



# Dr. Mark Odland: An Oral History

Early Years of the Transplant Program at  
Hennepin County Medical Center

HENNEPIN MEDICAL HISTORY CENTER

2023

Hennepin Healthcare, Minneapolis, MN

HCMC ORAL HISTORY PROJECT

# Dr. Mark Odland: An Oral History

## Early Years of the Transplant Program at Hennepin County Medical Center

Interviewed by Mary Ellen Bennett, RN

January 24, 2023

At Hennepin County Medical Center, Minneapolis, Minnesota

Edited and redacted by Mary Ellen Bennett and Michele Hagen

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Coordinated by

Hennepin Medical History Center

900 S. 8<sup>th</sup> Street

Minneapolis, MN 55415

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DR. MARK ODLAND

Interviewed in Minneapolis, MN

**MARY ELLEN BENNETT:** The following interview was conducted with Dr. Mark Odland on behalf of the Hennepin Medical History Center for the History Center's Oral History Project. It took place on January 24th, 2023, at Hennepin Healthcare. The interviewer is Mary Ellen Bennett.

We're so happy to have you here today, Dr. Odland. And we're excited to have you tell the story of your career with Hennepin County Medical Center and the history of the renal transplant program here at HCMC. And I'll turn the discussion over to you.

**MARK ODLAND:** Thank you Mary Ellen. It's nice to be able to talk about the transplant program here, especially, well, just the renal transplant program. But it really starts with Dr. Claude Hitchcock and a lot of what I'll tell you today may not be documented in a lot of places. It comes from personal conversations with Dr. Hitchcock, conversations with Robert C. Anderson who was the head of the program for many, many years, and also Art Ney contributed to that. But the story of renal transplant at Hennepin really starts with Claude Hitchcock.

Claude was a tenured professor of surgery at the University of Minnesota, and he told me this story that Owen Wangenstein who was the chief there, wanted him to come over here and fill the vacancy of the Chief of Service at Henn—well it would have been Minneapolis General Hospital at the time—and Claude didn't want to go. He said Dr. Wangenstein talked to him on a Friday. He said, “No, I don't want to go. I want to stay here,” and Dr. Wangenstein told him to think about it over the weekend. And he came back Monday and said, “I thought about it over the weekend, and I want to stay at the University.” And Dr. Wangenstein said, “Claude, you're going to the General Hospital.”<sup>1</sup>

On April 15<sup>th</sup>, Dr. Hitchcock reluctantly started here, and he was not happy about it. But what he told me is, after six months of being here he couldn't be dragged away. I think it was that finally he got to be the boss. He had a surgery residency that he could manage. He had other programs he could manage. He also had an NIH<sup>2</sup> grant that he brought with him from there. He was one of four faculty members, or the fourth full-time faculty member of Hennepin with Tom Lowry, John Coe in Pathology, and Dick Raile who was in Pediatrics.

Transplant was just really in its infancy and not much was being done around the country and none of it with any great success. And we have to remember, at the time, there was no tissue typing, there was really no medications to treat them, and some people were just using some steroids and there was no way of organ preservation during that time either. And the other, I

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<sup>1</sup> Dr. Claude R. Hitchcock (1920-1994) began his career at Minneapolis General Hospital in 1955.

<sup>2</sup> National Institutes of Health. nih.gov.

think, another issue with it is that there was no law concerning brain death. We had sort of all these obstacles to overcome, but Claude Hitchcock saw this as a potential field and a potential area where the General Hospital could be leaders in.

They started doing research in transplant and namely, first, starting out with the surgical techniques. And also, with organ preservation because at that time they didn't know how you could take an organ out of somebody and have it without its blood supply and being able to transplant it and have it function. And they just didn't know how that would work.

They started doing research in those areas. There was a baboon colony in San Antonio. The Southwest Research Foundation was running this. They were doing some preservation research and they were using the baboon model. Early, Dr. Hitchcock had tried to use the dog model to test these things, but they didn't—it didn't work very well. So, they created a relationship between Hennepin and this Southwest Research Foundation and traveled there to look at the baboon colony and how they could help. That research foundation had a baboon colony in Kenya, and they went to Kenya. When they came back, Dr. Bob Telander went to the research center in San Antonio for a year—came back so they could start doing the baboon research here.

