INTERVIEWEE: Kathleen Clem
INTERVIEWER: Jessica Roseberry
DATE: June 26, 2007
PLACE: Dr. Clem's office, Duke North

CLEM INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry, and I'm here with Dr. Kathleen Clem. She's associate professor and chief of Emergency Medicine in the Department of Surgery. It's June 26, 2007, and we're here in her office in Duke North. And I want to thank you so much, Dr. Clem, for agreeing to be interviewed.

KATHLEEN CLEM: You're welcome.

ROSEBERRY: I appreciate it. If it's all right with you, if we might start with just kind of how you came to want to be a doctor—if that's all right with you—we'll do a little background there.

CLEM: I was first was inspired to become a physician when I was working at NIH [National Institutes of Health] the summer following my graduation from high school. I was doing some research in the virology department under George Todaro and Dr. Ernest Plata. I had been planning to go to college following my work there that summer. And I had mentioned that I was planning to become a nurse to Dr. Plata, and he said, "Well why don't you become a doctor?" It hadn't even occurred to me that I could do that. All it took was for somebody to actually say that to me, and the light bulb went off in my head, and I said, "I want to do that." I'm the oldest of four children. My father conducted the National Symphony and the National Choral Foundation. His choral group opened the Kennedy Center in Washington, DC. My mother was a nurse. We didn't have a whole

lot of money. I had chosen a nursing career partly because I really liked the things that pertained to medicine, and partly because at that time, there was a national shortage of nursing, similar to now. I was able to obtain a full scholarship to college under some federal loans that were available for nursing students. What I elected to do was to begin to take my premed along with my nursing. When I started college, I had decided I wanted to eventually become a physician. I truly had no money to go to college. With four children, we just didn't have college funds. So I actually got my two-year degree in nursing. And with that, I was able to become a registered nurse and complete my college while working as a nurse to obtain my BSN [Bachelor of Science in Nursing] and complete all my requirements for medical school. At that point, I applied and was accepted to med school. But in the meantime, I had married and had two children. At the time I started medical school, my children were five and six. I fell in love with emergency medicine while I was working as a nurse in a little tiny hospital up in the hills of Tennessee. (I was completing my—we were in Tennessee when I was completing my premed and my bachelor's degree at Tennessee Technological University.) There were only three physicians staffing this small hospital, I think there were seventy beds in the whole hospital—at night, the physicians would go home, and I would be the only registered nurse in the hospital along with some licensed vocational nurses, and some aides, et cetera. And I was taking care of the Emergency Department. I was delivering babies. I was running codes. And I said, "You know, I really should get the education for this." And yet, I realized I liked it all. So when I started medical school, I already had, as part of my dream, to become [an] emergency physician. And indeed, that did happen. I completed a residency in emergency medicine, was chosen to be chief resident.

Interestingly, I didn't apply for that position. I was chosen by my peers and the attendings, and I initially declined the position. And they said, No, we really want you to do it. And so I did. But it wasn't ever something that I started out in residency, thinking I wanted to be the chief resident. Unfortunately, while I was chief resident, the private contracting group to which all the emergency medicine physicians belonged had to leave, because the school of medicine decided they wanted to have all the attendings in the Emergency Department as faculty members. There was a non-compete clause in their contract that would not allow them to do that. Well, the hospital and the medical center scrambled quickly to fill all of the open positions in the Emergency Department, and unfortunately they didn't fill them with people who would be approved by the residency review committee. Many of them were not board certified or appropriate to train residents. And so the RRC—Residency Review Committee—actually pulled the entire residency from the program while I was chief resident. So that meant that I was now in charge of journal club, organizing all of the resident conferences, trying to make sure that my colleagues and I received a good education—literally, without attending guidance. And I don't know if I was just naïve or what, but I just sort of took it in stride and dealt with it. This quality was noted by the leaders at the school of medicine, and they actually asked me to stay on once I finished my residency—as an attending—and to chair the search committee to re-establish the emergency medicine residency for them. So I did. And I recruited the new chair, the residency director—I pulled multiple faculty from around the community where I had been moonlighting as a resident and built the program. And, indeed, it was successful. This was at Loma Linda University. So while I was at Loma Linda, I became very interested in international emergency medicine. I

