

OREGON HEALTH & SCIENCE UNIVERSITY

ORAL HISTORY PROGRAM

a project of OHSU's Historical Collections & Archives

an interview with:

Karen Deveney, M.D.

interview conducted on: December 20, 2016

by: Liana Tsikitis, M.D., M.C.R.



Interviewee: Karen Deveney
Interviewer: Liana Tsikitis
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Transcribed by: Teresa Bergen

Liana Tsikitis: My name is Dr. Liana Tsikitis. And I'm interviewing my friend, mentor, and colleague Dr. Karen Deveney for the OHSU Oral History Program. It's December 20, 2016. We are in the BICC building at OHSU. Good morning.

Karen Deveney: Good morning.

Tsikitis: Karen, you're a Portlandian and you grew up in Gresham. I was wondering if you could share with us a little bit of your experience growing up in Gresham. And if you had any wish at a very young age to become a doctor.

Deveney: Well, Gresham was a lot different when I was growing up than it is now. It was in the '50s, immediate post-war period. And it was a small farming community, completely separate from Portland and consisting of about 3500 people. My family were farmers. My father actually was a rose grower who raised roses and sold the plants for wholesale around the country and was a very successful farmer. But he and my mother had never had an opportunity to go to college because they had grown up and married right at the beginning of the Depression and basically had to go to work. So they never had the benefit of an education. And they were both from farming families. My mother's family actually came by covered wagon there in 1852, along the Oregon Trail.

So I grew up and went to the same high school that my parents had attended; had some of the same teachers. And had my parents as hardworking generation, the Greatest Generation role models for hard work. But no one really in my acquaintanceship who was a college-educated woman. In fact, my father really, just wanted to allow, give me the benefit of going to college because he, and many of his friends had the same attitude, you need to have an education. That's something they can never take away from you. Which is what that Depression generation had as kind of a theme. So I was an only child and he wanted me to go to college. But had no desire to push me into any particular career. So I really didn't have any idea about going into medicine at that time because I never really knew any doctors except the family practitioner who happened to also be the mayor of Gresham at the time.

Tsikitis: I see. You went to Stanford for college?

Deveney: Yes.

Tsikitis: And you taught English after you graduated from college in high school.

Deveney: Yes.

Tsikitis: When did you decide to go to medical school?

Deveney: Well, it was during the time when I was teaching in this very difficult junior high school in San Francisco. I had met my husband at Stanford and we had married our senior year. And then he went to medical school and was accepted to Cal San Francisco. And we moved from Stanford up to San Francisco. And I commuted for a year over to Berkeley and got my teacher's credential and then got a job teaching in the San Francisco school district. And it was the mid '60s. It was a time of a lot of upheaval in our country. Civil rights riots and the Vietnam War. And there was a lot of unrest. And that unrest definitely trickled into the public schools, which were in kind of a bad shape at that time. And they had, in the school I had, 33 percent teacher turnover rate every year. And they changed principals and vice principals every semester trying to find something that would work and keep control of the chaos that was reigning in the school and it wasn't very effective. So it was a pretty tumultuous and, I considered, threatening and kind of dangerous environment. And it was almost impossible to really teach in that environment. And I said, you know, I really don't think I'm cut out for this.

And I would come home at night and say to Cliff, "Oh, you're so lucky. You're in medical school. You're doing something you love and it's so great."

And he said, "Well, why don't you go to medical school?"

And I hesitated for a little while with well, we can't afford it. And then I said, "Sure. Why not?"

So and then, I have to say, that from that point, it was great. Because going to medical school was a heck of a lot easier than trying to keep twenty-eight unruly fifteen-year-olds in line in the classroom. And feel the threat of being threatened by a knife or a gun, which actually did happen. A Molotov cocktail got thrown into the teachers' lounge. I feared for my safety and I said, "No, I really, I really don't want to continue this." So medicine seemed like a much better alternative.

Tsikitis: So medical school in the '60s. So you enter medical school and then continue with surgical residency. Tell me a little bit more about the women in your medical school class. How many were there? And then how you continued in residency, in surgical residency, at that time. Because I know there were not that many women at that point. So if you can tell me a little about your experience first in medical school and then in residency.

Deveney: Right. There were not very many women medical students at all in that time. I was starting in the late '60s. And feminism was really just beginning. So there were ten women in my medical school class. And I have to say, when I was applying to medical school, I was twenty-three. I was a couple of years older. And one of my very young interviewers for medical school said to me, "Tell me. What is a woman of your mature years doing applying to medical school?" You know, I was twenty-three and I was married. And I was a woman. But that's the code word he really didn't, I think, want to say.

So I looked at him and I said, "Well, I guess I just didn't feel I was over the hill quite yet."

And so then the other very kindly neurosurgery professor who interviewed me said, "How many medical schools are you applying to, Karen?"