That all continued then for probably five or six years until—and it wasn't just kidneys—they were also doing lung transplants. They were basically taking kidneys out of, or the lungs out of, the baboons and putting them on a preservation machine, which is really rudimentary when we think of it today, and then re-transplanting the organ. Finally, in—it was February 13th, 1963, felt it was time to do transplant. They had a woman who—with renal failure. And of course, they had no dialysis at that time. So renal failure was synonymous with death. And so, they were going to try a kidney transplant—and really the first time in the Midwest, certainly the first time in Minnesota that had ever been done.

The donor was a person who died of a malignancy. And, of course, they were—had to have cardiac death before they could take the organ out. They took the organ out, transplanted it into her, and it never worked. Within a week, she was back to either something had to be done or that she was going to die. So, they went over to the baboon colony and took a kidney from a baboon and transplanted that into her. Well, of course, you know, that didn't work either. But it was probably the first xenotransplant done in the Midwest, or certainly in Minnesota at the time.

And so, that didn't work. She did die. A month later, on March 11<sup>th</sup>, there was a young guy with renal failure who also needed a transplant. They transplanted him and that didn't work either and it failed within a week. Kind of a famous story—as Claude was making rounds one afternoon, they said, “This isn't working. He's in renal failure. He's not going to live very much longer.” And Claude said, “I'm not going to let this kid die.” He knew of...there was a guy. Bel,

Mel...it was Belner. Oh gosh I don't want to mess his name...Belding Scribner<sup>3</sup> was out at the University of Washington, and he had a rudimentary dialysis machine. Claude got on the phone and talked with Belzer, excuse me, Dr. Scribner, and made arrangements, found out where this dialysis machine was made by the Sweden Refrigerator Company<sup>4</sup> out in Seattle.

He called them and asked if he could get one of these machines and he said, "Yes but I need \$10,000 before I'll send it to you." He called a patron of his, Atherton Bean<sup>5</sup>, who was the CEO of International Multi Foods, and he wired him the money to buy the machine, which was flown out the next day. And then Claude and two surgery residents headed out to Seattle to learn how to do dialysis Dr. Scribner told him that it would take six months of training before they learned how to do dialysis, and he said, "We don't have that long." They spent less than a week there, came back, and put this young gentleman on dialysis.

That was the beginning of chronic dialysis in Minnesota. The fate of this young gentleman; he lived a little over eleven months but died of pneumonia after he was...getting sick going to graduate school at the University of Minnesota. That was sort of the start of the transplant at Hennepin. But it was also the start of chronic dialysis because no one had dialyzed people for a long period of time, except for this program out at the University of Washington in Seattle.

They received an NIH grant to start a dialysis with twelve patients that they could enroll into the program. The problem they had is that they had between twenty and forty patients that qualified for the program. And so, it really created an ethical dilemma. And nobody wanted to choose the value of one person's life over the value of another people's life. They did cheat and dialyzed more people than they were allowed to on this NIH grant. But the NIH sort of turned a blind eye to it also because they knew that it was such a hard dilemma to make choices—life choices like that.

This was also the start of the Regional Kidney Dialysis Program in Minnesota. That program grew to have satellite dialysis units all over Minnesota that...and also went all the way out to Pine Ridge Indian Reservation. We served several different Indian reservations throughout Minnesota. It really became a model program. When you think back to the model of the program, back in the early sixties, that they had nurse practitioners or practitioners that really ran the units. They consulted with the physicians back at Hennepin and the Hennepin physicians just

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<sup>3</sup> Belding Scribner was a pioneer in kidney dialysis in Seattle, Washington. [https://en.wikipedia.org/wiki/Belding\\_Hibbard\\_Scribner](https://en.wikipedia.org/wiki/Belding_Hibbard_Scribner)

<sup>4</sup> More information on the Sweden Refrigerator Company can be found at the Museum of History & Industry, Sophie Frye Bass Library. Online finding aid available through Archives West, <https://archiveswest.orbiscascade.org/ark:80444/xv80523>

<sup>5</sup> More information on Frances Atherton Bean III can be found at the Minnesota Historical Society. <http://www2.mnhs.org/library/findaids/00516.xml>

went out about once a month to these different places to see the patients. It's a model that's used today, but really was started way back in the sixties.