was asked to go on several mission expeditions, where I was the expedition coordinator—physician—for the group. And I really enjoyed that. So, as a result, I started one of the first international emergency medicine fellowships in the country. They are now multiple across the country. John[s] Hopkins and Loma Linda were some of the first that had these fellowships. And it was very enjoyable to do that. Now it's become very popular. There are journal articles written about it—their curriculum is out—and many, many medical schools across the country have these programs. I, at that point, felt I had the best job in the whole world. I was being sent three months out of the year to go on mission expeditions, had practiced medicine in nine different countries, started [an] emergency medicine residency training program in China—was just loving it. And then my husband received a job offer out here—really, his dream job. And since he had been following my career around for a few years, I decided it was his turn. So we came out here to North Carolina. And I looked at all of the different options for an academic position in the area. I looked at UNC [the University of North Carolina at Chapel Hill], and—at all of the academic medical centers within an hour to two-hour drive from here. And when I walked into Duke—I just have to be honest and tell you that I walked in, I looked at that old, run-down Emergency Department and saw how it was being run, and it was being run like emergency medicine had been run twenty years ago. And I said, "This place needs help. It can only come up. I'm coming here." And so I decided to come to Duke, with the idea that I knew it was going to improve, and I had already done something like that before—built something from the ground up and enjoyed it. I could see myself doing it again. I was here four months when the chair for Surgery called me in, and said, "Kathleen, we would like you to be the division chief."

Well, I had already been involved in several search committees. I'd expected to come to Duke and be in charge of international emergency medicine and a good team player, that's what I felt I was good at. So I told him no. I did not think that I was the right person for this role, that he needed someone with a lot more experience to work at a place like Duke, where the institution is so well-established, and the level of excellence is so high. He was—to his credit, he was very supportive. He said, "Well, what's keeping you from doing it?" And I made a laundry list of the things that I felt were important for the upcoming leader to have. And he said, "We'll help you get all those things." And he was good, he kept his word. He sent me to ELAM—the Executive Leadership Course in Academic Medicine. There was also a course at that time at Fuqua, for administrative leadership, that we—that multiple of the faculty had been taking. He assigned people to help me with the budget—just whatever I needed to succeed. I have to say—to his credit, he kept his word. And I developed a very detailed twenty-page strategic plan, and began working on it. The biggest roadblock that came up early on was that we needed to have a residency training program here. And, indeed, I had to let virtually all of the faculty that were here before go, because in order to have a residency training program, you have to have faculty who are residency trained and board certified in emergency medicine. The faculty that were here at that point didn't meet those criteria. So we had to let them go. And that made some very rough times for the early part of emergency medicine. And that being one of my first roles as a division chief—to fire 90 percent of the current faculty—didn't make me very popular. Not only in emergency medicine, but in—with my colleagues outside of emergency medicine. I can't tell you the phone calls I got, and the e-mails, and: "Why are you doing this? This is a wonderful doctor. I don't want this

