Duke Surgery Chief Resident Oral History Project

Dr. Cecilia Ong

By: Justin Barr, 11 June 2021, Duke University Medical Center

Justin: Good afternoon. This is an interview of Dr. Cecilia Ong. First name, C-E-C-I-L-I-A, last name, O-N-G by Justin Barr on the 11th of June as part of the Duke University Chief Resident Oral History Project for Duke University Medical Center. Thank you so much, Dr. Ong, for joining us. I really appreciate it. I was hoping you could start out a little bit with where you came from, where you went to undergraduate, and how you got interested in medicine as a career.

Dr. Ong: Absolutely. Thank you for the opportunity. It's a unique one, to say the least. I was born and raised in Southern California. I grew up and didn't really leave Orange County much in my first 18 years. I am the daughter of two immigrants from Vietnam who came over to the States sight unseen to essentially do college here after the fall of Saigon, and I owe everything now to their debt. They're an engineer and an architect. When I started, I'm only one of only two people in medicine in my family, but both my parents, despite the fact that they weren't in medicine themselves, had a huge interest in it. I think my mom if she had been not the eldest born of her parents and had a little bit more time and financial flexibility would have gone to med school herself. Because of circumstance and because they both essentially came over before the rest of their families to help sponsor the rest of their families to come over, both had to get through school quickly, which is something that none of us in the room have done by any stretch of the imagination. I think they instilled a lot of value in education and also the desire to give back to the community in numerous ways. For me, being somewhat interested in sciences and healthcare growing up from a young age, this seemed to be the clear pathway.

Going to undergrad at Yale certainly gives you a little bit more perspective on things outside of the things that you think that you're destined for. Certainly, I took my time to learn about a little bit of Vietnamese history from a certain Dr. Justin Barr. [chuckles] Got engaged in a lot of extracurriculars. I thought for a brief period of time about doing cultural anthropology after listening and talking with Dr. Paul Farmer for a bit. Little experiences like that have shaped us all along the way. I certainly think that if that had been a stronger influence may have changed my own course. Certainly, I was stuck with the pre-med route. Yale was an amazing time and got to meet some great people.

Justin: Did you go straight through from undergraduate to medical school?

Dr. Ong: I did.

Justin: Any key mentors at Yale that shape your future, shape your direction?

Dr. Ong: Absolutely. There is a different name for them now…The head of my residential college was Dr. Schonttenfeld who was actually-

Justin: Can you spell his name?

Dr. Ong: -S-C-H-O-T-T-E-N-F-E-L-D. I'm now going to blank on his first name. I'm very sorry, Dr. Schonttenfeld. In the past was called the master of our residential college, now, that name has changed. He was a psychiatrist actually through Yale New Haven Hospital that was also the formal head of our residential college. He gave me a lot of life and career guidance throughout my time there. I, early on, had this interest in global health with my own family's background, but then also, again, some of the things that I was exposed to and some of those anthropology and history courses that I took.

It's through Dr. Schonttenfeld, he actually set me up with not only the Yale Global Health Resources but also essentially gave me a travel grant to do some of my work abroad. That really set me up for some of the stuff I wanted to do in the future. I was able to go to Vietnam for the first time after my freshman year and worked with the WHO there, which is in itself a really interesting experience because one, I'd never been and two, the WHO offices are in Hanoi. My mother, knowing that my Vietnamese is rudimentary at best, decided to come with me. She, as a resident of South Vietnam, had never been to the north.

It was a very weird clash of cultures and history, and current expectations, and things like that when we got to the city. For the work that I did there, it was an amazing opportunity to look at the overarching HIV/AIDS advocacy work and legislation that had been passed, especially since the advent of PEPFAR. We were looking at the impact of PEPFAR as a whole in the country. Again, starting on that path, I don't think a lot of that would have been possible without Dr. Schonttenfeld's help. He's one of those that I still remember, still try to reach out to anytime I go back to New Haven.

Justin: Then you ended up coming to Duke for medical school. What about Duke was appealing?

Dr. Ong: Having that interest in global health, Duke's medical school curriculum is a little bit unique in that both of the basic science curricula of generally a two-year medical school curricula is condensed to one. Meaning that it leaves the third year open to do an academic endeavor of some sort. I had an interest not only in the global health space but also in translational medicine or translational science.

I was still trying to figure out where my research and academic home would be, and so I thought that Duke would provide me the flexibility to explore that. I was looking for a bit of a change in scenery, which I definitely got by moving to North Carolina. It just seemed like it was a culture of a lot of academic exploration and diversity.

Justin: You alluded to the fact that Duke students tuition do one research here; you ended up doing two. Do you want to talk about that a little bit?

Dr. Ong: I did. My first year, I caught the NIH bug, which sounds weird and current circumstances. Essentially, I applied to and it was the recipient of an HHMI, Howard Hughes Medical Institute grant to do a full year of funded research at the NIH and actually live on the NIH's campus, which is the closest to a scientific playground that I think you can get. This is the nerd in me talking. With that time, and again, I was at that point, leaning towards surgery already, but still looking at different-- there wasn't a lot of just basic surgical sciences that was interesting to me since I wanted to look a little bit at the immunology side of things.

