the University of Oklahoma while I was a resident in general practice. At the time, she was involved in studies of strict dietary measurements on children with different types of diseases, including leukemia. Their entire hospital could accommodate only 10 patients. Her position was labor intensive, but, as a result, we lived almost across the street from the hospital. I had a lot of time to spend in the hospital and did a lot of clinical work.

I think Shillings was concerned also about general practitioners doing surgery (in smaller towns) after essentially only 1 year of surgical training after internship. At about that time, they were stopping family practitioners from delivering babies in the hospital. Prior to that, the family practice physician in some smaller communities might have as big a practice as some of the obstetrics/gynecology physicians did. He pulled me aside one day and said, "Ron, if you go out and do surgery after this amount of surgical training, I'm going to kick your butt." Gil Campbell, who was also at the University of Oklahoma and who had trained with Waggenstein at Minnesota, also encouraged me to go into sur-

gery. He eventually became the chief of surgery at the University of Arkansas.

**WCR:** *Gil Campbell is the funny one.*

**RCJ:** Yes. John Shillings, Raney Williams, and Gil Campbell all encouraged me to go into general surgery, as did Jerry McCullough, who was my chief resident at the time. I decided that I wanted to be a general surgeon, still not knowing whether I would stay in Dallas or go back to Harrison. In the meantime, Jean Gladden had gone through a general surgery residency in St. Louis and returned to Harrison in 1950 to practice. He had had me up to scrub in a few times. By then my mother was working for him. I had serious concerns about whether I might go back to Harrison to practice. I didn't know what I was going to do until the last day of the general surgery residency. There weren't a lot of good positions open. King's County Hospital in Temple offered me a position starting at \$16,000 a year. At that point, Baylor's hospital staff was closed to a solo practitioner. I could have gone to Methodist or St. Paul Hospital, but you couldn't come to Baylor to practice unless you joined a group. At the time, I was not aware of any group at Baylor that needed a new surgeon. I decided to stay on the staff at the medical school.

The general surgery residency program with Tom Shires in Dallas was 4 years after a rotating internship (*Figure 9*). I had had a fair amount of obstetrics experience, including that at Gaston Hospital in Memphis, at Los Angeles County Hospital, and at the University of Oklahoma. I had probably delivered 300 babies. Urology would accept a year of internal medicine toward their residency and it was only a 4-year residency, so I already had had 18 months counting toward a urology residency. Medicine could have been finished in 2 more years. I had 6 months in pediatrics, and that was a 2-year residency. I could have gone a lot of directions but decided to go into surgery.

**WCR:** *You decided to stay at Parkland. You became a full professor of surgery within 10 years of joining the faculty at Southwestern. How did it develop?*

**RCJ:** I began as an instructor in 1964, became an assistant professor in 1965, and became full professor and acting chairman in 1974. We all did vascular, trauma, and general surgery then. When I started as a resident, we were on the trauma service every other night. When I finished my residency, I told Dr. Shires I thought that was too much and that every third night was enough. He agreed and it changed to every third night when I joined the staff.

At the time, we also ran the surgical service at the John Peter Smith Hospital in Fort Worth. We had some staff there, but nevertheless I went over to Fort Worth some and staffed the residents there. Occasionally, we got calls from the John Peter Smith Hospital at night, but we infrequently had to drive over there at night.

Initially there were 6 surgical staff at Parkland: as a chief resident I covered the general surgery service as well as a trauma service and took call 4 of every 5 nights at home. At Parkland Hospital, the residents did most of the staffing there at that time. Residents taught residents; chief residents often staffed the trauma services. We staffed a third-year resident with a fifth-year resident. The staff did a lot of trauma surgery with the residents and during the day followed the patients with them on rounds. There wasn't a lot of vascular surgery early on. When Parkland dropped

John Peter Smith Hospital, it picked up the VA Hospital and began doing a lot of vascular surgery there. We did any operations needed. We did head and neck surgery, commando procedures, radical mastectomies, thyroid resections, Whipple procedures, and vascular surgery. The emphasis at Parkland was emergency surgery, because the indigent population primarily needed emergency surgery or they had fairly advanced disease processes.

**WCR:** *Quickly you developed an interest in trauma, but you nevertheless retained a broad interest in surgery.*

**RCJ:** I developed an interest in trauma, particularly trauma to the pancreas. I reported the largest series of patients with pancreatic trauma in the literature (500 cases). I developed an interest in surgical oncology and ran the tumor clinic at Parkland for over 10 years. In 1977, I started a chemotherapy clinic and for 10 years ran the general surgery chemotherapy clinic at Parkland. My other area of special interest was antibiotics and surgical infections. In the mid 1960s, I began to do a lot of anti-biotic research studies.

**WCR:** *How did you get interested in that? That is relatively unusual for a surgeon.*

**RCJ:** Dr. Shires encouraged me to take a year off and go work with Dr. Bill Altheimer in Cincinnati. We had just built a new house in Dallas and I hated to take off another year. I'd picked up the surgical infection area on my own. I have done a lot of speaking nationally and internationally on surgical infections and antibiotics.

**WCR:** *What was your day-to-day life like in, let's say, 1980 at Parkland Hospital? What time did you get up in the morning? What time did you get to work? What time did you leave the hospital? What time did you get home? What time did you go to bed?*

**RCJ:** By 1980 we had enlarged the faculty quite a bit. Dr. Shires had left in 1974 and I had served as acting chairman. Bill Fry was the chairman in 1980. By 1980 there was not as much demand on faculty to staff a service every month as there had been back in the late 1960s and the early 1970s. When Dr. Shires went to Seattle, only 6 of us were left to staff Parkland and the VA Hospital in surgery. That's when we really had to work a lot. There was also a huge administrative load. By 1980, I would come in at 7:30 or 8:00 AM for surgery. We usually had surgery in the mornings. Sometimes we had clinics to staff either in the morning or the afternoon. By 1980 I was doing a lot of work in the clinic. I ran the tumor clinic 1½ days a week and a chemotherapy clinic 1 day a week, so at least 2 to 2½ days a week I was in clinic. I had my office administrative work to do, classes to teach with the junior and senior students, tutorial sessions with the students at least once a week, and rounds to make on the wards at least twice a week (usually Tuesday and Friday afternoons). I had a lab that I was trying to keep going and most of that was bacteriology related. I had one technician (who got her PhD while she was working with me). I had glass washers to help with the animal work I did, and I had a secretary. (When starting out there I shared an office with 1 or 2 secretaries.) I'd get home about 6:00 PM, but that's when I did my writing and reading. I did most of my writing on weekends.

**WCR:** *How did the Baylor move come about?*

**RCJ:** I was approached by Boone Powell, Sr., and asked if I would be interested in coming to Baylor when I finished my tour as acting chairman of the Department of Surgery in 1976. I think

he wanted me to join a group at Baylor. I would sometimes see him at social functions and he might say, "When are you going to come to Baylor?" I had stepped down as acting chairman in 1976, and, in 1980, Dr. Sparkman, who was chairman at Baylor, began talking about stepping down. Baylor formed a search committee and made a national search. Several surgeons looked at the position. I was asked if I wanted to consider it. I said yes and they interviewed me and I almost accepted. I couldn't quite work out what I wanted. The financial arrangement was a little unclear. A lot of the income was going to be based on private practice. After talking to many people across the country about life in a community-based hospital versus that in the university hospital, I decided to stay where I was. Then Jesse Thompson, who was chairman of the search committee, resigned the chair, put his hat in the ring, and quickly was given the position. John Fordtran had come to Baylor a short time earlier as chief of medicine, and we had worked together at Parkland. Reuben Adams had come to Baylor as chief of obstetrics/gynecology, and we'd also worked together at Parkland. I knew many of the staff at Baylor because many of them had made rounds at Parkland and had staffed us on a lot of our cases when I was a resident.