That was the start of chronic dialysis. And of course, it started a whole new field of dialysis access because you had to have a way that you could get people on dialysis and off...which required...at that time was all blood dialysis. It created a whole new field of surgery, of creating a way to do this with fistulas, artificial grafts, and maintaining those because they were really the lifeblood of the patients.

Our Regional Kidney Dialysis Program really became quite large over the years. It was run and owned by the Minneapolis Medical Research Foundation and was sort of the lifeblood of income for them. Kind of a back story to that is that often the Research Foundation paid the health insurance bills for a lot of the patients because that made it sure that they would get paid for the services they did. I think that's illegal today, but at the time it wasn't illegal.

There was a time, that was sort of between 1968 and 1972, the program was getting a little better. They found that steroids were as good...sort of the mainstay of immunosuppression. It was during that time Dr. Hitchcock performed a whole pancreas transplant, which was probably the first—again the first in Minnesota—that was done. Dr. John Haglin performed a baboon lung transplant during that time, which of course both of those failed during that time.

[break]

Just a couple of side stories that come to mind. During that period also, there was a really...kind of a famous transplant surgeon in Denver. Dr. Tom Starzl<sup>6</sup> was working there and they took six baboons out there and did—or excuse me, three baboons—out to Denver where he was at work at the University of Colorado. And they performed six baboon transplants there, which the longest one that worked was only a week.

The other interesting kind of a side note of this is that Dr. Hitchcock got a grant to put a helicopter pad on the old Minneapolis General Hospital. I was never there, so I didn't really understand sort of the logistics of this. But they got the helicopter pad put on there, and it was only used twice in the next six months, so they abandoned it. But they had a...an elevator that went down to, I think it was the first floor, next to the emergency department and also the operating rooms where they would..for the transport of patients. That room became known as the helipad.

Well, when they stopped doing transport patients, they then converted that room into a dialysis access room. And that's where we had the dialysis access program...also morphed into the Transplant Coordination office. The same people that did that—did the dialysis access—also

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<sup>6</sup> Dr. Thomas Starzl performed the first human liver transplants. [https://en.wikipedia.org/wiki/Thomas\\_Starzl](https://en.wikipedia.org/wiki/Thomas_Starzl)

did the transplant coordination. By that time, the preservation got better, and also the medications got better. I'll talk about ALG [anti-lymphocyte globulin] in a little bit, but I wanted to talk about the hyperbaric chamber before then.

Dr. Hitchcock convinced the county, and I believe he also had some other grant money to build a hyperbaric oxygen chamber. It was fashioned after a hyperbaric chamber in the Netherlands. It was two, big round chambers with an open door in between. And then another chamber that...each could be an operating room. The chamber was really to use for gas gangrene, carbon monoxide poisoning, decompression sickness and some soft tissue injuries.

But what Claude was really interested in—the theory was that—if you removed organs in this oxygen saturated field that the preservation would be better. They would have the recipient in one chamber and the donor in the other chamber and this was prior to brain death laws. Once they had a cardiac standstill, they would rapidly harvest that kidney, and then they passed it between the two chambers through this little chamber door and transplanted into the patient in the next room.

But then eventually, the preservation machines became popular. They learned that they could preserve organs using a cold electrolyte solution on a pump system, and that would preserve the organs for at least twenty-four hours or more. That was developed at a Minnesota Company also. It was the Waters Company<sup>7</sup>.

The other thing I wanted to mention, probably one of the biggest advances in longevity of kidney transplants was the development of ALG, anti-lymphocyte globulin. That was very effective in—not, you know—in controlling the rejection problem. But it also created—it was so powerful—it created a lot of infectious disease problems and that. In the seventies, it was really a time of learning how to avoid complications with transplant and managing all those transplants. I think during that time there weren't a lot of changes in the medications. It was still steroids. It was Imuran. And also, the ALG. People were maintained on the Imuran and steroids after that. But it wasn't until the mid-nineties where Tacrolimus became available and really changed the sort of atmosphere around transplant. Where, in the seventies it was very important to try to match—do genetic matching as close as possible and to transplant the kidneys as close as possible—that we were able to enter an era where we had a longer period of time. The drugs sort of overrode the matching issues and so it really changed things. And then it was just sort of fine tuning your protocols to get the best results. The interesting thing about that is, since that time, there's been lots of efforts to have medications that maybe you only had to take once a month, or have a long-term effect, but essentially, they haven't worked. And so, even today, the mainstay is

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<sup>7</sup> George Waters gave an oral history interview to the Minnesota Historical Society about his medical device company. <http://collections.mnhs.org/cms/display?irn=10445348> <https://wtrs.com/>

Tacrolimus, an Imuran cousin, and also plus or minus steroids. So that became very popular, or still remains popular.