I worked with the cardiovascular biology researcher, looking at immune responses to arterial or vascular injury, thinking that it would be applicable if I wanted to do-- The thing's still on my list at the time were surgery versus medicine-to-cardiology. I was trying to play the field. It was an amazing opportunity to really hear from some luminaries in the field. It was certainly a time where I started getting exposure and experience with getting lost in a basic science talk after the first 10 minutes. I want to say that that increased my time for getting lost from 10 to maybe 15 minutes, so progress.

It was, again, an amazing experience and I think as has been evidenced by Duke surgery residency as well, some of the biggest aspects of the experience that will stay with me are the people that I met, both, again, those luminaries but more importantly, the people of my cohort. After that, though, I had been talking to one of my Duke med classmates a couple of years ahead of me who, as his research, had done some global health work with a group up in Boston. It was a group that was in its infancy, but its mission statement sounded really interesting. A lot of the global health research that was being done at the time, including my own back in undergrad, was related to infectious disease. Very little was being discussed on a surgery standpoint. At that point, by the end of my research time at the NIH, I was leaning more and more towards surgery, but very little global health research was being done in that space. A lot of it was still mission work and things like that. This seemed to provide an opportunity to look at things from a more academic standpoint, which was really exciting.

I applied to this program in global surgery and social change. Still one of the longest acronyms that I will hopefully ever have to work with, but it was essentially started as the global surgery arm of Partners in Health. We were very much integrated into that system. Again, as a global surgery, or global health acolyte from a young age, this seemed to be the promised land as well. It was an amazingly formative experience for me. We were based out of Boston, but I had the chance to go to Haiti and work with some of the medical oncologists and surgeons at Cange, which was the founding hospital of the Partners in Health system in Haiti. I worked with them at a time that they were actually transitioning to a brand new hospital in Mirebalais, which

was this beacon of new development in medical and hospital development in Haiti. It's very exciting.

I think I hold the distinction of receiving the first EKG at this hospital because we needed to test out the system, and I knew where to put the leads on myself. I had the first EKG in their system. That was two of the most formative experiences of Duke med. All of this was against a backdrop of having great exposure to the surgery department, especially once I came back for my Sub-Is in my fourth year. All of that really convinced me to want to stay here for residency.

Justin: And you did. To go back one year, what was your surgery clerkship experience like as a second-year student, and then how do you think that differs, if at all from the current experience students have on their surgery rotations?

Dr. Ong: Yes, absolutely. I did surgery-- I'm trying to remember, it was so long ago. I think I actually did surgery pretty late in my year and was already started leaning towards it at that point. I was paired with Nestor Villamazar

Justin: Can you spell that name?

Dr. Ong: Nestor is N-E-S-T-O-R, Villamazar, I think is V-I-L-L-A-M-A-Z-A-R, and Jim Padussis, J-I-M P-A-D-U-S-S-I-S, on the hepatic biliary rotations and so fell in love with surg onc right from the get-go. Had Dr. [Brian] Clary as a clinical mentor from very early on, and had two amazing surgery residents who were incredibly kind, really thoughtful, I thought that they were great clinicians. From the little that I could tell from them in the OR, they seem like they operated incredibly smoothly. I was like, "This is what I should strive for." It was certainly not the first nor the last time I would hear some comments from people in the medical school, actually, who were a little bit concerned about my like and desire of surgery. Again, they portrayed me or characterized me as someone who was nice and thoughtful and thought that that would get beaten out of me during residency, if not beyond. Again, I had these two really amazing, I think they were chiefs at the time, to look up to as people who had achieved a lot of good with their clinical careers and still seem to be decent human beings.

Also, during one of my second-year rotations, I think in the ICU, I had the pleasure of working with a certain doctor Michael Lidsky, his last name is L-I-D-S-K-Y, while he was the second year in the surgical ICU, and the level of intensity that he brought to intensive care, no pun intended, has persisted until this day. Again, I just saw some really stellar examples of what it meant to be a surgery resident. The amount of responsibility that they bore on their shoulders, even as residents was incredibly inspiring.

Again, this was back a long time ago, we as med students had a lot more responsibility. We were a hybrid paper electronic chart at the time. We as med students wrote all of the notes and essentially had our residents co-sign them, and so we felt a lot more integrated into the team. A lot more able to, not necessarily

influence, but at least contribute to the clinical care of our patients during that time. I think the way that that's changed, some of the salient changes -- I'm sure some of the other residents have talked about it -- we've restructured how the rotations are run. We have these Sabiston teaching scholars who are surgery residents in their lab years who shepherd these medical students through their experience, provide a little bit more continuity from rotation to rotation, or at least a little bit of standardization. Provide probably a more friendly face than what the average norm is for surgery residents. I think that the students, the ones that I remember really excelling, have to find, or sometimes even create ways to contribute to the team. I think that it's tough, hats off to those who have done it well and gracefully, but it's just a very different environment when I was going through.

Justin: You said you did sub-Is when you came back as the fourth year. What sub-Is did you do?

Dr. Ong: I did both the Dr. Pappas and Dr. Clary sub-Is. I did my sub-Is at the same time as Dr. Brian Gilmore and constantly felt like…there was certainly no direct competition, but when you put anyone next to Dr. Gilmore, they're bound to feel inadequate. Sub-I was on to a time where, especially the way that they were run at the time, we were there for 28 days straight, rounding morning and afternoon all of the cases, all the clinics for our attending and often times the partner attending if that was the case.