When Dr. Thompson stepped down in 1986, Baylor again approached me regarding my interest in the position. After Baylor had a national search, I was offered the position again and accepted. I came to Baylor on July 20, 1987, and I've been here now for over 14 years.

**WCR:** *Were there any surprises after you arrived at Baylor?*

**RCJ:** I don't think so. I've enjoyed it and never regretted coming to Baylor. When I came in, we had 3 chief residents. Baylor earlier had been approved for 4, but one had been terminated shortly before I came. Baylor had started covering John Peter Smith Hospital when Parkland dropped it. (The VA Hospital was better for Parkland because it had more elective-type surgery than Parkland.) It was good for Baylor to pick up John Peter Smith because that gave Baylor a community-based hospital and a county hospital. We sent 5 residents to John Peter Smith Hospital.

I thought the Baylor program needed to be expanded. When I came to Baylor, there were 7 surgical services and 4 residents at each year level. It was not a university-type organization. There was a different format for residents rotating at night. They did not rotate as a team. I changed the program to a team concept and, over a period of 2 years, cut the number of services from 7 to 3. In about 1991, I asked the Residency Review Committee (RRC) to allow the program to expand to 5 chief residents. They agreed as long as we improved surgical education because you can't add residents only for manpower. In 1992, I requested that the RRC allow the Baylor program to expand to 6, and that request was also granted. There were only 2 other residency programs in the USA that were granted an increase at that time. The tendency through the years has been to cut down rather than increase the number of residents. I thought granting an increase spoke well for the program and for our attending staff. In 1995, I asked the RRC for an increase to 7, and that too was approved. Within a 5-year period we went from finishing 4 residents a year to the ability to finish 7 residents a year. We were surveyed in June 2001 and I asked that we be permitted to go to 8 chief residents. In July 2000, we integrated with the Presbyterian Hospi-

tal in Dallas. Tom Shires III, the son of the Shires under whom I trained, is the chief of surgery at Presbyterian. We have integrated John Peter Smith Hospital in Fort Worth and Presbyterian Hospital in Dallas into our Baylor program. We also rotate residents to Parkland on the burn service, and we rotate 2 residents to Children's Hospital for pediatric surgical experience.

**WCR:** *What's the advantage to the Baylor program of being connected to Presbyterian Hospital?*

**RCJ:** About 30 years ago the Department of Surgery at Southwestern ran the Presbyterian surgical program. At that time the chairman of surgery at Parkland was the chairman of surgery at Presbyterian, a large nonprofit hospital. The initial thought was that Presbyterian Hospital might eventually be a university hospital for the medical school. The location of the hospital ruled that out, and the surgery department discontinued its connection to Presbyterian after 5 years. Presbyterian had been without surgical residents until we expanded our program to include Presbyterian. Many of Presbyterian's surgeons trained in Dallas. I thought that bringing Presbyterian into our program would allow us to increase certain areas of surgery, particularly hepatobiliary, endocrine, and advanced laparoscopy. The connection with Presbyterian has worked out pretty well for our surgical residents.

**WCR:** *You now take 7 residents as interns and you try to finish all 7 of them 5 years later.*

**RCJ:** We also take 5 preliminary residents, i.e., residents taken for 1 or possibly 2 years who plan on going into some other specialty or eventually into general surgery. We are approved for 40 general surgery residents by the RRC.

**WCR:** *I understand that you get a terrific crew of residents. They have done extremely well in medical school. Can you talk about that a bit?*

**RCJ:** The applicant pool is very good. We get about 300 applicants from US medical schools each year. I screen all applications, review their records, and select about 150 to interview. Of the 150 offered interviews, all are in the upper half of their classes and most are in the upper fourth of their classes. There is a tendency presently in the USA for fewer students to go into general surgery. Two or 3 years ago, there would be at least 50 Alpha Omega Alpha members (AOAs) in that 150 applicant pool. We would interview 30 to 35 AOA's of the 150 to whom we would offer an interview. Of the 150 overall that we offered an interview, we'd end up interviewing maybe 110 and then we would match 7 from that pool. We have varied from having 5 or 6 to only 1 or 2 AOA's of the 7 applicants who eventually become Baylor surgical residents. It's been a good and talented group of residents. They do very well on the American Board of Surgery in-service training examinations. Usually 30% to 40% of them will be above the 90th percentile level, and 20% to 25% will be at or above the 95th percentile level. We have a few at the 99th percentile level.

**WCR:** *The 99th percentile level means that only 1% of the trainees at that level in other training programs in the USA have better scores than they did.*

**RCJ:** The exams don't go above 99%. Nobody makes 100%. Therefore, they are in the top 1% of the 8000 surgical residents in the country who take the examination.

**WCR:** *What are you most proud of in your training program? You obviously spend a tremendous amount of time making sure that your residents become good surgeons.*

**RCJ:** There are several things. First, when they finish the 5-year general surgery residency program, they are technically excellent surgeons capable of performing almost any type of general or vascular surgical procedure. They have good operative experience and the case log to back that up. Second, they have good judgment and diagnostic ability. Third, they have high academic performance. The easiest way to measure their academic performance, in addition to their medical school performance, is the American Board of Surgery in-service training examination taken while they are residents. And lastly, they perform well on the American Board of Surgery exams following residency. The American Board not only wants them to pass their boards, but to pass both the written (called the qualifying) and the oral examinations the first time they take them. In the past 5 years, 90% of our surgical residents passed the certifying exam (the oral exam) the first time they took it. Across the country, about 80% of surgical residents pass the qualifying exam the first time they take it, and a similar percentage pass the certifying exam.

**WCR:** *Your general surgery residents are in your program for 60 months. How much of that time is spent at Baylor, Presbyterian, John Peter Smith, Children's, and Parkland hospitals?*

**RCJ:** Of their 60 months, they spend about 18 at John Peter Smith Hospital; 2 at Children's, where they rotate during their first and fourth years; 1 at Parkland (on the burn service); 6 at Presbyterian, and 33 at BUMC.

**WCR:** *How do you pick a good surgeon when reviewing 300 applications? How do you decide after interviewing about 100 of them? You mentioned that you look particularly favorably on a candidate who has made AOA. But, as you implied, one can be an awfully intelligent person but not a good technical surgeon. What makes a good surgeon, and how do you pick them?*

**RCJ:** This is discussed constantly at program directors' meetings. When you are dealing with many applications, you have to start culling them. It's not fair to the applicants or to our staff to interview all 350 candidates for 7 positions. I start with class standing—academic performance. I look for their being at least in the upper half of their classes. I also look at the step 1 and step 2 scores, the old National Board of Medical Examiners, and I like them to be in the upper half of that group as well. We're constantly cautioned about selecting residents based on class standing, board scores, or in-service training examination scores. Nevertheless, they are very helpful.

I look at the dean's letters, which are compilations of their evaluations on rotations during medical school. I try to determine if they are hard workers, if they are dedicated, and what they are interested in going into. That influences some. I look at letters of recommendation and at what they've accomplished. I look at their own biographical data sheet as to what they've done. Some applicants are extremely talented, both in medicine and in extracurricular activities, such as music, art, and athletics. I want well-rounded individuals. Most letters of recommendation are favorable or the student wouldn't have asked that particular letter writer. If evaluation from the dean's letter is a bit different from that of the other letters of recommendation, that helps. Maybe a small problem that occurred in medical school is mentioned. If a

problem is mentioned more than once, that usually signifies a problem—either the applicant is probably not going to be suited for this program (whether he or she realizes it or not) or we are not going to be happy with the applicant.

A personal interview is required with 2 attending staff and one senior resident. At the end of each interview day we rank the candidates, and at the end of all interviews we do a final ranking.

Once they get into our residency, we look at how hard they work, how well they take care of patients, and how attentive they are to detail. We meet with each of them twice a year to go over their evaluations. Every month 5 staff surgeons on each service evaluate their residents. We accumulate a tremendous paper trail on the residents, and we follow them with their in-service training examination scores. Some residents don't perform surgically as well as others. Some have a natural talent, some don't. We realize that, but by the end of the fifth year they are almost all up to speed and operating very well, even though they may have struggled during their first 3 years and sometimes even into the early part of their fourth year.