doctor to leave Duke." It was very difficult for me to have to let those people go, but I knew it was the right thing to do. And I knew that emergency medicine would never reach a level of excellence that it needed to reach unless we had a residency training program here with physicians who were board certified residency trained emergency medicine. So I recruited an entirely new staff, with exception of two physicians who had grandfathered in. However, neither of them had completed a residency training in emergency medicine. And—as far as I know—I am the first residency trained board certified emergency physician to practice at Duke. Next I recruited a program director, and we worked very hard to become ready for—to begin a residency training program here. It was touch and go right there, at the very beginning, because in 1989, the Balanced Budget Act was passed, which essentially put a cap on the number of residents that you can have in any training program across the country—or, actually, not in the training programs, but in the total for each hospital. And Duke had already superseded their cap. So there really were no monies to put toward developing a residency training program, unless you paid for all of the residency slots *de novo*. And that's a very, very ambitious goal, to be able to start a residency program without any outside funding. So, essentially, the dean had to take residency slots from other services. That also didn't lend to our popularity. You can imagine cutting down the number of resident physicians in other programs. If that had not succeeded, I would not have stayed at Duke. Because that was pivotal to me, as to whether or not we would succeed in developing the program.

ROSEBERRY: The residency program?

CLEM: Yes. Developing a residency training program was pivotal in the whole process. It indeed was started, and approved, in 1993. And we received full accreditation from the

first visit from the ACGME [Accreditation Council for Graduate Medical Education] residency review committee. I continued to recruit faculty. We then established, in 2005, the Emergency Medicine Research Center. And we now have about twenty research projects, for which emergency medicine serves as PI, including NIH-associated grants—in collaboration with other services, and in collaboration with the Duke Clinical Research Institute—DCRI. One of the other things that I said from the beginning, when I first walked in, is, "This emergency department is ugly. It has to change." And so I went to the Medical Executive Committee, and I showed them photographs of their emergency department. I showed them the conditions that our patients were in. They said, Okay. Plan a new emergency department. I said, "What's the budget?" And they said, Well, just plan it. So I planned it. Came back—and it came back with the—it came back with what I felt was probably one of the world's best emergency departments. I mean, it had everything. And then when they unveiled the price tag, and it was ninety million, everybody kind of choked. And they said, I don't think so. And I learned a lesson there. So, went back and to re-plan, and I cut it by two-thirds. It came down to thirty million. At that point, it was approved. And right now, I'm sitting in my brand new office that's a part of this new renovation. We are scheduled to open up the entirely renovated, expanded Emergency Department the end of this year. The new part is beautiful. We still have some work to do on the waiting room and some of the other areas. But it's definitely a huge improvement. And I'm seeing that my patients are really appreciating all of the efforts that were made to make this a beautiful place. When I was working with the architects, I looked at the front of Duke Hospital, and I saw the circular drive. It's really an impressive institution when you walk up to Duke North. It just speaks of

healing. It speaks of competence. It speaks of professionalism, and it's inviting. So I wanted to design the front of this emergency department to look similar, because I consider the Emergency Department the other front door of the hospital. And if you drive up, indeed it does look like the other front door of the hospital. I wanted my patients to feel welcome from the start. Parking is always an issue, so I asked that we start valet parking so that my patients don't even have to worry about where to park their car. They can come in immediately. We now have a very healthy emergency medicine residency-training program. We have a strong group of faculty that are budding researchers—many of them strong researchers in several areas—and strong clinicians, and educators. And in fact, three of my faculty have won national awards for their education service. Most of my faculty are involved in national organizations such as the American College of Emergency Physicians and the Society for Academic Emergency Medicine as leaders. And I think that it's a success. One of my favorite sayings actually came from the president of MIT [Massachusetts Institute of Technology]. He said that the analogy for a pipeline—for people coming in to medicine, particularly women, is not entirely accurate. Liquids not people move in pipes. People move in stops, starts, they go around corners, they go up hills. They leave, they come back. And I think that's particularly true of women. I've had a very circuitous different course than you would, say, if you were going to write what would be expected for a CV [curriculum vita], for someone to be the first female division chief at a place like Duke, in the Department of Surgery. When I talk to successful women all around Duke, particularly on the Faculty Women's Committee, every one of them has a very unique, different story to tell. (And I know you know that as a historian.) But I think that's particularly true for women. And