And really, I was applying to only one, because we couldn't afford to go to Stanford Medical School. That was the only one in the Bay Area. And Cal Davis; I would have been in its first class and that would be a long commute. So I said, "Well, sir, just one."

And he said, "Well what will you do if you don't get in?"

I said, "Well, I'll apply next year. You won't get rid of me quite that easily."

So I entered a class of 142 and there were only ten women. And I really did encounter a bit of prejudice or stereotyping from my classmates, who tried to kind of get to know me and figure out what I was really doing there. And a lot of individuals thought well, women just didn't belong, because they wouldn't ever practice. They'd just get married and have babies and quit. And so it was really a waste of money and it was taking a position away from a man to have women in medical school class. But I just put my head down and worked hard, which is what the women of my generation did. I really never felt that it was appropriate to be a rabble rouser or call attention myself. I just wanted to do as I'd always done: work hard, do a good job, and prove myself that way. And so that's what I tried to do. And I did really well and earned the respect of the faculty in the department of surgery.

And so I think at that time, there were no women in surgery at all. There were a couple who had begun and then had dropped out. I really didn't know those individuals because they had preceded me by a few years. But I always wondered if they had been given a lot of difficulty in trying to make it through their residency experience and had just quit because they had too much pressure put on them by people who maybe didn't think they belonged there.

But I think that I was a little bit different in some ways, because the faculty knew me. So I was a little less of a threat. And I always just worked hard and didn't complain or whine or ask for favors. And my attitude was that you had to work harder in order to have a shot. And my generation of women kind of went along to get along. To make their way, rather than being protestors. I just put my head down and worked really hard.

Tsikitis: So you were, as you said, like the second or third, second female surgical resident at UCSF.

Deveney: To finish. I was the second one to finish the residency, yeah.

Tsikitis: And you talked a little bit about the discrimination and sexism you encountered. But definitely did not stop you. You had a great career. And you joined the faculty here in 1987. Tell me a little bit about coming back to Oregon. You and Cliff came back to Oregon. So tell me a little bit about that. Leaving California and coming here.

Deveney: Right. Well, we came here directly from Philadelphia. We had finished residency, been on the faculty of the VA in San Francisco, and been on the faculty of the University of California, San Francisco. And had a little brief interlude, we were in the Army in Germany. And then came back to San Francisco and kind of had a midlife crisis, so to speak, where we were, didn't quite agree with the way the department was, the direction it was going. So a lot of people on the faculty right then in surgery were looking around for other places. And we did, too. And we found a position that really was a great position for both of us at the University of Pennsylvania in Philadelphia and went there in 1985.

And right after we went there, I learned that my mother, who was a widow, living in the middle of the twenty-two-acre farm at that point, was developing Alzheimer's. And I, as an only child, was going to have a little bit of a hard time managing her from three thousand miles away.

So right away, we started kind of looking for other, for positions closer to home. And our really close friend and colleague, with whom we had made wine as a hobby for many years in San Francisco, Don Trunkey, was selected to be the chair at Oregon. And he called us up right

away and said, "Would you come and join us? I want you to run the education programs in the department. And I want Cliff to be the chief of surgery at the VA."

Well, we had just arrived in Philadelphia and we couldn't leave so quickly. And they were really nice people. And it was a really good position. But I really felt that, Cliff and I both felt, we really wanted to come back west. So we said, "Well, can you hold the job for about a year? Because we have to at least stay here two years." So we did. And then we came back in 1987 to develop, to build the program here, which at that time was rather small. The faculty was small. There were no women on the faculty. There was one research professor who worked for the department in research only, but no clinical women surgeons. And no residents that were women at that point. I mean, maybe one or two. But it was not as progressive as it might be and as we wanted to see it become.

And Don Trunkey said, "I want you to come. And I want to build the best darn department of surgery on the West Coast." And then he said, "And we're going to have fun doing it."

So we said, "Count us in."

Tsikitis: Yeah. That's very much a Don Trunkey kind of saying.

Deveney: It is.

Tsikitis: Best department, you know. So a lot of hard work all of those years. And now we're one of the, actually, we are the biggest program, surgical program, residency program, thanks to you. And probably I consider, I mean, of course I'm biased, the best in the country. So tell us a little bit about this transition from when you came in 1987 to today. A little of the hard work and how you saw that program growing. And the challenges that you had as a female program director in the department of surgery.

Deveney: Well, there were a lot of challenges. In part because it was still kind of a different time. There were a lot of, there was really some sexual harassment evident among faculty in some of the various hospitals. And not very many women wanted to go into surgery, because it was viewed as too difficult and that it was a very stressful, malignant situation. And our goal, both in the leadership of the department and in the education part, realm of it, and Cliff at the VA, was to build a department where, that was really one of respect for everyone and professional behavior, which wasn't always the case. And it was so different in those times because even the faculty in other departments would tell female medical students, "Don't go into surgery. You'll have a miserable life. You'll never be happy. And it will be terrible."