The transplant program grew. I should remember when we did our thousandth transplant, but it was probably sometime in the 2000s. I just don't recall exactly.

I think another part...I should mention the vascular access. It was an area in the transplant coordination area. It was always interesting because it was run by Mary Jane LaCombe. And she hired...almost everybody that worked there was a family member. It was pretty close knit, and Mary Jane ran it with an iron fist. But she—the one thing that she did—she kept a log just on three-by-five cards of all the patients and all the access procedures they had. So, if they came in, you could just look at the card and you had an instant reference to all of that. It was really helpful.

Her family was incredibly dedicated to the transplant program because it was a lot of work back then. When you had a donor, it started like a 48-hour cycle of no sleep, and someone always had to be with the kidney. We often were flying to Grand Forks or Sioux Falls or several other places. And it always seemed like, you know, the operation ended at the middle of the night. You flew back, and then you had to transplant the kidney as soon as you could. Because then they did the tissue typing and the matching process to make sure it was compatible, and that took time. It always seemed like then you were operating again in the middle of the night. And her family really was instrumental in keeping that popular.

The other thing that came out of this was the transplant clinic, which became an organized specialty clinic that was dedicated to these transplant patients. It was a very hands-on program, very tight relationships with the patients and the staff. And to this day, I think is a model clinic for Hennepin County now, or Hennepin Healthcare. And something that they should all be proud of.

[break]

When I finished my residency in 1984, I left. But Dr. Hitchcock asked that I come back and be part of the transplant team. I came back in 1986. And at that time, so it was...there were four of us doing transplant. And one of those was Dr. Art Ney. And we basically—Dr. Ney and I ran the transplant program, the Red Surgery Service, which was the biggest general surgery service. One day, it was probably 1988, Claude called us into his office. He sat us down and he said, “Art, you're going to be the trauma director. Mark, you're going to be the transplant director. Okay, get out of here.” And that was it. [laughs]

I had it easy because we already had a transplant clinic, we had the transplant coordination office, we had lots of things. Art had it hard because [laughs] there was no Level 1 Trauma program at the time, and he had to create that for Hennepin. That really was one of the



first trauma programs—Level 1 Trauma programs—in the country. There were three in one year and we don't know if we were the second or the third program to be verified in that year. But he and I ended up for about ten years of our career being the only transplant surgeons at Hennepin, which meant that [laughs] one or the other of us were on call.

It was probably in the mid-nineties...and actually Mary Jane LaCombe kind of pushed this on us. We knew that out in Maryland, and I think out on the...one place on the west coast were doing laparoscopic donor nephrectomies And I was probably the reluctant one, because I didn't know if it was safe. You have to remember back then, too, the equipment wasn't as good as it was today. So, one day Art and I went out to Johns Hopkins University, and we watched them do two donor nephrectomies. We came back and said, "We can do this." Our fellowship consisted of that day and we each got a hat that said "Johns Hopkins" on it and came back and started doing laparoscopic donor nephrectomies.

Dr. Ney and I did our first ones, I think it was the first week in January...I think it was 1998. But it was...it was successful. It really started...it really increased our live donor program significantly. Because the people—the recovery from it versus the old operation which required quite a big, large incision on the flank—I mean now it was less recovery time, and it was less pain. I guess patients kind of liked that. It became a very successful program.

But Art and I introduced that to the Midwest, too, and it was just another first in Hennepin County. I'm sure there's a bunch of other firsts in transplant, in our program, that I've failed to mention. But I think a lot of those things are important. Whether it's the preservation research, the surgical technique, the having the baboon colony, to do that, attempting other firsts with the lung transplants, xenotransplants. The transplant clinic setup, I think it was very unique. The Regional Kidney Dialysis Program was very unique to the region also. I think all of those really separated us from many, many other places. That's something I think a lot of people can be proud of. There are a lot of contributors to that.