There are huge caseloads at Baylor and at John Peter Smith Hospitals. Residents will finish their 5 years having performed over 1100 operations. In addition, they will have done from 250 to 300 endoscopies and will have "first assisted" on another 200 to 300 cases. They will have staffed another resident on another 150 cases as a teaching assistant, but they cannot get credit for this. You cannot claim a case if you staff it. The resident whom you staff gets to claim that case. The minimum requirement to take the boards is 550 operative procedures. The average across the country is probably about 975. We're above average. We don't want them to get up in the range of 1500 because that's too much work and not enough conference time and studying.

**WCR:** *Let's say I came in to see you or one of your staff surgeons because I had a nodule in my thyroid gland. I was referred to you to excise it. Would you or your staff person operate on me or would one of the surgical residents operate on me?*

**RCJ:** That's a common question. I usually say that one person doesn't do all the surgery. It takes 2 people to operate. A resident is going to be doing some of it, and a staff surgeon is going to do some of it. The staff person has full responsibility for the case from beginning to end, whether in a private or university program, and assumes any part of the operation that he or she wants to. It depends to some extent on the level of the resident. A more senior resident is going to participate more than a junior resident does.

If a patient says, "I do not want a resident to operate on me," those instructions are always honored. Fortunately, such instructions are rare. The patients often compliment the residents. The patients are reassured by a young doctor's being in house 24 hours a day and being available to be called on at any time, day or night, in addition to their attending surgeon, who may be busy with other patients or at home at night.

Often, a resident does most of the surgery with the staff first assisting. A first assistant can do almost as much surgery as the resident does. The residents are not put in a position such that they make all the decisions. The staff surgeon is always in the operating room and has control over the case. When the staff person first assists, he or she still has control over the case. The

resident is directed right down to the cut and tie on every case. The quality of the surgery that comes out is proof that the residents are complementary to the staff.

Let's say you take your thyroid nodule to a surgeon in a small community-based hospital where maybe an anesthesiologist is not available. Your operative assistant may be a nurse. At Baylor we have the luxury of having a resident who is in the third, fourth, or fifth year of training in general surgery as the first assistant or surgeon. The quality of surgery and postoperative care in a training program may be better than that in community hospitals without training programs.

**WCR:** *How many of your 7 chief residents, when they finish the 60 months of general surgery training, go on to train in another specialty like vascular or oncology or cardiovascular surgery?*

**RCJ:** Half to two thirds of them probably do a fellowship. The more common fellowships now are surgical oncology, vascular surgery, and cardiothoracic surgery. Of our 7 chief residents from last year, one is doing a breast oncology fellowship at Memorial Sloan-Kettering; one is at City of Hope doing a surgical oncology fellowship; two are doing vascular surgery fellowships; one is doing a colon-rectal fellowship; and a sixth is doing a critical care fellowship. Only one went directly into general surgery. Two or 3 years ago, it was almost the opposite, in that 5 went directly into general surgery and only one did a fellowship. Over the past 5 or 6 years, well over half have done a fellowship of some type. They usually get the fellowship they want.

**WCR:** *Ron, you finished your general surgery residency 37 years ago (1964). At that time general surgery included more than it does today. You did vascular surgery. You ran an oncology clinic and did all kind of neoplastic operations. You did it all. It looks to me like all these other subspecialties keep chipping away at general surgery. Do you encourage your finishing residents to go on to a fellowship somewhere?*

**RCJ:** Not necessarily. A lot of them feel they need to do so to get a "ticket" if they're going to enter private practice, particularly if they are going into a city of several thousand people. One of our finishing residents went to Weatherford, Texas, and he is doing all the surgery he can. The surgery is out there for the well-trained general surgeon, but many finishing residents feel they need some subspecialty area under their belts to attract the patients. If they do a vascular fellowship, they're probably going to practice primarily vascular surgery thereafter. If they do breast oncology, they're probably going to limit their practice pretty quickly to diseases of the breast. Cardiothoracic training will limit them to cardiothoracic patients. Each year for the past decade in the USA, 1000 general surgeons completed their training. Just under half went directly into general surgery.

**WCR:** *BUMC is located in a city with Southwestern Medical School and Parkland Hospital, and both have large residency training programs. Are you in direct competition with them for the best students from Southwestern as well as other medical centers? Does Baylor's having a very good surgical program put you in conflict with the medical school?*

**RCJ:** The answer to your questions is yes. We are obviously in competition because they interview the same applicant pool that we do. We have set up similar interview dates with them. It's not by chance that we interview on a Friday afternoon and they interview the next Saturday morning. We did this years ago

because it was ridiculous for somebody to fly to Dallas and interview at one place only when they may have wanted to interview at the other places as well. They'd have to fly back again at another time. We don't want to be in direct conflict on interview dates because that forces the applicant to choose one of the 2 hospitals prematurely. They may also interview at Methodist Hospital. They can fly out Saturday evening. With one visit they could theoretically interview at all 3 training programs in Dallas. Many applicants we interview also interview at Parkland. It's interesting how we vary on our rankings. We often rank some higher while they rank others higher. That fact probably points out the weaknesses in the selection process. Different people interview the same individuals and rank them differently.

**WCR:** *Ron, I gather that you are primarily on salary at Baylor and most of the surgeons on your staff are entirely in private practice. Have you been pleased with that arrangement?*

**RCJ:** I've been pleased overall with the arrangement. I'm not 100% salaried. I do have a private practice. I don't have a limitation on the amount of private practice that I can have except by the time that I have to devote to it. I can accept any private patient I want. I've tried not to be in great competition with the general surgeons on the staff. There are 5 or 6 general surgeons who are salaried to some extent, in addition to me, up to as much as 15% to 20% of an assistant professor's salary.

**WCR:** *Because they are spending a lot of time teaching?*

**RCJ:** They participate more in the teaching programs. Other surgeons participate a great deal in the Baylor teaching program and are not salaried at all and do not want to be salaried. I'm amazed at the number of surgeons who come to teach in conferences. At chief's conference this morning at 6:30 AM, 12 staff attended in addition to the residents. Many of our nonsalaried staff come regularly to the teaching conferences, and they have no obligation to come. They feel some obligation to participate in the training program because the residents help them with their caseload. Some of our busy surgeons could not do the number of cases they do if they didn't have the general surgery residents to help them. In a 24-hour period, they couldn't physically handle that many cases.

**WCR:** *You are running a huge surgical operation at BUMC. How many total operations are done at Baylor each year?*

**RCJ:** If those cases done at the Texas Surgery Center and at SurgiCare are included as part of the BUMC group, it's 40,000. Of that number, 10,000 (25%) are performed at SurgiCare or Texas Surgery Center/Texas Day Surgery. About 30,000 operations annually are done in the Roberts and Truett operating rooms. We now have 60 operating rooms, one of the largest operating room suites under one facility in the USA. Barnes Hospital and Jewish Hospital combined in St. Louis, and Cornell and Memorial Sloan-Kettering together in New York have about that number. There will be 4 more operating rooms in the Heart and Vascular Hospital scheduled to open in the spring of 2002.

**WCR:** *How many of the 60 operating rooms are being used every Monday through Friday?*

**RCJ:** Every one of them. We need more operating rooms. We're constantly reallocating rooms and the scheduling process in an effort to get more cases done in a timely fashion during the daytime without a lot of cases going well into the evening.