I can't remember which one, but maybe for both of them, my fellow was Dr. Kevin Shah. We were both very sleep-deprived by this point. I remember a choice circumstance when -- this was when the Duke Medical Pavilion in the Cancer Center had just been built and I had been away for two years for research, had come back to essentially a brand new hospital, was still getting lost, and felt very disoriented in my own institution. I remember towards the end of my 28-day stint, walking down a hallway, and being like, "Kevin, you can see all the way to the other building. It's so cool." Kevin Shah reminding me that, "That's what windows were created for."

Sub-I was a fascinating experience. Again, was a great way to get exposed to what it meant to be a surgery resident. It definitely increased my level of respect for any resident that made it through these really tough circumstances. Certainly, had some good training that made me want to stay for more.

Justin: You obviously were very familiar with the Duke Surgery Residency Program. What was this reputation like when you were on the interview trail, and then how did you end up picking Duke as a place to stay to train?

Dr. Ong: I certainly got a lot of questions, being the Duke surgery representative, or ambassador, I guess, on our interview trail. I remember both Brian and I fileded a lot of questions along the trail of like, oh, we've heard Duke is so malignant and things like that. Despite the grueling stuff I've experienced that we went through, I think we were already seeing a bit of a culture shift in at least how Duke Surgery Residency

was run, especially under the leadership of Dr. Migaly, who had just, I believe, started to transition to the main PD role while we were sub-Is.

During our fourth year, we had been exposed to the fact that there was an active chair search going on, Dr. Pappas was the interim chair, and all of that. I think that the perception of Duke on the interview trail was that there was a lot of flux going on. Then, added on top of that, this veneer of the Sabistonian era of Duke surgery being malignant. I think that Brian and I did a lot to at least try to dispel some of those myths given that, what we knew of Duke was that there were some incredible teachers and educators and passionate and compassionate people here. That was certainly an uphill battle.

Justin: Was the fact that there was not a chairperson named a concern for you when you were ranking Duke, or you assumed that there would land somebody capable?

Dr. Ong: As a med student, I did not understand what the job of chair meant, what influence that person could exert on the department by any means. I had heard some murmurings, of course, by the residents, but a lot of that seemed to be hearsay. I think that our medical school had actually given us some interview tips and tricks and some guidance in choosing programs. Actually, one of the things that had come up for us, I'm not sure if that did for other people, about looking for a program with stability.

That certainly was in the back of my mind when thinking about the fact that Duke was going through so much flux. I do remember someone here, I can't remember who, was just saying that Duke is for better, for worse, a large ship, and it is really difficult to drastically alter the course of a large ship. I was fairly sure that whoever they chose would not only represent the Duke that I knew but also continue it in a positive direction.

Justin: What year did you start internship and who was in your class?

Dr. Ong: I started in 2014, and in my incoming class were some of the current residents that I'll be graduating with: Brian Ezekian, Morgan Cox, Megan Turner, Soni Nag and two other residents, Brian Gilmore, who took an extra year for research so he's not graduating with us and Tosan Ehanire. E-H-A-N-I-R-E, sorry, Tuson. Tuson eventually at the end of our intern year left to do a plastic surgery residency program in Florida, I believe.

Justin: What was the intern year like for you?

Dr. Ong: A blur. I remember I started the year out at Duke Raleigh because I guess they thought that by virtue of being a Duke student, I would automatically know everything about the Duke system, and so they could throw me out into the yonder regions and be able to float. I think I started on nights, and I remember, I think everyone probably has the story of the first order that they ever wrote. Mine was, I

was asked to write an order for Tylenol for a thoracic surgery patient. I literally thought, do I need to check LFTs? Do I also need to ask the attending if it's okay for me to order Tylenol?

Then I realized it was an over-the-counter meds. There was a lot of that at the beginning of intern year, second guessing myself, not knowing whether this whole doctor thing was going to work out. I think that we've done a better job now, I certainly remember, especially at the beginning of intern year, just struggling to stay afloat, let alone seeing inside of an OR. I remember Sub-I being so busy in the OR, and then at the beginning of intern year just trying to remember how to put in orders without having to get paged five times afterwards to fix them.

I think that it took a while for me to feel comfortable enough to get off of the computer and into the OR. I certainly appreciate when I had the opportunity to do that, but it felt like since that time, I think we've been making more of a concerted effort to push interns into the OR which is great.

Justin: What are some of the other differences you see between your intern experience and the current intern experience?

Dr. Ong: Our current interns, I feel so bad for them that they came in during the depths of COVID, when I think a lot of what got me through those junior years of residency were my cohort and looking up to people ahead of me in the residency and seeing that they made it through okay, relatively unscathed. Also, I think the benefit of having more face time. I think that being said, we've restructured a lot of these rotations already and tried to make it so that the intern burden is a little bit more evenly dispersed and things like that. I think overall, intern year is going to be hard regardless.

I think that these interns have had a significant uphill battle with, again, learning the culture of a program for a program's culture that's been severely changed during the course of this past year. I'm hoping that with getting closer to normal things will feel less weird.

Justin: Any fun stories from intern year?