**BENNETT:** That's good. That's an amazing story. I just love hearing it. It just...

**ODLAND:** Well, I mean, you'd never get away with this today, right? You know, like, "Go over to the lab and get a kidney from that baboon and we're going to put it in her," you know? I mean, I can just see Claude saying that. He wouldn't take no for an answer and stuff. And they just did it. It's a different era.

**BENNETT:** Did you actually fly up to...say, the kidney was available in North Dakota, you would fly up there? Is that it? Take it out of the person and then come back with it?

**ODLAND:** Yes, we would. We would have...so you get notified. People like the U [University of Minnesota] had their group of hospitals they worked with. We had our group of hospitals we worked with. Mayo Clinic had their group of hospitals that they work with. If

somebody from Grand Forks would be brain dead and wanted to donate, we'd get in a small plane, fly up.

There were some spectacular stories with that. I remember one time going to Grand Forks and we landed in this thunderstorm. I was sitting in the co-pilot seat, and I couldn't figure out how we were gonna land because we were just going back and forth and back—bang! And then land. And it always seemed...this always happened in the middle of the night. I remember one night, I think we're coming back from Grand Forks also, but this would probably be a different trip. We had to fly up around Duluth to come back. I looked out and we had the most spectacular northern lights. And then another time, we were going through southern Minnesota, and it was the most spectacular thunderstorm and lightning storm that I've ever seen.

But so, you were exhausted, you're like, what am I doing here at four o'clock in the morning? Going home, going to back to work, having to work the whole day and be up the next night. But you had some spectacular things. Mary Kay [Jane?] Lacombe...they were in Sioux Falls and we're going back to the airport, right? They gave him a ride in the ambulance back and the ambulance got into a car accident. She and the kidney and the machine got thrown into the back of the, whatever, the front of the ambulance. Luckily, they weren't hurt.

To show the dedication of the staff, too, is...twice, when they couldn't place the kidney in the United States, they flew one kidney to Tehran and then they flew another kidney once to Greece. And I know Mary Kay [Jane?] had to fly...and they flew first class, and the kidney in a first-class seat next to them. They flew to Greece for that.

**BENNETT:** So, they must have had the transport...that must have been a pretty sophisticated transport device at that time.

**ODLAND:** Yeah, it was that Waters machine that was manufactured in Rochester, MN. It was, I don't know, two feet by two feet by two feet. You hook the kidneys up to a pump that pumps cold electrolyte solution to the kidneys to keep it preserved. That worked pretty well. But over time, they did studies, and just flushing the kidneys out at the time of removal, quickly cooling them down, and putting them on ice could preserve them just as well. So that kind of went by the wayside after a while. Which really took away a lot of the time issue with that too.

The other good thing that happened over time is—as the tissue typing and cross matching became faster and more available and we could preserve the kidneys longer—where we used to always have to do these in the middle of the night, that now we were kind of...we were able to postpone them a bit and do them at a reasonable hour. It was a lot easier to do them at that time.

**BENNETT:** Yeah, it's better to do them when everybody's rested.

**ODLAND:** [laughs] Yeah, right. Well, that's true. So that was a good part of that.

**BENNETT:** Do we have pictures of those machines?

**ODLAND:** Oh yeah.

**BENNETT:** Okay, and what about Mary Jane's cards?

**ODLAND:** I don't know where they're at. That's a good question—if they're over in the transplant clinic. I know there's some stuff in the History Center related to the transplant and dialysis.

**BENNETT:** I have not seen the cards.

**ODLAND:** The other thing that came out of that, was that transplant flow sheet. We had these big cardboard sheets with the patient's name and then dates and labs down one side, the date a daily thing down the other side. You could just look at this graph and follow the creatinine for...you could do it for twelve years in the end. But most of those labs were done up front.

**BENNETT:** That's impressive. It's really a story. I was going to ask you why you chose Hennepin to have your career, but I think that Hennepin chose you.