**WCR:** *In any one day in these 60 operating rooms, how many procedures are done on separate patients?*

**RCJ:** One hundred as an estimate.

**WCR:** *That's an impressive number. You obviously have a major responsibility at Baylor, running this huge surgical operation and the surgical residency program. You also have responsibilities to the hospital that are outside your department. I know there is no typical day for you, but could you describe a more-or-less average day for you at BUMC?*

**RCJ:** I get up at 5:00 each morning. I usually leave the house at 6:00, and almost every morning I have at least one 6:30 meeting. On an occasional Monday or Friday morning, I won't have one, but most of the time I have 1, 2, or 3 meetings at 6:30 AM. After finishing those, I have perhaps 1 or 2 mornings a week I do an operative procedure. I see patients in the office either 1 or 2 afternoons a week. I meet with students once a week, usually on Mondays. I try to attend the general surgery indigent clinic at Baylor on Monday afternoons from 1:00 to 3:00. Dr. Michael Ramsay and I are codirectors of the operating rooms. We help with the capital equipment allocation and other operating room matters. We meet on Monday afternoons from 3:30 to 5:00. Every Monday afternoon at 5:00 we have journal club, and once a month we have a medical board that meets Monday afternoons. We have a basic science conference every Tuesday at 6:30 AM. We have just started a T-1 line hookup with John Peter Smith that allows us to broadcast conferences either from John Peter Smith to Baylor or from Baylor to John Peter Smith so that our residents can participate in basic science conferences, some of which are given by John Peter Smith staff and some by Baylor staff. The staff and residents at John Peter Smith can now view grand rounds held at BUMC. I then attend various committee meetings during the day. Both the screening committee, which I have chaired for 10 years, and the physicians' advisory committee meet on Tuesday mornings, and I attend monthly quality assurance committee meetings.

**WCR:** *What is the screening committee?*

**RCJ:** It is the committee that processes and approves all the applications of all physicians wanting to join the staff at BUMC, regardless of specialty. We often have our individual conferences at noon on Monday. We always have surgical grand rounds on Wednesday mornings. We have a 6:30 AM conference on Thursday. On Friday mornings the cancer committee and breast site committee conferences are held. There's a lot of administrative work. I have the day-to-day operations of the department—scheduling of the residents, scheduling of the staff, emergency room coverage, etc., to deal with. I am also the residency program director, and with 40 residents they often have issues with which I have to deal. There are a lot of Residency Review requirements that have to be met and documented. Visiting named lectureships, about 10, must be scheduled annually. Resident applicants are scheduled each year for interviews.

**WCR:** *You wake up early. You get in early. What time do you leave the hospital as a rule?*

**RCJ:** If I have a late meeting, I'm not going to leave until 8:00 or 9:00 PM, but more often than not, I'm able to leave the hospital at 6:00 or 6:30 PM. It's 10- to 12-hour days most days.

**WCR:** *After you get home and after dinner, do you do any more work?*



**Figure 10.** Jane at the piano.

**RCJ:** I mainly take care of personal affairs in the evenings but also do office reading and paperwork that requires more time and concentration than I can give in the office. I have a few hobbies. I infrequently go out during the week except with visiting lecturers. Occasionally I do more work in the evenings at home. On weekends, we go out in the evening.

**WCR:** *It's unusual for you to come into the hospital on Saturday and Sunday.*

**RCJ:** I come in only if I have patients in the hospital to see. If I operate on a patient on Friday, I come in over the weekend to see that patient. We do not have organized conferences on weekends, and I don't take emergency room call.

**WCR:** *Let's get into your family and hobbies a bit. I've met your lovely wife, Jane, of course, and she's delightful and a great dancer. I understand that you 2 have taken a lot of dance lessons together through the years. You are a terrific dancing couple. Tell me a little about Jane and your children.*

**RCJ:** Jane is very bright. She stopped working as a dietitian when she was at the VA Hospital about 1964, about a year after our first daughter was born in 1963. She went back to work as a real estate broker after our 3 children finished high school. She got her real estate license and also her brokerage license. She did that for about 12 years and now does some referral work but is more at home doing the things she wants to do. She's been very interested in piano all of her life and has taken piano lessons continuously since junior high school (Figure 10). She's very interested in her music, including music composition. She plays classical music mostly but recently has been playing a lot of lighter music.

Jane has always been very supportive of my work in medicine and the amount of time I spend in it. She has been presi-



**Figure 11.** At the wedding of Cynthia Jones Lambert. Left to right: Jane Jones, Ron Jones, Cynthia Jones Lambert, Douglas Jones, and Mary Allison Jones-Snow.

dent of the Faculty Wives Club of Southwestern Medical Center and president of Medical Center Woman's Club and has served on the board of the Dallas County Medical Society Alliance for many years. She has chaired fundraising events, including raising money for an interest-free loan fund for medical students and residents as well as to benefit the Dallas County Medical Society Alliance.

We have 3 children. The oldest daughter, Cynthia Jane Lambert, is married (*Figure 11*) and has 3 children. She is an attorney and is married to Art Lambert, who is also an attorney. Cynthia went to Southern Methodist University and Northwestern Law School and then came back to Dallas. Cynthia lives in Highland Park and practiced as an attorney for about 10 years. After she had her second child, she decided to take off for a while so she could rear her children; she now has 3, 2 girls and 1 boy. The oldest is a 6-year old daughter.

Our son, Ronald Douglas Jones, is married and has 2 children. His wife, Jennifer, is from Tulsa, Oklahoma. He graduated from the University of Arkansas and obtained a degree in business administration. He is a certified financial analyst, works in the financial arena, and lives in Plano, Texas. Doug and I enjoy going to our farm in Arkansas to see the cattle and hunt. He hunts quail, ducks, and doves, but there we hunt quail. We look forward to those trips a lot.

Our youngest daughter, Mary Alison Snow, lives in Lewisville. She went to college at New York University and earned a degree in economics. She currently is teaching English at Hockaday. She married 2 years ago. Her husband, Ted, is a certified financial planner. They do not have children. Jane and I have 5 grandchildren (3 girls and 2 boys) ranging from 1 to 6 years of age.

**WCR:** *I'm very envious that all your children and grandchildren live in this area. That makes it nice.*

**RCJ:** *I'm very pleased that all the children are here and that everybody seems to be healthy.*

**WCR:** *What hobbies do you have? What do you do when you have time off?*

**RCJ:** *Ballroom dancing (Figure 12). When Cynthia became engaged to be married 9 years ago, we decided to take some dance lessons because we didn't dance very well. We wanted to know what we were doing for the first father and daughter dance. The children took dance lessons for 4 to 6 months before the wedding and then stopped. Jane and I liked dancing and continued. A teacher came to our home once a week on Wednesday nights. Because we enjoyed dancing, a friend suggested that we join some dance clubs.*

There are several dance clubs in Dallas, and each has 2 or 3 black-tie affairs each year. We joined 9 dance clubs and they have formal dances on weekends at the various country clubs. We now go to about 20 formal dances a year. We have continued to take dance lessons for 9 or 10 years. It takes a lot of practice for me to learn a few steps, so I have to keep at it or I'll forget most of what I've learned within a short period of time. It's like anything else. If you don't practice, you can certainly tell it whether anybody else can or not.

We've been members of the Dallas Symphony for years. We enjoy the symphony and the super pops. In the past 6 to 8 years, I have developed an interest in French antique clocks. I've been to a couple of national clock shows. We got back this month from the national clock show in New Orleans. It's been interesting to try to learn something about the different eras of clock making; the difference in the quality of the clocks; what it means to have a clock made in the 1700s versus one made in the 1800s or 1900s; and the value of the gilded French antique clocks. I have enjoyed learning about the mechanisms of the clocks and seeing the difference in the mechanisms depending on whether they are 100 or 150 or 200 years old.