Dr. Ong: Well, I don't want this to sound like I am beating my own drum, but there is a picture from my intern year that is still up on the wall, again, for six years. It was for an award that I essentially got for trying to convince a patient, it was a trauma patient, to not leave AMA while he still had chest tubes that were hooked up to suction. Somehow in the midst of all of this, this got communicated up the chain and then got to this strength, hope, and caring committee, but that was probably the most intern-iest of intern moments where something that had become so trite to us like these patients have to stay in the hospital trying to discuss that on a level of this particular patient was just really funny. I actually made it through all of intern year without having to do a rectal disimpaction.

Justin: That’s not bad. Have you made it through all of residency or if you never have that opportunity?

Dr. Ong: I had to do one rectal foreign body retrieval, which also required a little bit of that so I don't think I emerged completely scot-free. But I made it really close, because I had to do that this year.

Justin: That’s not a bad run after all. You progress intern year, some people say intern year is the most difficult year of the residency, would you agree with that statement or not?

Dr. Ong: I would.

Justin: What about intern year made it so difficult?

Dr. Ong: I think intern year, the uphill battle was learning how to be the most efficient version of yourself on the computer. There was a little bit of doctoring that you had to learn, but I think everyone reaches their stride sometime between February and April. The rest of that year, you start to feel like I've got this and can start to, again, get into the OR, and feel like you are a true surgery resident. I think the difficulty with the second year is because we're in the intensive care unit a lot and the surgical ICU, again, I did a rotation there, so it felt a little bit familiar, but CTICU is a completely different animal.

That, and then you're pairing it with consults and trauma, which also feels like not only a new experience, but then every single experience is a relatively new one and every rotation is very different than the one before. I think you go through a lot of cyclic…feeling like you don't really have your bearings during the second year. I think it took a little bit longer to feel comfortable with the second-year tasks and some of them, I'm not sure if even, by the end of it, really felt super great about. I think all of that was also misery loves company. I think our classes are at their most cohesive during second year. From that standpoint, I loved hanging out with my classmates even more.

Justin: Any fun stories from JAR year.

Dr. Ong: Only sad ones. Nothing is really jumping out, I think it was all even more of a blur than intern year. I think there were a couple of patients that I had seen as consults who, I think everyone in my class ended up seeing as consults at various points in time. They were these recurring patients, so I think one of them in particular has scarred us all with the number of returns to the ED and the level of complexity of her story. I think the other benefit was, it was a very complicated EC fistula patient. I think the benefit of that was after you met her the first time you couldn't forget it.

Justin: You venture off into the lab, what's your lab experience like?

Dr. Ong: I had a rocky start, so I was initially planning on working with Shelly Hwang. I was planning on working with her in collaboration with a researcher at the National University of Singapore , Duke NUS on a translational project, looking at breast cancer in these different contexts. Again, knowing that I had this interest in global health, but unfortunately in the process of putting together the NRSA grant that we're all required to do, there were some differences of opinion between me and my mentor, Dr. Hwang. The whole concept of the NRSA grant seemed to be dedicated towards ensuring not just that your science was good, but that your mentorship, I think, was the main thrust of it. Again, having never met these people from Singapore and essentially not having enough support from them at the outset of the project to really get a good concept down, get a good training program down, looking back on it, I think that the grant was kind of doomed to fail from the get-go.

Whereas, by contrast, I think some of my other colleagues or the people who have come behind us have had a lot more success with that when they've been able to model their grants off of very directly something else that someone else has done here. That unfortunately led not only to a rocky start, but I was concerned it'd lead to a little bit of bad blood with Dr. Hwang. I ended up still staying to work in her lab, just because at the time there weren't many other surgical oncology-directed translational experiences that I was excited about.

I worked mainly in the lab of Dr. Jeffrey Marks and was able to transition out of what was a dark time to at least be productive. I look back on that time, and it was definitely a process of soul searching and made me reevaluate, of course, now what could have gone better and things like that. I think that all in all, it turned out well. I was able to still pull in a global mobile health component by the end of it, but certainly, it was a rocky experience.

Justin: How did you manage to weave global health into your research experience, and is that a traditional focus of research for Duke surgery?

Dr. Ong: It certainly has not been in the past, especially from the residency side. I'm incredibly proud of what we were able to do. Again, to Dr. Hwang's credit, she was able to pull together this coalition of people interested and of the same mind in dealing with breast cancer. One of the people that I've worked closely with during my project in the lab was Dr. Alison Hall of, currently, Duke Pathology, but not in a month and a half. She was one of the two main breast pathologists that we worked with. She also, I found out later, had an interest in global health.

She and I started talking more about this and then essentially put together a project where we would travel to Tanzania to look at and compare breast cancer between or among African-American and Caucasian women who were treated here at Duke with breast cancer patients in Tanzania, trying to find, again, for Alison and my interests differences in the immune response to the tumor and the tumor microenvironment.

This was based off of some of the basic groundwork that I had done in my own project that had found some distinct differences among these racial populations in

the phenotype of the immune response. Alison and I wanted to continue that among the Tanzanian population. We worked closely with Dr. John Bartlett of the Duke Global Health Institute and actually stayed at his house in Tanzania while we were doing this project. Essentially we collected all the tumor and then Alison was able to bring this all back and she scored all these herself for all the immunohistochemical stains.

We found some interesting findings that the immune response of African women was just phenotypically very different than Caucasian American women and that Black American women were somewhat intermediary in this response raising the question as to whether there's a difference in tumor biology that engenders this difference in the immune response.