So right away what we started to do was build a faculty, sort of build it up in all the different divisions of surgery. And not allow unprofessional behavior by faculty, so that when a medical student came on our rotations, they were treated with respect. They were not demeaned. They were not going to be harassed. And it was unacceptable behavior. So slowly that caught fire and we got a few people, a few women, to come and take a chance on coming to this program. And we built it up by building up leadership in different departments. Don hired some women faculty. It was nice to have Julie Hansen, plastic surgery, and Sue Orloff and that was a start. And then you had, finally, a critical mass of individuals who could be role models for other women to come.

And I think the most important thing over the years has been to use the residents as our best recruitment tool. And if you have residents that are enjoying what they do, have a good, positive spirit, treat one another warmly and respectfully, then that will be a message to other people applying that this is a great place to train. And kind of that's we over the years did it, I'd say.

Tsikitis: Which is wonderful. And when I was a resident at Brown and before I was at OHSU, and I came from Greece, I was at Brown. And I heard like how wonderful the program was then and it was 1990s. And now, like, I go to the interviews, and it's all over the country. They say OHSU is one of the most respected, wonderful, benign programs, you know, for surgery. And so, it's thank to you, Karen.

Deveney: Well, I just interviewed a student yesterday who was applying. And he, you know, I said to him that this, what we really want to have here is a culture that respects everyone and the hard work that they do, because our residents work so hard and care so much about the patients. And it is not fair to them to add more pressure to them or to be disrespectful of them and put more pressure on them when they themselves put much pressure on themselves. What we do is something that's difficult. And we don't need to make it harder for them.

Tsikitis: I'm going to change a little bit the theme. Apart that you're a national leader in surgical education, and we talked about the residency, you have been the go-to person for colorectal surgery here in the state of Oregon. I know you've done more pouches for ulcerative colitis patients. And you wanted to share. And I wanted to ask you, tell us a little bit about that experience and building that career in a time, you know, when you were the only female surgeon here. Those are difficult surgeries. So if you can share with us a little bit about your experience, and a little bit about your work in your clinical research in IBD.

Deveney: Okay, sure. My career in colorectal surgery was not the same path as it is now. When I was finishing training in surgery in the mid-late '70s, there really was no such thing as a colorectal surgery fellowship. There were proctology fellowships. And they were mainly office-based benign anal disease. And there were some wonderful surgeons in San Francisco who had that kind of practice. And around the country there were very few fellowships in specialties of surgery. Even if you were going to be on an academic faculty, you didn't do a fellowship. There was no such thing as a colorectal fellowship. There was major abdominal surgery. There was no such thing as a hepatobiliary, esophageal, pancreatic, all those things just didn't exist. You finished general surgery, you had a mentor, you worked with that mentor and developed your career after you had finished your residency. And slowly built your practice and your reputation.

So at the time I finished, my mentor, who was Larry Way, who was the chief at the VA in San Francisco, said, "I want you to join me over here. And I want you to do the colon and rectal surgery over here at the VA. All of it. And we're going to develop a program in colorectal cancer and inflammatory bowel disease to teach the residents and to take care of the veterans."

So why did he say colorectal surgery? Well, during residency I was, in one year of the residency where we had a rotation in endoscopy, in GI endoscopy, with a gastroenterologist. And at the time I finished, the American Board of Surgery had said, "We need to teach surgeons endoscopy." But there was no faculty in surgery who really knew how to do that. But he said, "You had a rotation in endoscopy so you're going to set up the colorectal program. Have a

colonoscopy clinic, work with the GI people, follow up all our colon cancer patients as a clinical research project to look at what factors you need to look at in follow-up of colon cancer to try to detect treatable, curable recurrences.”

So that sounded like a great plan to me. So I worked with our GI staff at the VA and we set up this program. And so then everything came to me in the colon and rectal realm. And through that, I learned how to do these procedures. I went often and worked with one of the faculty in surgery who did pouches, learned how to do them.

So when we came here to Portland, I already had that experience behind me. So I set up the same kind of program here at the VA and at the university that we had had down in San Francisco so that we were kind of early adopters of teaching colonoscopy and endoscopy to surgical residents. And now, of course, that’s become really important. The numbers required have increased. And we kind of were early adopters of that program. And so, then there was only one other group in Portland that really did pouches, Gene Sullivan’s group. And so we kind of shared all the ulcerative colitis patients. And slowly I just built, over the twenty years, first twenty years I was here, an experience doing ileo-anal pouches. And doing rectal cancer and colon cancer.