**WCR:** *How did you get interested in clocks?*

**RCJ:** *I've always thought they were pretty and wanted to buy one. We were at a meeting in Milan, Italy, about 10 years ago and heard that an international antique show, which occurs in Milan only once every 2 years, was happening at the same time. We went to it. We looked at French antique clocks there and in other cities near Milan. We found one made probably in the 1795 to 1805 era and bought it. The gentleman who sold it to us has a lot of French antique clocks and has written a book on them. He gave us a copy of the book and in its front he inscribed: "This is the beginning. This will start 250 pieces." People who collect French antique clocks (or any types of clocks) say it can become a disease. The more you get interested in it, the more you want to buy one. We began by trying to find different types of clocks rather than buying more of the same of each one. We try to buy the types we don't have. We recognize that there are differences in qual-*



**Figure 12.** Jane and Ron dancing.

ity. Some have very unusual appearances, mechanisms, and methods of telling time. Some have automation and/or music.

**WCR:** You mentioned that when you were a boy you collected stamps and coins. Are you continuing those collections?

**RCJ:** I have a lot of match covers from growing up days and I still collect some. I still have my childhood collection as well as my coin collection. The other thing I've had an interest in through the years is high-fidelity and stereo equipment. We like to listen to music.

**WCR:** What are your weekends like?

**RCJ:** We take care of the swimming pool for one thing. We usually do errands that we haven't done during the week, like going to the cleaners and the bank, getting gas for the car and getting the car washed, maybe going to the grocery store, and maybe going to church on Sunday morning. If we spend time with the children it's usually on Sunday afternoon or evening.

**WCR:** You and Jane spend a lot of time together on Saturdays and Sundays. You are not a golfer.

**RCJ:** I never felt that I had the time for golf. I have never been a golfer.

**WCR:** Do you play tennis now?

**RCJ:** Not much. I played tennis not only during high school but on through college, medical school, and even in residency and after residency for a while. I haven't played tennis in a number of years.

**WCR:** Ron, are you as good a surgeon at age 68 as at, say, age 40? Do you lose any technical skills or do you get better with all the experience?

**RCJ:** You gain a lot of surgical knowledge with experience. Dr. Gil Campbell once said, "An expert is somebody who has made a lot of mistakes." By my age you've been in a lot of situations and you begin to know when to stay out of trouble that you might not have recognized early on. You do gain a lot of surgical judgment with age. I think if you continue to do a specific operation you're just as good at it if you are healthy regardless of your age. If you go for a number of years without doing a particular operative procedure, you're probably not going to go back and do it, and if you do you probably would not be as good at it. A lot of surgeons tend to do fewer types of procedures as they get older. You tend to box yourself into certain procedures that you feel comfortable doing. If you develop a severe tremor, a health problem, or a visual problem, then you need to cut back or stop. I think most people probably know what their limitations are as they get older and when they should be operating and when they should step aside.

**WCR:** You've done a lot of different things in your career. From a professional standpoint, which accomplishments are you most proud of?

**RCJ:** If I picked one area professionally, it would be teaching students, residents, and physicians and having been professor and chairman of surgery. Work with the American College of Surgeons has been extremely important to me; that plus my publications and my participation in national meetings. I've had the opportunity to work with the American College of Surgeons from the local chapter level starting out as local arrangements chairman and working on to chapter president. On the national level I became involved with the Commission on Cancer (Figure 13). I was a field liaison person for Parkland and then the



**Figure 13.** Dr. Richard Wilson giving a plaque to Dr. Jones in recognition of his tenure as vice chairman of the Commission on Cancer, 1982–1983.

state chairman of the field liaison program. I became the western area chairman over all of the field liaison people in the western half of the USA. Eventually, I became the national chairman of all the field liaison physicians in the USA. The field liaison physician is a physician appointed in a hospital to try to get that hospital to become an approved cancer hospital accredited by the American College of Surgeons. When I started as the national chairman, we had about 600 field liaison people throughout the USA. When I finished at the end of about 4 years, we had 1700. That expansion gave me some feeling of satisfaction in that we now know that most patients treated for cancer in the USA today are treated in hospitals that are approved as cancer hospitals by the American College of Surgeons.

**WCR:** What that really means is that the standards in those hospitals are better than in the other hospitals.

**RCJ:** You would think that would be the case. The process for appropriately managing patients with cancer is going to be better overall in a structured environment than it is where there is not opportunity for multidisciplinary consultation. Everybody has the opportunity to have good cancer care. I eventually became vice chairman of the Commission on Cancer, which comprises members not just of the American College of Surgeons but of 25 to 30 different organizations, including the National Cancer Institute, American Cancer Society, and American College of Physicians. All the major medical organizations in the country are represented on the Commission on Cancer. In fact, these organizations make up the majority of its members, not the general surgeons.

Another thing I'm proud of is the opportunity I had to help with the development of the Dallas ambulance service back in the late 1960s and early 1970s under Mayor Wes Wise (Figure 14). He had developed what was called "The Greater Dallas League of Municipalities." He decided that that organization should give attention to the ambulance service in Dallas. In 1969, he appointed a committee to organize a countywide ambulance service. At that time there were about 26 municipalities in Dallas County, including Garland, Irving, Mesquite, Highland and University Parks, and Dallas. They all had repre-



**Figure 14.** Mayor Adeline Harrison giving special recognition to Dr. Jones from the city of Dallas. The recognition began as follows: "Only rarely does a community live with the talent, the understanding of people, and the compassion for people in the person of one man. Even more seldom does a community benefit extensively from one man's wisdom and concern for the good health of his fellowman. Dallas and its people have benefited from the expert counsel of that special man. That man is Dr Ronald C. Jones."

sentatives on the committee, which I also was on. Initially Dr. Frank Kidd chaired the committee. I represented Parkland. Dr. Shires was initially appointed to it and he asked me to serve in his place. Because the mayors of the different municipalities felt that Dallas would reap the most benefit, all of them except the mayor of Dallas rejected the idea after a year of discussion.

With Assistant City Manager Gene Denton and some city council members, we moved forward with a Dallas committee, which I was asked to chair. The name was changed from the Medical Advisory Committee to the Dallas Ambulance Committee. Voluntarily, I spent about half my time for 3 years on this project. I could do this only because I was full time at the medical school and Dr. Sprague was interested in this activity, which he considered worthy of my time. I met with hospital administrators, cardiologists, and others concerned about which hospital or hospitals would receive the patients coming by ambulance.

The second big obstacle to overcome was who was going to pay for the ambulance service and how much it was going to cost. A group from Darien, Connecticut, surveyed Dallas County and Dallas proper. At that time, 1969 and 1970, patients who were severely injured were transported by funeral homes, usually with one driver and nobody in the back. The vehicles were hearses or station wagons. That was it. The average driver, when I chaired the committee, made \$1.60 an hour and had had 18 hours of Red Cross training. Fewer than 25% of the ambulances even had a blood pressure cuff in them and fewer still of the drivers knew how to take blood pressure. Patients were strapped on a gurney in the back of the vehicle. If they happened to vomit, they might well aspirate because they could not turn over. There were some possible but subtle conflicts of interest among some funeral home directors in Dallas and members of the city council. Some council members did business with funeral homes, and therefore it was difficult to take the ambulance business away from the funeral homes and give it to the city.

What other organization was going to take on ambulance service? Was it going to be the police department or the fire department? There were no standards in the USA at that time. Seattle, New York City, and Houston had started fire department-based ambulance services. Assistant Fire Chief Bill Roberts and I went to the first national ambulance meeting held in Houston, Texas. We worked closely with guidelines from the US Department of Transportation and made recommendations that eventually were reviewed by the city council. Would they be approved? The price was estimated to be a million dollars annually. We were going to have to buy 16 or 18 ambulances. We put the ambulance calls on computer to see where the hot spots were in the Dallas area. We were going to place the ambulances in the fire stations if it was going to be turned over to the fire department. We had to figure out how to train firemen to handle these emergencies. When it went for vote after all this preparation and work, the council voted it down. They said it was too costly.

Eventually, I became chairman of the Emergency Medical Services Committee for the Dallas County Medical Society and of the Emergency Medical Services Committee of the North Texas Council of Government, which represented an 8-county area. I was on the Disaster Committee for the new airport that had just been built. I had a pretty good handle on emergency medical services in Dallas. We worked with the city council again and within a year got the ambulance service approved.