All of that is to say that it is not common for Duke Surgery residents to get involved in that. It was certainly fortunate for me to have found that. We have attendings who do global surgery work and other aspects, and I've certainly worked with them, but to have the ability to actually go in-country and collect tumor tissue was quite new.

Justin: Was that well supported by Dr. Miglay and Dr. Kirk or was it you going quasi-rogue?

Dr. Ong: Not at all. Going quais-rogue. Again, through Dr. Bartlett, I feel incredibly fortunate that these mentors have essentially just footed the bill for me along the way. I was able to get this grant through the Global Health Institute to fund the research or to support my travel. All of the research funds were through Alison's own academic allowance through her department. I think I got Dr. Migaly's blessing to go, because going into the lab, we already signed away our, I guess, rights and responsibilities as surgery residents in general, but I felt like I should let 'dad' know.

Justin: Did you ever consider taking an additional year to finish the project or you were at a good stopping place after two?

Dr. Ong: I was at a good stopping point and I thought I'd done enough remedial time along the way already.

Justin: You hope into SAR-1 year. What's SAR-1 year like out of the lab?

Dr. Ong: It was amazing in terms of the operative experience. I still felt like the first couple of months were drinking from the fire hydrant in terms of reminding myself how to talk to, let alone take care of, patients and then operating for the first time in a long time. I started at Duke Regional and many congrats to Phil Fong in particular for shepherding me through that experience. I think again, my first two years, I certainly could have been more proactive about getting into the OR but certainly, did it in full force once I came back out of the lab. It just reinforced for me that it's where I wanted to be.

Certainly, I think that sense of self-doubt and discomfort that we came back to SAR one year with again, not really knowing what to trust of our own abilities, has subsided a little bit. I do think, philosophically speaking, that there is some utility and benefit to always questioning your own abilities and skills and habits and doing things. I felt that there was a lot of benefit, especially coming out of SAR one year or being in SAR one year where you're on services like acute care and trauma and things like that, where you have a lot of different attendings and a lot of ways that these attendings will do things. That can feel very disorienting, but it's also, has become beneficial, at least in terms of exposing me to different ways of doing things. I still think that the most defining experience of SAR one year was being out at Duke Regional with Hope Weissler, who was out there as the vascular junior resident. That's just feeling like we were stamping out vascular disease one amputation at a time. I think there were some experiences out there that felt like they certainly pushed me to extend what I felt comfortable with doing myself.

Justin: Any fun stories from SAR one year?

Dr. Ong: I should have come with more stories. I did try to come up with some.

Justin: What were some of the rotations you did SAR one year? You mentioned the regional hospital.

Dr. Ong: Regional, Raleigh. I do remember that it was one of my first operative experiences back with Kevin Shah, now that I was a resident. I wish I could put into words doing a laparoscopic case with Kevin, where he's seen me go from learning how to drive the camera as a sub-I all the way through to learning how to operate with sticks. Somehow him feeling the same amount of disappointment for both experiences. I've been thinking about hepatic biliary this whole time, but one of the cases that really gave me a newfound respect for it was when we had to do this re-operative--. It was a person who'd had recurrent, upper GI bleeds, and so had had multiple embolizations and ultimately somehow killed off his spleen. We were trying to shuck out this dead spleen. I think on a number of occasions, when we were elbows deep, Kevin and I kept looking at each other and reminding ourselves that this is the life that we had or will choose for ourselves. Somehow that being a mantra for us to get through what was ultimately I think a seven-hour case.

Justin: Sounds agonizing. You liked him enough to give him a teaching award this year?

Dr. Ong: Yes. Again, similar to what I was saying about Dr. Fong, I think Kevin also seeing us at Raleigh, we were just out of the lab, taught us a lot about laparoscopy and taught, if not exemplified the value of patience. The fact that I will forever hear in my head, "Uh, No, no, no.-- Okay." [chuckles]

Justin: I don't know how that's going to be transcribed.

Dr. Ong: I don't either. Good luck.

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Justin: You mentioned that you're already considering hepatobiliary at this point. You said you had a positive experience on the services as a sub-intern . Can you talk a little bit about your career choice and moving into hepatobiliary, when that solidified, and how you tried to sculpt the final years of your residency to maximize your future?

Dr. Ong: Sure. I again, did one of my sub-Is and even as a second-year worked with Dr. Brian Clary who, shortly upon me entering to surgery residency, decided to leave and go be chair UCSD. I tried to not take that personally. I have visited him at San Diego since, and he has assured me that it is not personal. Dr. Clary was again one of those first people who I'd saw my first Whipple with him, saw the level of meticulousness that he brought to what was initially an incomprehensible operation. By the end of it, especially now having the operative experience I do, just seems like still wizardry, but more comprehensively so.

I was just really drawn to, again, the level of complexity of the cases, the amount of interplay that we had with other disciplines, and coming up with these plans. Still time and time again, in most of these multidisciplinary discussions, the ultimate say, coming down to what the surgeons were technically able to do. It just felt like this constant challenge to not only the surgeons on this call, but to me myself, like about, "How good can you be?" This is one of those fields that, to me, feels like, it'll be a technical challenge through the majority of my tenure.