one of the things that works is to embrace the fact that there's diversity in the paths, there's diversity in how women think. And if that is embraced and nurtured for the long term, you're going to reap positive results for the institution—and for the good of medicine for the country—that would not be realized otherwise. And I absolutely have felt that here, in the fact that I've had people who were willing to invest in me, to make the process work. And by giving me an opportunity, I've been able to be successful. Duke emergency medicine is at a level that it would not have been had Duke not said, Okay, take this goal, run with it, and let's see what we can do. Now, has it been easy? No, it's not been easy. Nothing worthwhile ever is. I would say it was quite intimidating, to walk into that first division chief meeting in the Department of Surgery up in the library, where I was the only female sitting in a group of Caucasian, older men—very powerful, a lot of gravitas in the room. And I'm a blue-eyed blonde, and when you talk to me or look at me, the—power is probably not the first thing you think of. But I'm fearless. (*laughs*) And so I kept at it. And it was interesting. I do things that are uniquely feminine. For instance, at the holiday time last year, rather than just send out corporate cards, I actually took the time to write a note to all of my colleagues who are also division chiefs in the Department of Surgery. And I included a note about what I appreciated about working with them, and the collaboration that we've done, and why things are better because we work together. And I got one letter back from a division chief who said, "In all my years at Duke"—and he listed the number, and it was impressive—"I've never gotten a letter—a note—like that from somebody." He said, "I guess that's what happens when you let women in medicine." He says, "I hope you know how much I enjoy working with you." So I was impressed that he would even take the

time to reciprocate. I think that I've brought something else here that wouldn't be, other than just program developments, and that's a culture change. It's absolutely known in the Emergency Department that we have to be professional. I expect the people who deal with us to be professional. I expect people to be courteous. I have a saying, "We don't give it, and we don't take it." And I mean it, for my faculty. So I expect when the other services come down that they treat us courteously, and my faculty are expected to do that. And that has had repercussions with my residents, too. I will tell you, that wasn't true when I got here. They were yelling in the trauma rooms, people throwing instruments, obscenities. And the respect for emergency medicine was not there. That's no longer true. You will not see that happening in this emergency department. It's a different world. The culture has changed, and I think it's for the better.

ROSEBERRY: How have you been able to—in that room full of men, how have you been able to kind of shift their thinking?

CLEM: Well, I'll have to be honest, and—I did a lot of listening. I was very quiet. And I still am, when I go to division chief meetings. First of all, I'm not a surgeon, and I'm in the Department of Surgery partly because they don't know what to do with emergency medicine. I think what we need to do is become a full department. And I think that the move toward that is underway. But because I'm not a surgeon, a lot of the things don't apply directly to me. But on the things that do—and the things that did—I would listen very carefully. And my approach is much more one on one. I would talk individually with the other division chiefs and with the chair, regarding the changes that I think needed to be made. So I would say that I'm a quiet force for good. Even though I'm really not shy. I do a lot of behind-the-scenes work. There are downsides to that. For

instance, if you think that this whole Emergency Department and all of this came about just by accident, and it just happened—no, it happened by a lot of collaboration and by leadership behind the scenes. And yes, there are people who helped. I absolutely could not have done it by myself. But there's been somebody here pulling it all together, and that's been me. And when they had the official groundbreaking ceremony for this new emergency department, I wasn't even listed as a speaker. I was invited, like anybody else, just on the ollie, ollie-in-come-free e-mail. I wasn't on the schedule. And when they were ready to have the photographs with people—with the golden shovels and the little hard hats, I wasn't even listed as someone to be in the picture. And I said, This is not right. I couldn't put myself on the program, but I knew I belonged there. So I went up, and I took a shovel. I put a hat on, and I said, I'm in this picture. And I am. So. And I think a lot of that is gender-based, absolutely gender-based. Because the people they invited to talk were men. There were no women invited. And it was hard. And then when they had another opening ceremony—when they opened up the new part of the ED [Emergency Department]—they announced it for a time when I was going to be away at a professional meeting. And I had said, "I can't be there at that time. I would really like for you to change it." They went ahead and had it without me. I honestly don't believe if you had the—if it had been a brand new orthopedic department, that you would open that up without the division chief for Orthopedics being there. But somehow or another, it just wasn't important to them whether or not I was there. And I think that's gender-based. However—I'm telling you this just because I'm going to say that there are issues having to do with women. On the other hand, I'm tougher than that. I actually know the truth. And I know this place wouldn't be here without my influence. And it's okay. I