Tsikitis: Still in colorectal surgery, how do you think, since we’re such a large program now – we have also a colorectal fellow, we have also a resident, they need to benefit – and I always find as a teacher for both residents and fellows, teaching endoscopy, there’s always this challenge on how you marry those two. Tell me a little bit about what you think about that. Like the fellowship in big programs when you have such large volume also of residents and you’re obligated to teach both. Have you thought like how we could do this a little bit better, so both benefit? We tend to, as colorectal surgeons, we tend to always, like, protect more our fellow, in a way, when he’s in the rotation, because he’s going to be doing this, or she’s going to be doing this, for the rest of their lives. Tell me a little bit about those challenges and how were you able to marry those two, and do it in such a nice way.

Deveney: Yeah. Well, this is a major challenge of being a program director is that for me as a program director in general surgery, fellows are the enemy of the residency. Because the fellows are going to just naturally take experiences away from the residents. So it’s really important to structure the resident and fellow experience so that there’s as little overlap as possible. Certainly between the chief residents and the fellows. And the fellows can be great teachers for the junior residents under the right circumstance of less complicated procedures. But from the standpoint of obeying the rules of the Accrediting Council for Graduate Medical Education, the chief residents and the fellows have to kind of be separate.

So I was very fortunate in several ways. One, we have a very high volume. Two, we have multiple hospitals in our program. And three, we had a program director in colorectal surgery who was very respectful of that problem and worked with me to structure a program that prevented the overlap of chief resident and fellow to the degree possible. And we did that, I think, in a way that the fellow and the resident still both get good experience. By having the fellow at one of the other hospitals for a lot of the time, two of the other hospitals, actually. And then not for a really long time here. And also, there are experiences across the city at the other hospitals where the residents do get a lot of colorectal experience, too, with some of our community hospitals. I think there are twenty-three or twenty-four colorectal surgeons in Portland. Which then the fellow can’t be all those places all the time, but we have residents in

those places. So having a large residency, having multiple rotation sites, and structuring it to try to avoid those conflicts is really important. And I was a rabid dog about keeping fellows and chief residents kind of separate on the rotations to the degree we could.

Tsikitis: The past, not just few years, I think it's more than five years, you always have shown interest in developing the programs in outside the Portland metro area. Rural surgery in Grants Pass, one-year rotation for the fourth-year surgical residents. The Coos Bay now rotation. Tell us a little bit what instigated you to work towards that. And how did you develop the program? Because now you're one of the national names in developing rural surgery. In, you know, all medical schools in the country.

Deveney: Well, early on when we were here, I would begin to get calls from rural hospitals, rural surgeons and hospitals. "Do you have a resident that is finishing that would like to come out and practice in" X little town." And I would, but they would already be taken. They would be going into practice, going into doing a fellowship, or going into community practice more in the city area. And we had a medical student who wanted to go into surgery, and, in fact, wanted to go into rural surgery. And worked with me and Dr. Trunkey to actually do a survey of the rural hospitals in Oregon. What the age was of their surgeons, how many surgeons they had, what their needs were, what the surgeons felt that residents would need to have in order to be successful in a rural practice. And also, what the needs were in that community. And it was obvious that the rural hospitals had great needs for surgeons to replace their aging surgical population. And in fact, one of the greatest workforce needs for our state was to provide well-trained surgeons for those rural communities.

So we figured out how could we do this. And it just, some of it was serendipity. We happened to have a resident in the middle of the residency who had grown up in Grants Pass and who had worked with some of the surgeons in that community as a high school student. And had shadowed them, and had gotten to know them. And we were talking one day about this, and he said, "You know," he said, "I'll bet that those surgeons in Grants Pass would like to have a resident, and this is how we could do it." Because we realized that you needed to have no competing learners in fields like urology, ENT, ortho, or OB/GYN if you were going to have a resident learn those expanded skills that you needed to have to be in a rural community and be effective to meet the needs of the population.

So he talked to his surgical mentors down there. And the CEO of the hospital actually saw that as a wonderful opportunity to develop some cachet as an institution. And he said, "Send a resident down. We'd love to have them." So initially we set it up as an elective, because the accrediting body for surgical education wouldn't accept that as a rotation. And eventually we had good success with that, and more residents were interested in doing that. And so we set up the program under the RRC's approval eventually by, I think, it was 2003 or four to have it as an approved rotation.

And the interesting thing is, when you develop these rural programs, you really have to work with, collaborate with the hospital where you're sending the resident to have it be something that's mutually acceptable. Our rotation length up here is six weeks or two months. People who are down there, the surgeons, really didn't want such short rotations. They said, you know, "We've never really taught residents before. We're reluctant to turn over our patients and work with someone, a new different person every two months. It's just too frequent turnover. We have to learn to know them and trust them and know what their skill set is."