It just was very exciting, if not humbling to me, to just constantly being in that position. Working with Kevin out at Raleigh really solidified that, and going into SAR 2 year, tried put some of those rotations early on. I ended up working with Dr. [Sabino] Zani on his rotation early on, I think in the fall of our SAR 2 year. That was really the first-- I'm trying to think. We'd had some robotics simulations and things while we were in the lab, but it still felt like we hadn't even mastered how to do open, if not, laparoscopic surgery. Robotics just seemed like this unattainable goal.

Dr. Zani, through a lot of persistent communication, drove home to us that each of us should be able to develop some set of robotic skill set. I can't say that I did it much. It's more of a see one do one, teach one at that point. I do think that the robotics certification program and things like that, that again, the junior residents were getting a lot earlier than we have now, has made huge strides in our level and my personal level of comfort. This thought that now, looking forward, that I actually want to have MIS and robotics as a significant part of my practice. It's made it just feel more attainable.

Justin: What was SAR-2 year like for you aside from Dr. Zani's robot service?

Dr. Ong: Getting the first opportunity to work with Dr. [Peter] Allen who, I think that again, I will not be the first nor the last person to say, is probably one of the best additions to do surgery that we've had in the past couple of years. I didn't work with him that much SAR-2 years. I think the rest of our SAR 2 year was also starting to gain more-- At least forcing myself to think more independently in the operating room

during the conduct of a case. I think SAR 1 year, again, like to mimic the progression of my intern year, coming back out of the lab was just learning how to work with my hands and make my hands do what my brain wanted them to.

Then I think SAR 2 year was development of more of this operative decision-making, that I think I had taken for granted SAR 1 year, again. Only certain attendings will really let you into the decision-making behind why they're doing one thing versus another. I think SAR 2 year I really challenged myself to do more of that. Again, nighttime operating with the trauma and ACS crew and things like that, you are given those reins a little bit more frequently, again to people like Dr. Agarwal's credit, Dr. Montgomery. Now, looking forward to this prospect of giving trainees the reins, it's just terrifying, and for them to have let us do that to such a great extent was an amazing learning opportunity.

There are still times where I hear Dr. Agarwal on my brain saying, "Why don't you just caribou that?" which, to him, is using the kitners to essentially tear through some tissue. It's a very effective way to do things; it just hurts me from a hepatobiliary stance. Like all of those, again, to echo what I said about SAR 1 year, getting exposed to different people's ways of doing things and then find something that worked for us, was an amazing, illustrative experience.

I do also think that SAR 2 year, being a bit closer, both in age and then I think emotionally to the chief class, when I was a SAR 2, I felt pretty close with Jeff Sun, Alice [Wang] and Hang Hang in particular. I think as juniors, we didn't really get a sense for how this department was run as a whole. We were, again, passive observers and recipients of how the department was conducted. Again, being that SAR-2 role and then seeing them as the chiefs and getting this preview of what our lives would be as these chiefs, I think the things that generally made it to our ears were usually things that are a little bit more cynical and sarcastic.

Again, understanding these personalities too, it also makes sense. I think that that also changed, not necessarily changed the tone, but I think that was also part of my growing up process. Again, I'm a pretty optimistic person in general, and probably a little bit overly so. I think that that was one of the first circumstance-- not the first, but a very clear circumstance in which there were other ways to interpret what was going on in the department and some of the changes and things like that.

I think some of the most fond memories I have of SAR 2 year were, again, overnight operating on big traumas and things that, as a sureg onc fellow, I don't think I'll see ever again. I think it also demonstrated for me why I am more suited to hepatobiliary, where you can plan out as much as you can, to the fullest extent everything that you want to do. Hats off to people who can go into a trauma scenario and just be able to make stuff up on the fly. I'm not one of those people.

Justin: Got to know yourself.

Dr. Ong: Yes.

Justin: During SAR 2 year, COVID-19 hit the world. How did that affect your experience as a resident?

Dr. Ong: On the surface of it, it certainly felt like I wasn't going to be in the operating room as much. At the beginning of our time, we did do a platoon system where the residency was broken up into thirds, and only 2/3 of the entire compliment was in the hospital at any one time to at least keep some fraction of us out, as we're learning more about how the disease spread and things like that.

I think on the surface, looking at the schedule, it may have looked like a vacation, but I think for us emotionally and mentally to think about-- With so much uncertainty about the disease process and things like that, for me, being one of only two people in my family to be in medicine and fielding a lot of questions from my family and also not knowing how to answer or address their uncertainty and concerns, and then feeling like there was-- Especially of the early stages of Duke's response, again, I feel like uncertainty is the best way to describe it, but that there was not a lot of standardization in terms of how things were being responded to and things like that.

I think it felt very amorphous and unsettling at the very beginning. As we got into it though, I think that Duke's response seemed to be in line with many of the other academic institutions of its size. I got the chance to speak to not too many of my other friends who are in other programs, but certainly felt like Duke was still supporting us as a training program and things like that, trying to keep us safe. I certainly remember that there are circumstances, though, that felt like rules and regulations were being made up on the fly which, again, understandable, given how much the situation was evolving at the beginning.

I do think that being a senior at the time meant that we weren't directly dealing with as many COVID-positive patients. I can only imagine the mental burden that the juniors who were in the ICUs taking care of these patients day by day were having to go through. I only remember for myself feeling this sense of uncertainty and a little bit of fear going into every patient encounter, coming home at the end of the day and things like that, but even that started to subside.