Prior to the approval, we were told by the county health department that one third of the babies born outside hospitals were dead on arrival. When that ambulance service went into place, that number went straight down. We had several thousand false alarms with the old ambulance service annually. If they had a false alarm the funeral homes were automatically paid \$18. More than \$400,000 was being spent each year on false alarms when the fire department ambulance service went into place. We were able to convince the funeral homes that we weren't going to take away interhospital transfers or their taking the patient from the hospital to home or home to hospital. What we were interested in was resuscitation of severely injured patients or the patient who had had a heart attack or stroke in the field. They finally agreed to this, realizing that it wasn't going to be that big a hit to them. The ambulances seen today are the ones that Bill Roberts, who was the assistant chief of the fire department, and a group of us designed.

The next thing was to train the people. We got volunteer physicians and respiratory therapists to train 160 emergency medical technicians. The ambulance service started in November 1972. It has grown significantly from then. When we first started it, the average emergency medical technician had 30 hours of college so we had a pretty good group of people who were enthusiastic and wanted to be trained. But the emergency medical technicians also wanted still to be firemen. We had to rotate them back and forth so that they would get experience in both areas. Things improved.

Prior to that time, nobody had ever been trained in delivering a baby en route to a hospital. We put the emergency medical technicians in several private hospitals. The first morning they were there I got a call that it wasn't going to work. The physicians did not want emergency medical technicians seeing ba-

bies delivered. The physicians (including those from Baylor Hospital) thought it was a breach of confidentiality. I asked if it would be better for the baby to be delivered by somebody who had never seen a delivery or better to be delivered by somebody who has seen a delivery and knew how to clamp cords, take care of babies and suction them, and cut down on this large number of dead-on-arrival newborns. Thus, we trained all the emergency medical technicians for obstetrics in Parkland Hospital. Now they feel comfortable and they can deliver babies en route to the hospitals.

We also developed a telemetry system. That was another big obstacle. A lot of hospitals wanted the system because they believed they'd get more heart patients if they had it. But, who was going to monitor it? No physician wanted to sit there and watch a radar screen. The emergency medical technicians ended up doing the monitoring, and the system was placed in Parkland Hospital with support from the county medical society and the Dallas County Hospital District. We then had to be overly cautious not to put patients into Parkland Hospital but to put them in their primary physician's hospital. Hospitals without emergency rooms were excluded. The entire ambulance endeavor took 3 to 4 years of work, but a lot of satisfaction came out of it. Training of advanced emergency medical technicians was undertaken by Dr. Jim Alkins and Dr. Erwin Thal.

**WCR:** *When you see a fire department ambulance riding around Dallas, it must give you a feeling of satisfaction.*

**RCJ:** Yes. I know how it developed and how much effort went into its creation. After we got it up and running, some citizens of the other municipalities called me to say "Why didn't we get a chance to have part of that?" And I responded: "Would you like a copy of the letter from your mayor who turned it down?" I've kept those. I have a whole file drawer on the history of the Dallas ambulance service and will probably give it to the fire department when somebody develops enough interest in it that they want to take it on and organize it.

**WCR:** *Are there other professional accomplishments that you are particularly pleased with?*

**RCJ:** I trained a lot of medical students and residents, and that has given me much satisfaction. We have trained nearly 80 general surgery residents at Baylor in the nearly 15 years I've been here. That's more than were trained during the tenures of the last 3 or 4 chiefs at Baylor spanning almost a 50-year period, primarily because we've been able to expand the program.

**WCR:** *How many medical students are in surgery at BUMC?*

**RCJ:** We are usually allocated 2 junior medical students, sometimes 3, from Southwestern in surgery during their junior year. They also can come on an elective basis during their senior year if they are particularly interested in surgery. We also can accept students from other medical schools throughout the USA, but we never have >6 medical students at a time.

**WCR:** *Have some of the medical students who rotated through Baylor come over later as residents?*

**RCJ:** Yes.

**WCR:** *How many hours of sleep do you need to feel good the next day?*

**RCJ:** I'm fine with 7 hours. I'm okay with 6 hours but not on a regular basis.

**WCR:** *Ron, I understand that you were chief resident at Parkland Hospital when President Kennedy was shot in Dallas. Could you fill in some of those details?*

**RCJ:** That was on November 22, 1963, and I was senior resident at Parkland. Dr. Malcolm Perry and I had just finished a vascular operation and gone down to the cafeteria for lunch. It was about 12:30 PM, and the operator began to page various physicians STAT. We knew that President Kennedy was in town and would be in a parade on his way to the Trade Mart to give a 1:00 PM speech. The overhead STAT pages were for Dr. Tom Shires, chief of surgery; Dr. Kemp Clark, head of neurosurgery; and Dr. Fouad Bashear, head of cardiology. I went to the telephone located a fair distance from where we were and called the operator and said, "This is Dr. Jones. Why are these doctors being paged STAT?" She said, "Dr. Jones, the president has been shot, they are bringing him into the emergency room, and they need some doctors." I turned around and Dr. Marion (Pepper) Jenkins, head of anesthesia, and Audrey Bell, the operating room supervisor, were at a table nearby. I said, "You are not going to believe this, but the president has been shot and they're bringing him to the emergency room." Dr. Jenkins said, "I'll get an anesthesia machine." (At the time, we didn't have anesthesia machines in the emergency room.) Ms. Bell said, "I'll get the operating room ready." By then the pages were constantly going off and people were beginning to stand up in the cafeteria. Dr. Perry and Red Duke, who was a fourth-year resident, also came up and asked me what was going on.

We all went down some back stairs out of the cafeteria to the emergency room. We went to trauma room 1. (We had 4 trauma rooms in addition to the cubicles where patients were seen.) The door to trauma room 1 was open, and that's where Dr. Perry and I went. Trauma room 2 was closed; Dr. Duke opened that door and went in and found Governor John Connally. The president was already in trauma room 1 with Mrs. Kennedy just to the left of the door as we walked in. The Secret Service, police, and Doris Nelson, the emergency room supervisor, were already there. They were letting people into the room. One problem was that they didn't know who should and who should not be in there. We of course did not know what types of injuries he might have and what specialist would be needed. Very quickly the room filled.

I saw the president as I walked in. He was motionless, his eyes were open, and he never spoke. I never saw him move. Dr. Carrico, a second-year resident assigned to the emergency room, apparently saw him move. He was attempting to intubate him. As we looked at the president, Dr. Perry, who was right in front of me, and I decided that he should do the tracheotomy and I would do the cutdown because they could not get into a vein percutaneously. By then the room was full, and I couldn't get to a venous section tray. They handed me one over the heads of other people. Barehanded I did the cutdown and put in a polyethylene catheter and got the intravenous fluids going. Dr. Perry started the tracheotomy.

**WCR:** *You considered the president dead at that point?*

**RCJ:** Occasionally, you think a patient just wheeled in to the emergency room is dead but then a faint heartbeat is heard. The room was fairly noisy at that point. We didn't make an attempt to listen to the heart. (That became another issue later when Oswald came in.) I didn't listen, so I don't know whether he had

a heartbeat or not. Dr. Carrico thought he had seen some agonal respiration. Whether the president was really breathing or not, I don't know. We didn't know whether he was alive or not. Because of the possibility that he could have died just as we walked in, that he did have a faint heartbeat, or that he could be resuscitated, we decided to do something rather than nothing.

Parkland was not known as a trauma hospital in 1963. It had opened only 10 years earlier (1954). Dr. Jenkins got down shortly thereafter with an anesthesia machine and hooked it up. Dr. Perry continued the tracheotomy. He made the incision in the neck through what we thought was an entrance wound. When we all walked in we saw that he had a small injury in the anterior neck, midline, and we knew he had an injury in the back of his head. We weren't sure to what extent, but we'd worry about that as soon as we got intravenous fluids in and an airway open. Dr. Perry made the incision for the tracheostomy right through what we thought was an entrance wound. A little bit into the tracheotomy he heard a gush of air.