**ODLAND:** [laughs] There's a little bit of that, I guess.

**BENNETT:** That's a good thing.

**ODLAND:** I always wanted to go into surgery. I was a Med student here on rotation and, in that time, Dr. Hitchcock used to have Monday afternoon rounds. All the med students and the residents, they'd walk around and that. At the end of the rounds one day, he wanted to see a patient down—I think it was in the burn unit at the time—and I was sort of walking next to him, a little behind him. He turned around to me and he said, “Well Mark, do you still want to be a surgeon?” And I said, “Yeah, I certainly do.” And he says, “Okay, come back here in the fall and we'll arrange it.” My junior resident and intern said, “Well, you're in.” [both laugh] And that was it. That's how I got here. It was a six-year program at the time. I went back to my hometown in North Dakota for two years. But before I left, Claude was asking me to stay and I said, “Well, you know, I'm obligated.” Then he kept calling and then I had...the practice situation in Minot was not good and so I had to leave. It was easy coming back.

**BENNETT:** What was your favorite thing about working here at Hennepin County Medical Center?

**ODLAND:** I liked the diversity of the patients. Yeah, that was always really nice. I liked the fact that we never turned anybody away. We never asked about insurance or ability to pay or any of that. Instead, we just focused on the problem at hand and took care of it in the best way. The financial part never once interfered with our decision making.

The other thing I loved about the transplant program; it was so easy to manage. Because if we had an issue or a problem or whatever, it was always—someone would say—what's best for the patient? And that's what we did. There was never any question. We always did what was best for the patient. That part was really easy too. The dedication of the whole staff, of where the rubber meets the road. It was always a great effort by everybody to take good care of the patients. That was what kept me here for all those years.

**BENNETT:** Can you describe the culture that you felt at Hennepin? By culture, I mean how the staff interacted with each other, interactions that you had with other physicians and other departments, general overall feeling when you went to work.

**ODLAND:** It sort of changed over the years. We kind of laugh about it when we talk about this now. Back then, the surgery department was really powerful. To the point where, like in the morning at the cafeteria, this was the surgeon's table and nobody sat there. This is our place. Of course, we were there probably an hour earlier than everybody else too. Over time, it became more collegial. Of course, they hired a lot more people during the years. And then when the faculty group came into—was formed—they increased a lot. I think for the most part there was really a collegial atmosphere here. Not to say that there weren't moments, but I think especially in the surgery, anesthesia, radiology, we always had a great working relationship because we had to count on each other to do...to work in the best interest of the patient.

**BENNETT:** Can you tell us about an experience you had while working here as a surgeon that was especially meaningful or striking, outside of your transplant work? Because you did many surgeries that weren't transplants.

**ODLAND:** There are several that stick out in my mind, and one is...I was on call the day that a police officer [name redacted] was shot breaking up a bank robbery in [town redacted] and he was shot three or four times, abdomen, chest, and in the leg. Gosh, I must have operated on him, oh, nineteen times, I think, over the years. His wife [name redacted] was just a hoot and was just so thankful to us and so nice to all of us, for taking care of him. It was really easy to take care of him. Saved his leg. He's still doing really well. His twenty-year anniversary this year...got a note from him and [name redacted]. That's very gratifying.

There is another, maybe not so gratifying, but I had a patient who was sent from western Minnesota. She was between her junior and senior year [name of school redacted] working on a road construction crew. She was driving a compactor and she got too close to the side of the road, and it rolled over...and it rolled over her. It crushed her leg, her pelvis. Her abdominal muscles were severed off her pubic bone. Her bladder was transected twice, and completely. A dislocated pelvis, and, uh, gosh, I can't remember how many times we operated on her, but she had all this muscle damage to her buttocks and thighs and all that.

It was really kind of devastating to our whole team, operating on her every day. But, you know, you just did what you had to do. She was alive, and you didn't know what the endpoint was going to be. Finally got her through all this, and I remember the first day I told her parents. I said, "You're gonna have to think of her as being like a paraplegic after this, because she's probably not going to have good use of her legs." But we...she came to the hospital once and we were going to build her a bladder out of her intestines. And she was just mean and nasty to me, and she says, "I don't want to see you. I don't like you." And then she said, "You saved my life. Go away." I just said, "[name redacted] you know, if you really feel this way," I said, "I'm going to help with this surgery, but after that I can't take care of you anymore." Then she got nice, became nice to me after that and she went on to law school, adopted children...adopted a child. I haven't had contact with her for a while, but very, very nice.