I think that from an operative standpoint, we were certainly concerned that our operative exposure in volume would suffer. I think at the beginning, it certainly did. I know that now, looking at the numbers in hindsight, it seems like we've recovered and rebounded. I don't think that I'm graduating with any numbers that are in any way not comparable to those of graduating classes before us, but it certainly feels that if there were rotations that you were going to be on during the midst of COVID and to be honest now, I can't even remember, because it all felt like it glommed together. I think I was supposed to be on maybe another surg onc or colorectal service and I was pulled off of that and things like that. I think in the grand scheme of things, things ended up evening out, but for those first couple months, it just felt very unsettling.

Justin: Part of this first covid months, of course, as you're transitioning from SAR-2 to chief, what's it like to be chief after you've been here 12 years?

Dr. Ong: It is certainly a different perspective. My first month of chiefdom was in November of this year and-

Justin: You mean as admin chief.

Dr. Ong: -as admin chief, yes. I think to answer the broader question of being chief, people kept telling me and continue to tell us that this is the most responsibility that we'll ever get in our academic careers which is, I guess looking back on this, frustrating, but then also enlightening about the rest of how academic surgery is structured. There is a certain amount of respect and things that you get, but to everyone's credit, I think the family environment of Duke Surgery is such that as you get more senior, I think you're given a commensurate amount of responsibility and respect anyway.

I don't know that me being an admin chief and banging my chest about that really changed much of anything. I will say that being admin chief again during the month of November was when we had our first COVID-positive residents in the program…

Justin: For the record, that was me.

Dr. Ong: -[laughs]. I didn't want to out you officially on the Duke archives. HIPPA and all that. It was you and another resident. This was, again, COVID-confirmed, who knows how many other residents may have been COVID-positive before then, but it was also a time where, again, this fear surged again about what potential impact this was going to have on our residency compliment and things like that, but more importantly, for each of these resident, there is such a diversity in terms of how COVID affects people that we had no idea what it was going to mean for your training overall, how long you guys were going to be out for, whatever lingering effects might be persistent and things like that. For me, I think that was probably one of the bigger emotional burdens, because I was concerned that you guys got it from work. For us to feel like whether there was more than we could have done to protect our residents or things like that, all of that was [/] and I think certainly made me feel-- If there was ever a time where I felt like leadership had lapsed, it was somehow that I felt somewhat personally or emotionally responsible when people became positive.

I think the other flip side of this was that the residency showed an incredible amount of support, at least I hope. It felt like that. When residents needed to be on things for COVID, quarantine and things like that. I am very proud of both Drs. Kirk and Migaly for financially even more so than their emotional support but for financially supporting residents during that time. I think looking at Dr. Migaly's response even now with, again, some people who might have some lingering effects and things like that, I think that it's demonstrated how much the leadership, again, especially Dr. Migaly cares about us as individuals, not just as cogs in the machine.

That being said, I think that there's a huge diversity in terms of even the leadership's response and how much we interacted with them, how much of a physical presence they felt during COVID and things like that. I'm very interested to see, after everything starts to return to normal, what vestiges of COVID remain after that transition happens. I think that being an administrative chief or being a chief during this time-- We were reflecting on this earlier today that some of the biggest goals that we had for a chief class at the beginning of the year were mainly just to promote and encourage unity and collaboration within the residency.

I know that chief classes of yore -- And I think your class in particular -- have far loftier goals than we did, but I think in the context of COVID and seeing what a toll it had taken the last couple of months of SAR 2 year I think made a huge impact on what we prioritized or wanted to prioritize moving forward. Again, I've alluded to some of the struggles that the intern class has gone through. I can imagine maybe not feeling as integrated into the residency because we haven't had some of the big banner events and items that would make them feel welcome to this program.

I think this also brings it back to what and who really drives the culture of the program. Is it from the ground up or from the top down? I think throughout this year, a lot of those questions have swirled with our class, again learning if and how to lead and learning how to lead a little bit remotely and how to inspire people to align with the culture that they don't necessarily experience or understand yet. I think that those were some of the major challenges and struggles that COVID provided us on a day-to-day, other than, again, more of the firsthand or secondhand experience of dealing with COVID itself.

Justin: You've been at Duke for 12 years and associated with the surgery department for much of those. What changes have you seen the surgery department undergo in that decade with Allan?

Dr. Ong: [laughs] Decade with Allen! It has been quite a long time. I think that when we first came in, especially with Dr. Kirk first joining, again, I had the experience of seeing when Dr. Pappas was the interim chair before we signed up Dr. Kirk to join that role. It felt like it was a department that was certainly geared towards an education of the residents, but I didn't really understand how cohesive it could be, I think, until first Dr. Kirk really got here and almost led by example by hosting and rounding with us on chair rounds.

I still remember to this day his comments to us at the about halfway point in the intern year. Again, this was his first year as chair. Still, to this day don't know whether it was prompted by some perception that things had gone wrong or it was just that he recognized that it was doldrums in the year and wanted to reinvigorate us and our work ethics. He gave us all a talk in the seventh floor conference room that essentially culminated with, "We needed to be not only better, but we needed to be the best that we could because patients were entrusting us. Patients were naked, cut open and paralyzed on the table and trusting us with their lives. I think that that has stuck with us to this day. Again, some of the concerns are that Dr. Kirk hasn't been

able to give that talk to the current interns. How much of that has to come from him versus how much of that comes from watching what I think are very strong residents go through and have the same level of personal responsibility that he instilled in us that first year.