can deal with it. The reason I care is because of the people coming up behind me. And if I don't make a difference, those kind of things will be perpetuated for the women coming behind me. And that's not okay. So for that reason, I make sure that those issues are addressed, and that we move forward. In the strategic plan that I developed, the only thing we have not accomplished to date—and this was eight and a half years ago—is that we are not a full department of emergency medicine. And I would like to be a chair. At the present time, that opportunity is not here for me at Duke. And as a result, I have chosen to take a position somewhere else, and I'll be leaving in two months. And I will be chair at another institution, where there is a department of emergency medicine. But I feel good about what I've accomplished here. Emergency medicine is better throughout the country because of what Duke is doing, and certainly my patients are better cared for here at Duke as a result of the work that all of us have done over the last eight and a half years.

ROSEBERRY: So would say, overall, that you were—you felt not supported in the changes that you've made? Or—

CLEM: I think I have been personally supported. I think that—and I think that the institution has, indeed, responded to what has happened. But I'm not going to tell you that it was easy. It wasn't like I walked in, and I said, We need this, and they said, Oh, okay. Great idea. It was much more of that I had to do my homework, and I had to go from office to office with a dog-and-pony show, over and over and over again, to get each of the changes made. I had to enlist allies, I had to develop multiple allies, listen to a lot of advice from people who understood and worked with the Duke culture longer than I have. I had to—well, when doors were shut in my face, I had to climb through

windows. And if their windows weren't open, I had to climb on the roof and come down the chimney. And sometimes I had to make a new door.

ROSEBERRY: Who were some of those allies?

CLEM: Well, some of the allies were allies in that they helped me understand the Duke culture. And I would use the saying that if you eat a frog every morning for breakfast, that's the worst thing you have to face all day. So I would go to them, purposefully, just to find out what are going to be the barriers, and how am I going to address them. Allies—absolutely, the Women's Faculty Committee has been awesome. It's there that I felt like I could relax, be myself, say what I was thinking. I had people to network with who understood what was going on. I would say I purposely would seek out other women who were in leadership positions, go to lunch with them, go to their house with them, meet with them at Washington Duke for tea—whatever. So I would definitely say the Women's Faculty Committee was awesome. As far as people who helped me get where I needed to go, one way or another, I would definitely list Robert Anderson, who was the first chair. And I would list also Danny Jacobs, who is the current chair. Greg Georgiade has been a great one for helping me to take the pulse of Duke and to find out which ways to go. He really gave me a lot of advice when I needed it as far as how Duke would respond. Dennis Clements has been there for me. Ann Brown, of course. Marilyn Telen, she's been great. And I would say my own colleagues in emergency medicine that I recruited and brought here have been—particularly my female colleagues—have been somebody there for me that I could have a collaborative leadership relationship. And it's been definitely true. I really work well in that milieu of collaborative leadership,

where—yes, I ultimately make the decisions, but I listen very carefully to the people around me.

ROSEBERRY: So in Surgery, I know—has been, just as a field, pretty male-dominated. And I wonder if there are female surgeons that you see in the department—

CLEM: Janet Tuttle (Betsy)—she and I went to lunch recently, and we talked a lot about what it's like to be in here. And yes, I would say—since I'm the only female division chief, there isn't anybody else that really does exactly what I'm doing—but I think they understand some of it, of what it's like. One of the things that it's been hard for is—a lot of people would say I needed to be much more blunt and "in your face," or whatever. But that isn't my natural personality to do that. And one of the things I've not been willing to do is sacrifice who I am. So I suppose I might have been able to make some of my changes with more direct force, by being a little more direct. It just isn't my personality. I just decided I wasn't going to do that. I was going to do it my way with grace. And I did.