**BENNETT:** That's amazing. I'm sure there are many, many stories like that.

**ODLAND:** Just one other one. This always struck me. Because it wasn't a big deal of, you know, taking care of them or that. I had this...he was from western Wisconsin. Came to us because he had an esophageal cancer. I operated on him for it. It was probably a little more meaningful to him because he had just taken care of a friend who—for the last six months of his life—while he died of esophageal cancer. We thought we had resected him to no known disease, but six or nine months later he ended up back in the hospital with brain mets<sup>8</sup>. I went up to his room every day and most of the time he was sleeping. But I knew the next day he was going to go back to Wisconsin, to hospice care. I went...I stood in the door of his room, and this was the first time that he'd been awake. Obviously emaciated and very weak, but he rose his hand up to me and said, "Thank you." And, uh, and so it was a little thing that I did for him. But patients could always be grateful. So even the little things.

**BENNETT:** And you remember that. You eventually took the role of Chief of Surgery. What was your favorite thing about that position and what was the biggest challenge?

**ODLAND:** I became the interim Chief of Surgery, and at the time I felt that some of the quality of the department was not what it should be. [laughs] I had no intentions of...I wasn't going to apply to be the Chief of Surgery. I had no intentions of doing that. But I took it upon myself to fix a few problems in the department. And after I did that, they said, "If you can do that, you should be the Chief of Surgery." I said, well, I wasn't intending on doing that. Basically, I never applied, never went through an interview process, and became the Chief Surgeon, I think for eight years. The nicest thing, I think, at the end of that, when I retired and left, I thought the department was in really good shape. Finally, we had a good burn unit, good surgical care, good trauma care, good transplant surgeons. Rebuilt the Urology department and

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<sup>8</sup> Brain metastases.

hired two new people. The neurosurgeons were now committed fulltime to Hennepin. I thought when I left that everything...the department, was in really good shape.

**BENNETT:** Well again, they chose you. [both laugh] But it's good to leave when you feel like things are in good order and a good job...

**ODLAND:** Yeah, yeah...

**BENNETT:** And you've made a difference.

**ODLAND:** [conversation regarding Dr. Odland's retirement redacted]

**BENNETT:** Do you have anything else that you'd like to share regarding your work at HCMC? Anything you forgot to mention that you think is important for us to remember.

**ODLAND:** Oh gosh. No, I don't know. I can't think of anything offhand. I've said enough.

**BENNETT:** Well, you said a lot and it's a great story. The history of the renal transplant program is so impressive. Thank you for helping keep the story alive. That story truly shows that Hennepin County Medical Center was, and is, a pioneer in renal transplant. And your work has made a difference for all the generations that will go forward. You've certainly had a wonderful career here and have played a very important role in the field of surgery and renal transplant. It makes me proud to have worked here with you in this amazing institution. On behalf of the Hennepin Medical History Center, I want to thank you for the years you spent at Hennepin and all the contributions that you have made to the institution and the patients you've served.

**ODLAND:** Thank you.

[end interview]

## CHRONOLOGY

- 1952 Born May 25 in Harvey, North Dakota
- 1974 St. Olaf College, Northfield, MN  
B.A. Chemistry
- 1978 University of North Dakota School of Medicine, Grand Forks, ND  
M.D. Medicine
- 1978-1984 General Surgery Residency  
Hennepin County Medical Center, Minneapolis, MN
- 1979 Licensure, Minnesota
- 1984-1986 General Surgeon  
Medical Arts Clinic, Minot, North Dakota
- 1986-2017 Faculty Member  
Hennepin County Medical Center Minneapolis, MN
- 1986-1988 Renal Transplant Fellowship  
Hennepin County Medical Center, Minneapolis, MN
- 1987 American Board of Surgery Certification
- 1996-2017 Surgical Director, Renal Transplant Program  
Hennepin County Medical Center, Minneapolis, MN
- 1997-2017 Associate Staff, Abbott Northwestern Hospital, Minneapolis, MN
- 1997-2017 Surgical Director, Renal Transplant Program  
Abbott Northwestern Hospital, Minneapolis, MN
- 2003-2006 Assistant Chief of Surgery, Department of Surgery  
Hennepin County Medical Center, Minneapolis, MN
- 2006-2008 Interim Chief of Surgery, Department of Surgery  
Hennepin County Medical Center, Minneapolis, MN
- 2008-2017 Chief of Surgery, Department of Surgery  
Hennepin County Medical Center, Minneapolis, MN