So they agreed only to a much longer rotation of a year. Which actually turned out to be wonderful, because those residents get a really good sense of what it would be like to practice in that community. Not just they're going to be there two months and then they come back, but they're going to be there for a very long time. They need to develop relationships with the referring doctors, learn how you keep the referring doctors happy, give them information, make sure that the patients have good follow-up. And also, you're going to see your patients when you go to Safeway and go to the checkout counter. And the person is going to lift their shirt and say, "Hey, Doc, my incision's doing real well, right?"

So it's a completely different experience than up here. And it proved to be very successful. We got it approved. And then more people wanted to do it than we could accommodate. And so then Coos Bay came up. That was another possibility, where again, the hospital director was very receptive to it. And that, we set it all, that's how we set it up. But it took quite a bit of work. There's a lot of hoops you have to jump through to get approvals. Program letters of agreement and all that. And make sure that you're meeting all the same requirements that any of the residents would have up here. So, long answer.

Tsikitis: No, no. It was great. Did the GME office here at OHSU have any difficulty like working with those outside sites? Like for residents going out there? Did you find any difficulty from here? Not so much like they, they welcomed us there. Didn't the GME office here also work with you in establishing those program?

Deveney: Actually, they really, they did. Part of it was that our department did all the work as far as getting those letters of agreement and all that. And then also arranging the funding for it. The funding is always the big issue, because residency programs have been under a cap since 1997. The balanced budget agreement of 1997 limited the number of residents that could be funded. Because of the crazy way graduate medical education is funded in the U.S. through Medicare dollars, which makes no sense whatsoever, but that's the way it is. But they put this cap on to save money. So if we wanted to expand our program, we had to find the funding for it. So the funding actually comes from the outside hospital and flows through our GME office and then to the resident to pay their salary and their benefits.

And the only, the biggest difficulty we had was actually the housing. And so we, initially at Grants Pass, one of the faculty had a house that he let the residents rent for a very low cost. And then he moved away and they sold the house. And so then we had to skirmish to find a suitable place. Because the hospital didn't have a place that was suitable for someone to live for an entire year. It had to be really an apartment or a duplex or a small house.

So we have had some fun doing that the last couple of years and actually getting donations of furniture and identifying a house and renting a U-Haul truck and taking ourselves the furniture down and furnishing the apartment. So we pay for the housing and the hospital pays for the salary and the benefits. So it works out as a good collaboration. But I think that's been kind of the most difficult thing is setting that up so that it was a satisfactory place for them to live.

[Pause in the interview]

Tsikitis: So what advice would you give to other program directors in the country that are trying to develop their own surgery programs?

Deveney: Well actually I've had quite a bit of experience in doing that, because of our program that has, I've done some publications and speaking about it around the country. And so other programs have called me and wanted me to consult how to set up a program. And one of the things that I tell them is that you need to select your faculty very carefully, select the site very carefully. You need to make sure that the faculty in that site are well-respected, are highly competent and professional and have a lot of integrity and that they will be good role models for the residents. Because when the residents go there, again, as I said before, it isn't just a six-week rotation. They're there for either six months or an entire year. And they need to be seeing the top of the game. They need to be seeing really highly competent people and working with highly competent people who are excited about doing it. And are not using the residents as the people to do the work. But actually are excited about teaching them. So identify the faculty and the site carefully.

Although the goal is to train surgeons to go to a rural community, and maybe preferentially even a very small community if possible, that's probably not the best site to have for your site for teaching the residents because the volume isn't high enough. If you have such a long rotation, they wouldn't get a high enough volume of cases. So you want to pick a site that actually is a more medium-sized hospital, maybe 100 beds, in a place that has a rural feel but isn't necessarily frontier in size.

So, for that reason, Grants Pass which is, when we started the program, was 23,000, but had a catchment area that was larger, and had a very nice hospital of a hundred plus beds. And then Coos Bay, again, it's a slightly smaller community, maybe 20,000, but it also has a hospital that's of a pretty good size. And in the hospital, you want to have specialists. So that the residents can learn how to do C-sections, learn how to do difficult catheters for when, excuse me, when a patient needs to have a suprapubic catheter or difficult Foley insertion. Those are things that the urology residents learn up here. But our residents in general surgery wouldn't get to do. But in that smaller hospital, there is no such program. There isn't a urology residency, an OB/GYN residency, or an otolaryngology. So the faculty in those, the specialists in those fields work with our residents. And they learn a lot about how you manage common problems in those specialty fields. Because it makes no sense to have to send a patient from a rural hospital five hours away – maybe in an ice storm or fog or snow, it's not possible, anyway – for a common problem that doesn't require a super-sophisticated, complex solution. So we, that's kind of how we do it.

[Pause in the interview]

Tsikitis: It's really making a general surgeon a general surgeon, you know, like being able to. We celebrated Dr. Deveney last year as a president of the Pacific Coast Surgical Association. We had a regional meeting in a very nice place in Hawaii, Kona. Tell us a little bit, Dr. Deveney, about your experience in working through the ranks to become the president of such a prestigious society. And what advice would you give to me or other female surgeons that want to sit at the table and eventually become leaders?