I asked if he wanted a chest tube put in and he said yes. I was on the left side of the chest and put in an anterior chest tube. I did not get any blood or significant air out. It was hooked up to a closed drainage bottle. Then we wondered if it was on the other side. We decided to put a chest tube in over there also. I couldn't reach across the table, and Drs. Paul Peters and Charlie Baxter on the other side put a chest tube in on the right side. By that time Dr. Perry had the tracheotomy in, and the portable electrocardiogram machine had arrived. (We did not have electrocardiographic monitoring machines in the trauma rooms at that time.) We hooked it up, and it showed only a straight line.

About that time the question came up of whether to do closed chest massage (a procedure relatively new at that time) or to open the chest. By this time Dr. Jenkins and Dr. Kemp Clark had had a chance to look at that head wound a little more. They signaled to us that it was a bad head injury, worse than we had originally thought because we had been busy doing other emergency procedures.

Mrs. Kennedy was still near the foot of the table, and she apparently had passed word through somebody not to pronounce the president dead until a priest had come. We did do closed chest massage. After that I left the room. Then I was approached by an FBI agent holding out his badge and saying, "I'm so and so with the FBI and I need to call J. Edgar Hoover and tell him the condition of the president." I knew that the president was dead at that point, but that had not been announced. I indicated that he was not doing well and in just a few steps more another individual came up and said, "I'm so-and-so with the Secret Service and I need to call Joseph Kennedy and tell him the condition of his son." I took both of them up to the front of the emergency room trying to get a phone line out so they could call. I couldn't get a line out. Everybody was calling in. (I didn't realize how quickly the word had spread.) I took them upstairs to the switchboard operator. I left them there at the switchboard and went up one more floor to the operating room. That's the first time I heard that Governor Connally had been shot and was going to the operating room. Dr. Robert Shaw, who was the first thoracic surgeon in Dallas and who ran thoracic surgery at Parkland, took Governor Connally to the operating room with a sucking chest

wound and injuries to his wrist and leg. Police were everywhere and Parkland was blocked off. There were police cars as far as you could see in any direction.

I went home earlier that afternoon than usual. Jane, who was working at the VA Hospital, came by and picked me up. Newspapers began calling home wanting to know what went on. My hometown newspaper called. That was Friday. I was at the barbershop Sunday morning when I got a call from Parkland to staff a stab wound to the neck. While sitting in the lounge in the operating room posting area a short while later, the phone rang and the operator indicated that Oswald had been shot. Dr. Perry happened to be in Dr. Jenkins' office and here we were again. This time Dr. Shires was in Dallas. (Shires had been in Galveston when President Kennedy was shot, but they flew him back to Dallas and he was able to explore Connally's thigh.) I went to the emergency room and we were there before Oswald got there. This time I listened to his heart. Oswald was not moving, his eyes were open, staring, no motion, but he had a heartbeat. His heart was beating! He had been shot in the left lower chest. The first thing I did was a cutdown, and I did it in the cephalic vein again because it was prominent. Dr. Jenkins intubated him right away, then I put a chest tube in, and we took him to the operating room. We had him in the operating room within about 7 minutes. Drs. Shires, McClelland, Perry, and I operated on him. About the time we controlled the bleeding, his blood pressure dropped to zero. It had never been >60 mm Hg systolic despite his getting intravenous blood and fluids. He lived about an hour from the time he arrived. He had a lethal injury with a lot of blood vessel damage.

**WCR:** *What did you learn from the Kennedy and Oswald experiences?*

**RCJ:** I learned 2 or 3 things. You need initially to examine the patient to assess the injuries. Had we turned President Kennedy over and looked at his back we would have known that the back of his cranium had been blown off. We would have described his injuries more, measured the injuries, looked at the clothing a little more, and tried to determine how and where he was shot. We would have looked at that head wound. Where was it located exactly? What was the extent of it? We would have done a lot more examination today than we did then. This would not have changed management or the outcome but might have answered some questions that people have today. With Mrs. Kennedy's being present we didn't want to pry into that. We had never experienced an assassination.

We learned that we needed a red "hot line," which we implemented thereafter, so that we could get a line out or get to the lab or outside the hospital. We put in red phones immediately throughout the hospital for emergencies. We learned something about communication.

We saw the opportunity to write a trauma book, and we wrote one. It was probably the first book written on multiple-injured patients. Prior to the 1960s, most trauma books addressed fractures. They didn't address injuries to the chest, abdomen, and various organs. We never wrote about the assassination.

We learned something about having areas set aside for the press. What do you do with the press when a disaster like that happens? Where do you put them, and how do you gain access to them and they to you? How are they screened prior to com-

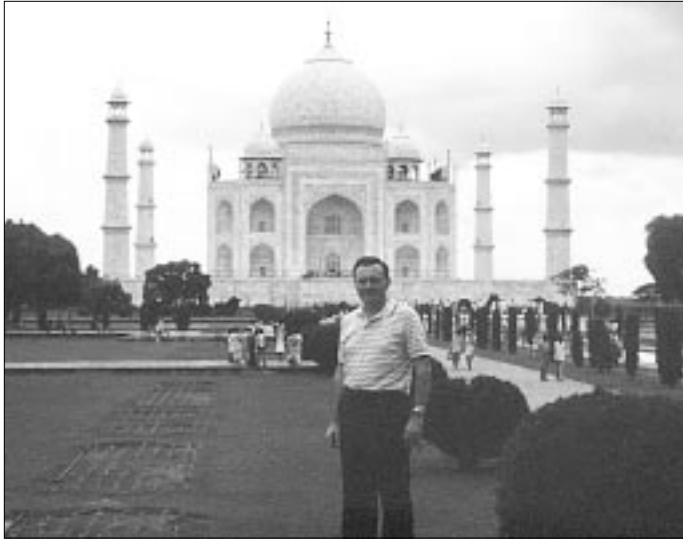


Figure 15. In front of the Taj Mahal.

ing into a hospital if there is concern about an assassination or an attempt at injury to other people? That's never going to happen twice in any one person's lifetime. Can you imagine the chances of taking care of a president who has been assassinated?

**WCR:** *Why did you leave President Kennedy's room?*

**RCJ:** We had other staff there, and I felt like I had done all I could. I wanted to see other people's reactions and what was going on outside. I felt like my time in there was over. Some people did stay. It would have been nice if somebody had stayed there and had seen how things went. It would have been nice if President Kennedy had been autopsied in Dallas instead of Bethesda, Maryland, where somebody could have known what we saw. Bethesda didn't initially pick up that there was even a wound in the front of the neck. They were having trouble the next morning. They of course found the injury in the back of the head. They did not find a bullet. They saw an injury to the back of the chest. They couldn't put it together. They didn't realize that there was a wound in the front. I think a lot of things would have been resolved had President Kennedy been autopsied in Dallas.

**WCR:** *Ron, I'm sure you've done a lot of traveling through the years. How do you fit that into your already busy day-to-day schedule? How enjoyable are these travels for you?*

**RCJ:** Through the years I've had the opportunity to travel to a lot of countries and give presentations. If you have enough lead time, you can organize your schedule to accommodate being gone for a few days. In many of these instances, it was less than a week. I work around travels. If you have a lot of staff, sometimes they can help cover while you're gone. It is more difficult to get away when you have a private practice, but even then you are usually able to work things out. If it's a nice trip in a nice location and somewhere in the world you've never been, it's well worth taking the time. It's educational. Jane and I have traveled all over Asia and Europe on several occasions. I really enjoy being able to see something like the pyramids or Jerusalem or the Taj Mahal (Figure 15). I don't know how many hundred presentations I've given, but I've enjoyed doing them.

**WCR:** *You not only give a lot of talks, but you are on a lot of different committees. You've mentioned the American College of*



Figure 16. With his family—Jane, Cindy, Mary, and Doug—in Paris.