I think that is one of the things that maybe has changed, again, difficult to extricate from the effects of COVID in particular. I think some of the other things I look on the current residents in lab, the academic interests that my own class has come out with and I think that there is a diversification and broadening of what I think it means to be a Duke surgery resident and an academic surgeon within the Duke confines.

I think that that's been a wonderful process to see because I think, again, as a junior resident coming through and seeing all these chiefs come through with basic science credentials, and things like that, it made me feel like I was going to be less of an academic surgeon by not completely adhering to that model. I certainly think that there's become a more all-encompassing definition for what an academic surgeon can mean, and I think that that's huge.

I think the last thing, again, I haven't met the incoming group of interns, but being involved in that search process, again, made me look back on my own application, going from med school to residency and being like, "I would have never gotten into this program today." I think that the standards and what students behind us are achieving is incredible. It does also make me concerned about what the ceiling, if there is ever is a ceiling, what that's going to look like. It's a little bit terrifying.

Seeing the amount of care and thought that goes into crafting each class and adjudicating and evaluating each of these applicants was incredibly enlightening. I know that Dr. Migaly this year has also put in a huge amount of effort that has paid off in terms of looking at more diverse criteria than I think we have in the past. I think that, again, being someone who maybe didn't fulfill or maybe fit the numbers game that maybe previous classes of surgery residents may have adhered more closely to, I really appreciate this idea that we're looking for more broad criteria for our applicants and for the people who are going to join and become Duke surgery residents. I'm glad to see some of that taking shape as well.

Justin: You've spoken very highly about Duke Surgery and seem to have an overall positive impression of the place, but no program or residency is perfect. If you had a magic wand, is there anything you'd want to fix about Duke Surgery?

Dr. Ong: Sure. Again, you know me. By nature, quite optimistic. Again, going through my own lab experience and things like that, looking back would have definitely benefited from more direct mentorship and guidance and sponsorship. I think that that's become something that again, to ask the trainees themselves to seek that out is certainly a way to approach it, but I think now, the structures and potentially their personalities are probably more better-suited to providing some of that mentorship and guidance.

I also think that there's been a shift in the residency and so I think, again, like the senior residents that I had when I was growing up as a junior resident were of a very different personality type than I think that we have in our residency now. Not necessarily that I would change any of that, but I certainly I think could go back and tweak some specific interactions I've had with other residents in this program throughout the years. Again, I think overarching things aside, I think we have a great group of residents now. I think the main things come back to mentorship. I certainly think that there are ways in which we are doing better now.

Justin: That's certainly good to hear. Where are you headed from Duke?

Dr. Ong: I am going to be doing Surgical Oncology Fellowship at the University of Chicago, starting in about a month and a half.

Justin: Well, that's exciting!

Dr. Ong: It is.

Justin: How do you see your career playing out from there?

Dr. Ong: I am hoping to be specifically focused on hepatobiliary and still maintain this academic presence of being both translational and looking at the global space. As many people, including Dr. Allen, have reminded me in the past, it is a little bit of uncharted territory. It'll take a lot of intentionality. I think I've benefited in the past of a a lot of serendipity as well of meeting like-minded people. I can only hope that, again, the hopeful mentors that I have at the University of Chicago are already aligned in this way.

I'm hoping that I can translate my experience in breast cancer to more hepatobiliary malignancies as well. I'm hoping that I can continue this mentality of being a Duke surgery resident through and through, because I think it has really made me hopefully the surgeon I will be in the future, but it has made me the surgeon I am now.

Justin: Well, that's certainly awesome. Anything I didn't ask you that you want to make sure we get on the record?

Dr. Ong: Well, these last couple of days and weeks have been this process of both fear and nostalgia, and looking back on our experience and then looking forward as well. I felt over the past couple of weeks that it won't feel real until I start turning in my badges and start turning in my pager. Then one of the last most formal things that we'll do is sign our photos for the Duke Surgery wall Hall of Fame, Wall of Fame. It was told to us that one of the previous classes had essentially chosen one of their favorite attendings to mirror their quote for posterity.

Dr. McCann passed away this year. I guess, to go back to one of the regrets that I have is that since he passed during COVID and I know that there are a lot of still

restrictions about gathering and things like that, we still haven't really been able to give him a formal memorial service. It's scheduled for October, but even the department hasn't really--We felt it's been a little bit lacking, but we were able to find Dr. McCann's picture on the wall, it is still up there, and so we, as a class, are all using his benediction as our quotes for the wall.

Justin: What is this benediction?

Dr. Ong: I will read it to you. It's probably in typical McCann fashion. I don't want to get it wrong because I can't misquote Dr. McCann:

“To Dr. Sabiston with sincere appreciation, Richard McCann.”

Short and sweet, but with his quintessential mustache.

Justin: Well, as you mentioned, very McCann-like. Well, thank you much for your time. I really appreciate you sharing your thoughts.

Dr. Ong: Thank you.

Justin: I'll get the transcript to you shortly.

Dr. Ong: Thanks, Dr. Barr.

Justin: My pleasure.

[01:09:15] [END OF AUDIO]