Deveney: Well, I think there are a couple of things. One is that you have to choose which organizations that you really want to be your life's work. The ones most appropriate to you. For me it was the American College of Surgeons and the Pacific Coast Surgical Association. The

number of hours I was working here was too great to try to belong to absolutely every organization and be president of every single one. Maybe some people can do that. But I'm a little too obsessive-compulsive, and take too much time doing each individual thing. So first of all, deciding which organization you really, that resonates best with you. And then getting involved. Right away when you become a member, volunteer. You volunteer for a committee and you work hard on that committee. And you work your way to be in the leadership of that committee. And then you, that's kind of how you get recognized.

In the American College of Surgeons, I began on the Committee for Surgical Education for Medical Students and worked to be president of that, or chair of that committee. And wrote SESAP questions for the surgical self-assessment program in surgery for many years. And things that were related to education. And then also in the Oregon chapter of the American College of Surgeons, got on the council and became, was program chair. And then, that's how you are recognized as being someone who's willing to do the work. And that's really how you reach the leadership positions.

And then I reached the position of being elected governor from the state of Oregon to the Board of Governors in the American College of Surgeons. And, so, then I worked hard in that role. And they elected me to the Executive Committee and to the Secretary of the Board of Governors of the American College of Surgeons.

And it was similar in the Pacific Coast Surgical. I started out making it known I'd like to be active and was put on the program committee. So I helped choose the program for the Pacific Coast. Read all the abstracts and be on that committee. And then also active in our Oregon-Hawaii caucus. And made it known I'd love to be the counselor for our caucus, and became the counselor. So just by getting to know everybody and working up through volunteering for the jobs that maybe some people don't want to do because they take a little time. But again, you choose which ones you want to be involved with and make it known that you're interested.

Now in the case of the Pacific Coast Surgical Association, one of the reasons I chose that one to be the one that I was most interested in developing leadership of was that I trained at UCSF, so I knew all the San Francisco people. I knew all the UCLA people, USC people, and friends at the University of Washington. And then was here in Oregon. So I think that it requires being social, getting to know the people in the organization, and then volunteering for the positions to do the work. And to be honest, I think at the time, although it took a long time for the Pacific Coast Surgical to elect their first woman president, I was the first woman president. And the organization has been around for eighty-nine years. But that, and maybe it was about time, but I think they needed a woman president.

Tsikitis: So as the medical education is changing, our structure of our residency may change. We've had a lot of different mandates that come even from Medicare and Medicaid and the bundle payment and the one and the other, and all these pressures that we foresee in our everyday practice. How do you foresee that medical surgical education may change because of them? And how could we really, adjusting with the times, what else would you recommend?

Deveney: Well, I think that a lot of the changes that are being proposed, I'm not that absolutely thrilled about. They've been talked about for a long time, and I don't know if they're going to go through, either. But they're talking about cutting down the period of basic education to maybe three or so years, three or four. And the specializing sooner. I actually think that's the wrong direction to go because I think we're saturating the specialties. And even now, I think what we

need for workforce needs in America are really general surgeons to just take care of people. People who know about surgical disease and can refer if necessary but be able to take care of the majority of bread and butter types of operations in their home communities. So I don't know how successful that's really going to be to have earlier specialization. And I'd like to actually see that rethought a little bit.

I believe we're probably going to see a change in how graduate medical education is funded eventually with these changes. And I have no idea what the next administration's going to do with healthcare. But the idea that all of graduate medical education is funded through Medicare is just not sustainable. And a more logical way of doing it would be for all of the payers to have the responsibility for funding graduate medical education. Or else we aren't going to have an adequate workforce in medicine. And so I think we need to do that.

[Pause in the interview]

Deveney: I guess my feeling about educating surgeons is we need to continue to provide surgeons with the broadest education possible so that they don't understand only what their little narrow specialty is, but actually have a broader understanding of surgical disease in general. And I worry that the early specialization creates a bunch of silos. So that if you're a hammer, everything is a nail. But you don't really have a broad understanding of other surgical fields. You need a broad surgical education first.

I think that's true also in medical education in general that the people who are being trained for primary care need to have a greater understanding of what the indications are for surgery and what's appropriate, so they don't fail to refer appropriately when people have a problem that is surgical and that they really understand what risk, what surgical risk is, and can work better with their colleagues. It is going to need to be a more collaborative, team-based environment in the future with all the specialties interacting in a more effective, knowledgeable ways, than I think they actually currently do.