ROSEBERRY: Well, you said you were making new doors when the doors were closed. Are there examples of that—?

CLEM: I went to Russ Kauffman, who is no longer here, when I had heard that we weren't going to have the residency—that they had decided that there just wasn't budget for it, and there wasn't enough support. And I just went to him, and I laid out my case. And I said, "We have to find a way to do this." And he told me later that my visit to him was what made the difference, because he said, "You don't ever brush aside passion." He said, "After I talked with you," he said, "I knew it needed to happen." And so he made some very difficult decisions, as a vice dean. And in part, I think that's why he left

is because of some of the difficult decisions he had to make. It wasn't just emergency medicine, but he had to make some difficult decisions. And so, in that way, I made new doors. I could tell you one story; but I can't put it on the tape.

ROSEBERRY: Okay. Do you want me to put it on pause?

CLEM: Yeah, just—well, you could stop. I could just tell you, and then you could maybe think—

(*pause in recording*)

ROSEBERRY: You had mentioned that the Emergency Department was the front door, or the other front door. And I wonder if we can talk a little bit about that.

CLEM: It is. Well, first of all, there are many, many people from across the United States that see Duke as a beacon of hope and healing. Many times they don't know how to access Duke. They don't know how to get here. They're embarrassed to tell their current physician that they're going somewhere else. They're at their wit's end. And when people don't know what to do, they come to the Emergency Department. So I get people from all over the United States who come here, needing tertiary, quantinary care, who come in self-referred. Forty percent of all of the hospital admissions come through the Duke Emergency Department. For many people who need emergency care—or emergent care—we are the first view they have of Duke. And I feel that if this is what people are experiencing when they first come in, not only is it important for patient care, but it's also important for the understanding—the vision—that the people who come here have of Duke when they present.

ROSEBERRY: What categories of cases are you given? Or what are common things that people come for? Or how—what does it look like in the Emergency Department?

CLEM: One of the myths that is across the country, and especially is true here at Duke, is that our emergency department is overcrowded because of people who really don't need to be here—the sore throats, the sprained ankles, the people who can't get an appointment somewhere else. And while that certainly does add to our patient volume, that is not the reason for overcrowding. We can see those patients and move them through rapidly. We have a fast track. Those patients are seen and treated, and released, rapidly. What clogs emergency departments and our Emergency Department here at Duke is the sick patients, the ones who need admission, the ones who need prolonged work-ups with multiple specialty consults. Those are the patients that make our emergency department crowded. And I think a lot of people don't realize that. So what I would say is, we see everything from a newborn infant who goes home and appears healthy when they leave, and then a—there's a problem with their heart two days later, and they present here—to the very extremes of age. I took care of a patient who was a hundred and four the other day, who was very healthy, and was climbing on a ladder and fell. So those are the extremes of age. As far as illnesses, we treat everything from traumas to heart attacks, to broken bones, to infectious diseases—HIV, influenza, tuberculosis. We treat—virtually everything that is seen here at Duke, we also see in the Emergency Department—so very, very broad practice of emergency medicine. So.

ROSEBERRY: And both insured and uninsured.

CLEM: Both insured and uninsured. Absolutely. We do have a large percentage of our population that is uninsured. And, in fact, that isn't due to the fact that resources for them are limited in the community, and they use the Emergency Department as a default. However, I don't think that is our primary reason for overcrowding. We do take care of

them, and I think that all efforts—I mean, many more efforts—need to be directed toward providing more community resources for them, because it's the right thing. But it's not because I don't think they should be in our emergency department. It's just—it's not the best way to provide care for them, if the emergency department is their primary care. You need to have a doctor outside the ER.