## **ACADEMIC APPOINTMENTS**

- 2000-2017            Assistant Professor of Surgery, Clinical Scholar Track  
Department of Surgery, University of Minnesota
- 1984-1986            University of North Dakota

## **COMMITTEE APPOINTMENTS**

### ***Hennepin County Medical Center***

- Patient Care Quality Assurance Committee, 1986-1994  
Chairman, Utilization Review Committee, 1986-1994  
Chairman, Trauma Quality Assurance Committee, 1987-1995  
Health Care Advisory Committee, 1988  
Cancer Committee, 1989-1992  
Graduate Medical Education Steering Committee, 1989-1994  
Transitional Institutional Coordinating Committee, 1990-1994  
Member, Pediatric Chief Search Committee, 1990  
Quality Council, 1992-1993  
Readmission Quality Improvement Project, 1992  
Medical Staff Quality Committee, 2006-2008  
Medical Executive Committee, 2008-2017  
Clinical Practice Committee, 2012-2017  
Claims Review & Disposition Committee, 2013-2017

### ***Hennepin Faculty Associates / Minneapolis Medical Research Foundation***

- Board of Directors, Hennepin Faculty Associates, 2003-2011; 1993-1995; 1987-1989  
Executive Committee, Hennepin Faculty Associates, 2003-2011; 1993-1995  
Chairman, Risk Management Committee, Hennepin Faculty Associates, 1993-1995  
Hennepin Faculty Associates-Hennepin County Medical Center Joint Policy Board, 1993-1995  
Physician Practice Steering Committee, Hennepin Faculty Associates, 1993-1995  
Promotion Committee, Hennepin Faculty Associates, 1988-1989  
Board of Directors, Minneapolis Medical Research Foundation, Interim, 1989-1991  
Ad Hoc Primary Care Task Force, Hennepin Faculty Associates, 1990



## COMMITTEE APPOINTMENTS (CONT.)

### *Regional*

Executive Committee, Regional Kidney Dialysis Program, 1994  
United Network Organ Sharing, Representative for Hennepin County Medical Center, 1993  
United Network Organ Sharing, Representative to Metropolitan Mt. Sinai Hospital, 1988-1991  
President, Minneapolis Surgical Society, 1998-1999  
Quality Assurance Committee, Metropolitan Health Plan, 1986-1992

## ORGANIZATIONAL LEADERSHIP POSITIONS

### *Constellation/Midwest Medical Insurance Company*

Board of Directors, 1996-2017; Vice Chairman 2006-2007; Chairman 2007-2017  
Risk Management Committee, 1996-2017  
Claim Committee, 1996-2017; Chairman 1998-2006  
Investment Committee, 2005-2017  
Governance Fellow, The National Association of Corporate Directors: 2011  
Governance Committee, Midwest Medical Insurance Company, 2006-2017  
Governance Committee, Constellation, 2006-2017

### *Utah Medical Insurance Association, Inc., Portland, Oregon*

Board of Directors, July 2013-2017

### *LifeSource - Upper Midwest Procurement Organization*

Board of Directors, 1989-2006  
Advisory Board, 1987-2006  
Kidney/Pancreas Allocation Committee, 1994-2006  
Finance and Audit Committee, 2004-2017  
President, 1993-1996  
Medical Director, 1993-1996  
Chairman, Kidney Allocation Committee, 1990-1993

## AWARDS AND HONORS

Minneapolis/St. Paul Magazine "Top Doctor" Award – Renal Transplant  
1997, 1999, 2000, 2001, 2003-2016  
Minneapolis/St. Paul Magazine "Top Doctor" Award – General Surgery  
2001, 2003, 2004, 2007

### **PAST SOCIETY MEMBERSHIPS**

Fellow, American College of Surgeons

Fellow, National Association of Corporate Directors

American Society of Transplant Physicians

American Association for the Surgery of Trauma

Minneapolis Surgical Society

Hitchcock Surgical Society

Minnesota Medical Association

Central Surgical Association

### **COMMUNITY SERVICE (AS OF EARLY 2023)**

Guardian Ad Litem, Hennepin County Juvenile Justice Court, 2017-present

Mentor, VANTAGE Program, Minnetonka High School, 2017-present

Normandale Lutheran Church Council, 2019-present

Normandale Lutheran Health and Wholeness, 2019-present

Normandale House Family Sponsor

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