Figure 17. Dr. Jones and Doug Jones with cattle in Arkansas.

*Surgery on several occasions. You are a member of a number of national committees. How many trips do you go on annually now?*

**RCJ:** I don't travel nearly as much now as I used to, mostly because of the position that I have now. I just can't be gone too much and do my job. When I travel, it is usually to a meeting. I go to meetings of the American College of Surgeons, the American Surgical Association, and either the Western Surgical Association or the Southern Surgical Association and occasionally to the Southwestern Surgical Association. I have to go to the Association of Program Directors meeting at least once a year and maybe 1 or 2 other meetings. I don't travel to major meetings more than 6 times a year. Sometimes Baylor has a meeting somewhere that I'm asked to go to.

I try to go overseas on a vacation every year or every other year (Figure 16). I still have the farm in Harrison, and now I get up there only about once a year. Someone takes care of the place. I keep the house locked so that when I go there I just open it up, clean up a little bit, and that's where we stay. My son and I usually go there together (Figure 17). It gives us a little time together. I still have cattle there and run the farm just like it was run when I lived there. It takes some attention to detail. I have to keep the place up: fences repaired, pastures mowed, tree limbs cut, etc. I try to take care of the farm by remote control, so to speak.

**WCR:** *Ron, this has been terrific. Is there anything that you would like to discuss that we haven't?*

**RCJ:** We've covered a lot of things. In 1995 I received the Ozark's Ambassador Award from the North Arkansas Commu-

nity College in my hometown of Harrison, Arkansas. This is given to a native of northern Arkansas who has represented the area with distinction outside the state of Arkansas. Previous recipients from Harrison included William Stiritz, chief executive officer of Ralston Purina; David Banks, head of Beverly Enterprises, the national nursing home chain; Robert Eagle of Eagle Lincoln Mercury of Dallas, and former US Representative John Paul Hammerschmidt. All these came from a town of 5000 population.

**WCR:** *I want to thank you, not only on my behalf, of course, but on behalf of the readers of BUMC Proceedings for being so open in your discussion so that we all get to know you better.*

**RCJ:** Thank you.

### RCJ'S BEST ARTICLES AS SELECTED BY HIM

(Publications are numbered according to his curriculum vitae.)

1. Jones RC, Shires GT. The management of pancreatic injuries. *Arch Surg* 1965;90:502-508.
5. Jones RC. General principles in the management of traumatic wounds; Blood, plasma, and plasma substitutes in traumatic wounds; Initial care of the injured patient; Wounds of the skin and subcutaneous tissue. In Shires GT, ed. *Care of the Trauma Patient*. New York: McGraw-Hill, 1966:33-44, 111-124, 187-193, 240-258.
14. Jones RC, McClelland RN, Zedlitz WH, Shires GT. Difficult closures of the duodenal stump. *Arch Surg* 1967;94:696-699.
21. Jones RF, Smith AL, Jones RC. Effects of topical chemotherapy in cancer surgery. A clinical study. *Cancer* 1968;22:1250-1253.
30. Shires GT, Jones RC. Initial management of the severely injured patient. *JAMA* 1970;213:1872-1878.
38. Shires GT, Jones RC. Pancreatic trauma. In Carey LC, ed. *The Pancreas*. St. Louis: Mosby, 1973:335-350.
39. Phillips J, Heimbach DM, Jones RC. Clostridial myonecrosis of the abdominal wall. Management after extensive resection. *Am J Surg* 1974;128:436-438.
40. Jones RC. Transportation and resuscitation of the severely injured patient. *Dallas Medical Journal* 1974;60:331-337.
47. Jones RC. Rabies. In Conn HF, ed. *Current Therapy*. Philadelphia: WB Saunders, 1978;48-51.
48. Jones RC. Management of pancreatic trauma. *Ann Surg* 1978;187:555-564.
52. Jones RC. Challenge of the field liaison program. *The Bulletin* [published by the American College of Surgeons] 1979;649:20-21.
59. Jones RC. Antibiotics in trauma. In Condon R, Gorbach S, eds. *Surgical Infections*. Baltimore: Williams & Wilkins, 1981.
63. Shires GT, Jones RC. Pancreas in abdominal trauma. In Schwartz S, ed. *Principles of Surgery*, 4th ed. New York: McGraw-Hill, 1983:199-210.
64. Jones RC, Shires GT. Bites and stings of animals and insects. In Schwartz S, ed. *Principles of Surgery*, 4th edition. New York: McGraw-Hill, 1983:211-221.
66. Thirlby RC, Kasper CS, Jones RC. Metastatic carcinoid tumor of the appendix. Report of a case and review of the literature. *Dis Colon Rectum* 1984;27:42-46.
67. Jones RC, Schouten JT. Breast carcinoma. In McClelland RN, ed. *Selected Readings in General Surgery*. Dallas: Robert N. McClelland, 1985;12(1).
70. Jones RC, Thal ER, Johnson NA, Gollihar LN. Evaluation of antibiotic therapy following penetrating abdominal trauma. *Ann Surg* 1985;201:576-585.
71. Jones RC. Management of pancreatic trauma. *Am J Surg* 1985;150:698-704.
73. Jones RC. Current concepts of pancreas and liver trauma management. *Gastroenterology* 1986;91:486.
76. Jones RC. Newer antibiotics for the surgeon. *Am J Surg* 1986;152:577-582.
77. Hobar PC, Jones RC, Schouten J, Leitch AM, Hendler F. Multimodality treatment of locally advanced breast carcinoma. *Arch Surg* 1988;123:951-955.
79. Jones RC, Vanderpool D, O'Leary JP, Hamilton JK. Biliary lithotripsy. In Cass A, Stahlgren L, eds. *Principles of Biliary Lithotripsy*. Armonk, NY: Futura Publishing, 1989:71-80.
84. Jones RC. Epidemiology—risk factors. In Hindle WH, ed. *Breast Disease for Gynecologists*. Norwalk, CT: Appleton & Lange, 1990:29-37.
85. Jones RC, Hendler FJ. Fibrocystic changes of the breast. In Hindle WH, ed. *Breast Disease for Gynecologists*. Norwalk, CT: Appleton & Lange, 1990:155-165.
86. Jones RC, Jones SE. Treatment of advanced malignant lesions including inflammatory carcinoma. In Hindle WH, ed. *Breast Disease for Gynecologists*. Norwalk, CT: Appleton & Lange, 1990:215-226.
87. Foreman ML, Jones RC. Laparotomy. In Webb W, Beeson A, eds. *Thoracic Surgery: Surgical Management of Chest Injuries*. St. Louis: Mosby Year Book Publishers, 1990:256-263.
89. Jones RC. Infections in trauma. In Gorbach S, Bartlett J, Blacklow N, eds. *Infectious Diseases in Medicine and Surgery*. New York: WB Saunders, 1992.
90. Grant MD, Jones RC, Wilson SE, Bombeck CT, Flint LM, Jonasson O, Soroff HS, Stellato TA, Dougherty SH. Single dose cephalosporin prophylaxis in high-risk patients undergoing surgical treatment of the biliary tract. *Surg Gynecol Obstet* 1992;174:347-354.
95. Jones RC, Shires GT. Trauma. In Schwartz S, ed. *Principles of Surgery*, 6th ed. New York: McGraw-Hill, 1994:175-181.
101. Jones RC, Foreman ML. Pancreas. In Ivatury RR, Cayton CG, eds. *Textbook of Penetrating Trauma*. Baltimore: Williams & Wilkins, 1996:631-642.
103. Jones RC. Surgical infections in trauma. In Gorbach S, ed. *Textbook of Infectious Diseases*, 2nd ed. Philadelphia: WB Saunders, 1998:927-932.
107. Jones RC. Infections in trauma. In Gorbach S, ed. *Textbook of Infectious Diseases*, 3rd ed. Philadelphia: WB Saunders, in press.