ROSEBERRY: Has this expansion of the department—will that help the problem of overcrowding? Will that—?

CLEM: Yes, it will. Absolutely. It will definitely help. However, eventually, we'll outgrow this new emergency department, too. And we actually made some plans out front where, once those three cooling towers become obsolete, we can expand out. So there's already a contingency plan. I give it eight to ten years, and we'll have outgrown this one. The number of emergency department visits across the country have increased in the last ten years from ninety-three million to a hundred and fourteen million. And in the same timeframe, we've closed two thousand emergency departments. We've gone from approximately six thousand emergency departments across the country to four thousand. So when you increase that volume, and you decrease the number of emergency departments, it's obvious that the number of visits to emergency departments are going to increase.

ROSEBERRY: So is there a problem within—with other departments—that this is kind of the first—this is that front door, this is—it sounds like there might be some competition for being the first place that someone would go, or—?

CLEM: Well, actually, I don't know that you would call it competition. I said the only advertising we need is that sign that says "emergency" out front—and that's really all we

need. At this point, I think we have all the volume we can accommodate. What I wouldn't mind doing is advertising our excellence, because we really do have excellence in emergency medicine here. We have state-of-the-art physicians, nurses, residents, equipment, et cetera. And I'm very proud of the practice of emergency medicine here. I really am.

ROSEBERRY: Can you talk a little bit more about what the Emergency Department looked like when you first came?

CLEM: Oh, of course. Designed thirty years ago, and it was—had an area for medical patients and an area for surgical patients. And the surgery residents ran the surgery side, and the medicine residents ran the medicine side. And then there was an area for pediatrics. The residents would work twenty-four hour shifts. There wasn't always an attending on duty with them. When I first came, the residents would see the patient, they would talk among themselves about it, they would present it on the phone to somebody—a chief resident or attending outside of the Emergency Department—and didn't even talk to me about the patient. And that was completely foreign to me. And I said, "I want to know about these patients. These are my patients." And they looked at me like I was made out of green cheese or something, because why would I care? You know? They're taking care of it. Nope, I'm an emergency physician, and I want to know about all the patients. Because they had not worked with a residency-trained emergency physician, they didn't know how it worked. Duke had to be educated on what emergency medicine is and what we do. And that was one of my first jobs as I understood it—was to teach them about—about the specialty of emergency medicine. Because most of them hadn't

worked with emergency physicians before. They didn't know what our specialty was—anything about what we do.

ROSEBERRY: Was that received well? That education?

CLEM: Some was, and—some of it was, and some of it wasn't. I'll give you an example. In triage, the nurses would send patients to different areas, and then they would page the—what they felt was the appropriate resident to see patients. So a patient came in with an eye complaint, and the nurse put them in the eye room and paged the ophthalmology resident. Well, and I went in and saw the patient. I used the slit lamp, I diagnosed their corneal abrasion, I treated them, I sent them out, told them to follow up. And after the patient had been seen and treated and left, the ophthalmology resident came in. And said, "Where's the patient?" I said, "Oh, I took care of it. You don't have to see that one." And he said, "Well, the patient needed a slit lamp exam." And I said, "Yes, I know. I did that." And they said, "You know how to do that?" And I said, "Well, yes. That's part of my training. That's what I do." And then the fact that I would sit down and suture somebody up or actually, you know, put an ultrasound on somebody's belly to see if there was a baby's heartbeat, people didn't expect somebody from emergency medicine to do that. They didn't know what an emergency medicine attending would do. So when I brought in my first group of attendings, one of the things I really looked for were people who would be just absolutely crackerjack clinicians. Because I had to show the institution what we're made of.

ROSEBERRY: So you have to know a little bit of everything.