What I see now is really a developing siloes and I think that's a regrettable situation. I don't know whether the changes being made in medical education will reduce those or not. But I think it's an important thing to do. So we continue to try to educate surgeons here who have a broad knowledge base, good technical skills, basic ones, and have a good idea about all the specialty areas of general surgery so that they can be more effective advocates for their patients in the future.

Tsikitis: Great. Thank you, Dr. Deveney. Are there any questions you wish I had asked?

Deveney: Well, one thing that comes to my mind is what qualities I think that women have that make them perhaps more suitable for leadership positions in surgery than has been previously recognized. And I think we're seeing some evidence of that right now in that there are in the last few years many more women that are in positions of leadership in departments of surgery. There are now sixteen major academic institutions that have chairs that are women.

And there was just recently an article also that came out. I just heard it on NPR yesterday. That there was a study showing that women physicians have better outcomes than male physicians for hospitalized patients. And the factors related to that are that women are more collaborative. And they say more nurturing and supportive or empathic with their patients. They take more time. So I believe that some of the qualities that are important for leaders are

situational awareness, emotional intelligence and those are overworked words, maybe, but the ability to be collaborative and not autocratic. That's what I'd like to see. And think that women do bring, and I've seen that among the women who have become department chairs in the departments of surgery in the last few years at Hopkins and Stanford and University of North Carolina and Arizona and a lot of other places around the country.

Tsikitis: That's wonderful.

Deveney: So maybe it could even eventually be many more.

Tsikitis: Very good. Excellent. Thank you.

Deveney: Is there anything else? Is that enough time, or what do you think?

Morgen Young: We've been just about an hour. So looking through what questions, I mean, we could talk a little bit about the department of surgery in general. If you had particular surgeries that stick out in your mind. I've been told by other surgeons that that's a very clichéd question to ask. But from a person who's outside of medicine, I find that interesting. Your colon cancer research. But if none of those topics –

Deveney: Those topics don't, I can't remember any particular cases that come to mind. I mean, they blur at this point.

Young: Sure. I'm sure that they do. Is there anything related to research that you would like to discuss?

Deveney: No. Not my big—the only thing might be a little bit about, I mean, it's really more surgical education.

Young: That's great.

Deveney: So I think changes I could perhaps say a little more about changes that have happened in the department since I've been here, which I touched on a little bit but didn't say too much about.

Young: Yeah. I mean, what we're really trying to capture with these oral histories is the history of the institution as well as individuals associated with OHSU. So anything that you can speak to the broad history. And if you're not feeling well, I can also sit there and ask questions, too. So it's up to you. If you're up for it, we can keep going.

Tsikitis: I'm okay now. I really appreciate it, also, the breaks. Yeah.

Young: Okay. Wonderful.

Deveney: I think maybe like a question like how has the department of surgery changed over the years.

Tsikitis: Yes. Actually, that would be great.

Deveney: That would work.

Tsikitis: Yeah. Absolutely. Yeah. You want me to start? Since 1987 to now, how have you seen the department of surgery changing, and where do you see the department of surgery going towards to at OHSU?

Deveney: Well, it has been a phenomenal increase in size and numbers of divisions and in national prominence, I'd say, since we came here in '87. It started under Dr. Trunkey and then continued under John Hunter, building fantastic divisions of the department and very nationally recognized people. When we came here, there were basically two general surgeons and two surgical oncologists. And they did have urology transplant program, wonderful, already under the leadership of John Barry. But we were a sleepy little place, really, with very low volume and not really well known outside of our area. So it has grown phenomenally. We now have three colorectal surgeons on the staff. We have transplant programs. We have kidney transplant, liver transplant program started, cardiac transplant programs started, thoracic surgery, very highly regarded, a hepatobiliary program, esophageal, and trauma is phenomenal. And that has all come since 1987.

Dr. Trunkey worked hard to establish OHSU as a level one trauma center. And that whole concept of trauma designation has developed. And we're one of the leaders in research in trauma and excellent trauma care.

And so our faculty is huge. Many, many more women in every single division. There are chiefs of division in several. And about a third, I think, of the faculty are women now. And half of the residents are women. And what it has done is create a critical mass of people. And it's only when you have enough individuals of a specific type that is called a critical mass that can work together to make a change in the culture of the organization. And I would say that really has occurred. And that the number of women that are among the residents has now liberated the men to be more humanistic and more concerned about their family life and so on as well. And not be kind of trapped into a corner of having to be macho all the time and created a lot more humanistic environment for us all to work with. It's much more collaborative. And the entire institution is now just very well recognized, I think, nationally. And is a tremendous place to live and work. I mean just, just coming to work and riding the tram is enough to just lift your spirits.

And we're moving into the twenty-first century in, I think, a big way, with a lot of really great programs. And the leadership is really solid to keep moving in that direction. And hopefully do some great discoveries and continue to build the momentum and become leaders of the future. I think that the leadership that we have has really positioned us to do that.

Tsikitis: With the campus expanding now, the waterfront and building, you know, the outpatient hospital, I always found that it would be challenging with our resident, you know, numbers, to be able to cover all our patients. Have you thought about that? Just like being in the everyday grind here and talking about how we're going to cover, when it comes to attendings, you know, down to as we're expanding, how do you see, do you see our residency growing more?

Deveney: I don't think that that's possible.

Tsikitis: Okay.

Deveney: I think it would be, right now is probably a little too big, in fact. My idea about what the best strategy would be to move into the future would be to actually shrink our residency just a little. Because thirteen residents a year is a lot to manage. And it's not really to do the work. It's to learn how to be great surgeons. And there's some overlap. But I think from the standpoint of just getting the work done, I think that instead of having more residents, I think having more mid-level providers who are in the trenches to do many of those tasks is a better use of people's time.

What I see is happening, not just in expansion down to the waterfront, but also moving out into other communities, the institution has an outreach mission at the moment, which I think is extremely important and healthy for a large academic institution to do, to become more supportive of the area that they are operating in and moving out into smaller hospitals and having kind of like spokes on a wheel environment. And I think we would be able to have a separate more community-based residency program maybe under the leadership of one of our partners, like Salem Hospital or, and have almost like our rural program be like that. And then have a smaller nucleus program up here maybe with 10 residents.

And for care of the patients down on the waterfront, I don't think we can really spread residents any thinner, because it really would probably not be safe care. But I think it could be done with some really well-trained advanced care providers. The question comes up of hospitalists, which is a way that some of the other non-surgical departments are using to help take care of the patients in the more outlying ambulatory places or in the ambulatory centers. But for surgery, I'm not sure that that would work very well, because a surgical hospitalist wouldn't really keep their surgical skills up if they were mostly doing patient care. So I think advanced care practitioners would fill the bill a little bit better. And we have that in each of our major general surgery services now. And they're highly skilled and highly effective. So, that would be my way of approaching it, I think.

Tsikitis: Okay. You alluded how we need to make general surgeons well-educated, well-rounded, in order to be able to send them out and handle a lot of problems. That they should not be transferred to a tertiary care facility. With the technology advancing so very fast, and the pressure that we see practicing physicians, you know, the robot came out, you need to get robotic skills. The one, the other, technology and marketing has put a lot of pressure on physicians. And it's become hard even to step back and say, stop, we need to reassess. Cost comes into play in all those things. We want to continue to be on the forefront, on the cutting edge of technology. But we want to also train our residents to be very good general surgeons. Do you foresee that we'll have, if this, a specialty track starts and we cannot stop the wave, and we have them two, three years, do you foresee that we'll have a general surgery sub-specialty? Like do you foresee this as happening like after two, three years, and then whoever wants to continue into rural surgery or general surgery will have like a surgeon track? As they have with colorectal, vascular, in order to meet with all this technology advances?

Deveney: That may be the default that we have to go to.

Tsikitis: Okay.

Deveney: And I guess it would be okay. It's interesting because you never can really, if you look back at what leaders in surgery have said about predicting the future in surgery, they were never very accurate. And I don't think we can be very accurate about what's going to come to pass and what isn't. And I think that some of the technology is misguided. I don't personally think that the robot is going to end up being very important for general surgery. And probably not even for many of the specialties. For certain ones, it is. It really seems to work great for urology and for OB/GYN, in the pelvis. And maybe for rectal cancer only. But unless they change the robots drastically, and get a little more competition for the company, the single company that has a monopoly and charges way too much, I don't think that our economy can really tolerate this continued escalation of cost for medicine. And the advantages aren't there. There is no advantage to a robot for most of general surgery. All it is is more expensive and more time-consuming. And so, unless, unless something changes drastically, another company that is less expensive, more competition, comes on the scene, I don't see that eventually really panning out. Even though the hospitals want to market it as such, eventually it's, in fact, it's at a breaking point now. Part of the problems about healthcare delivery are the extreme cost, which is unaffordable. Our country is at a point where it finally has to face the reality that we can't expend an increasing proportion of the GDP on healthcare and have anything left to do anything else.

Young: Perhaps we can take another pause. Do you have any memories of individuals, colleagues, like Dr. Trunkey, your husband, that you would like to share? Memories of specific residents?

Deveney: I'd rather not do that.

Young: Okay.

Deveney: I don't think it will be—

Young: It won't add anything.

Deveney: It would be concocted. I mean, I can't tell stories very well about things like that, I don't think. I gave a really great president's presentation for the Pacific Coast, but this is not the same environment. I think it would be—

Young: It wouldn't be organic.

Deveney: It would not be organic. It would be just thrown in there, to be honest. Yeah.

Young: Well, if there are any other questions, or any final remarks you want to make... And otherwise, we can wrap up.