CLEM: Yes, our training—actually, emergency medicine's one of the few specialties where you actually spend more of your training outside of where you're going to be

practicing than in, because we need to learn the emergency aspects of every part of things. And so for an ears-nose-and-throat emergency, I need to be able to handle those just like an ENT—otolaryngologist—just for that emerging. Now, obviously, I perform do the rest of their practice. But for somebody having a heart attack, I need to be able to understand all of the emergency management of a heart attack, I have to be able to do. Trauma management—I have to be able to know how to do all of those things, just like a trauma surgeon would do while in the Emergency Department. So for those components, we need the training from all the other specialties. And that's what emergency medicine does, it takes the pieces of all of the other specialties and applies them to just what is important in the Emergency Department.

ROSEBERRY: Well, I know that we have a female department chair, and I'm wondering if you think that there's a place at Duke for women department chairs. We have one. And is that something that you feel Duke is receptive to?

CLEM: I do think Duke is receptive to that. I don't think that my gender is what's keeping me from being chair right now. I think it's just where emergency medicine is.

ROSEBERRY: Where the department—?

CLEM: Yes, well there is not a department of emergency medicine. There's only a division. I don't think it's my gender that's keeping me from being chair. It's the way emergency medicine fits into the institution. And in fact, if they do indeed make it a department, I wouldn't be surprised at all if they chose a female chair.

ROSEBERRY: Are there women that you see in the division now that might be able to step up and assume that role?

CLEM: Not currently. However, I have multiple colleagues across the country who would—who are women who would really be interested in that role. Because I've already talked to them. So if Duke asks me, I would be glad to give them multiple names of people I think would do an absolutely wonderful job, and they are female.

ROSEBERRY: Well, it sounds like your time here has been very much as an administrator. Is that—?

CLEM: It has. That's what I've been speaking about. But I've also been practicing emergency medicine. I do—0.4 of my FTE [full time equivalent] is as a clinician. So yes, I practice medicine here a lot. I've also done some research here—not at the level that I had hoped, because I've been so busy getting this entire program up and going. I would say that's probably been the hardest thing, is that I did sacrifice some of my research career by taking this role so early on in my career. Really I should have been full professor, I think, before I became division chief and took this on. Having said that, there's still time. I'm going to work towards being full professor at my next institution. I'll get there. It's just—it was a little career detour that I hadn't anticipated. And I'm looking forward to getting back into some of my research.

ROSEBERRY: Well, tell me about the Faculty Women's Committee.

CLEM: Very excited to be invited to be on the committee. I'm not really sure how I ended up there. I'm guessing it was because of Marilyn Telen, who has—was asked to be the chair early on, and she had helped me be as my ELAM mentor, because she had been through ELAM—the Executive Leadership Course in Academic Medicine. But I don't really know how I ended up on the committee or how I even heard about it. But I do know that as soon as I was invited, I was so excited to be there. I think that sitting

around the table with—there's just something very special and uniting and inspiring about sitting around the table with an entire group of very bright, accomplished women scientists. I'm just in awe of the group. I know this sounds really corny, but I really am. They're amazing.

ROSEBERRY: Who are some of the women in that group?

CLEM: I'd have to walk around the whole group to tell you. I respect all of the group. I could give you—if you could read off the roster, I would tell you I respect the whole group. One of the things I appreciate, too, is their honesty. I mean, they're just not afraid to say what it is—and yet, they're very supportive. Never felt anything but support in that group.

ROSEBERRY: What are some of the issues and topics that the committee has dealt with?

CLEM: Well, some of them have been in subgroups. I was invited to be involved on a group that was looking at paternity and maternity leave. And there was a huge issue, because while the school of medicine was willing to move ahead with making sure that maternity and paternity leave were available to faculty, there was a disconnect with the PDC [Private Diagnostic Clinic]. And so I was able to sit on a group that helped that to go through. And now we have it. So I would say that was a—something big that I got to be a part of, as the Women's Faculty group, is the maternity and paternity leave—family leave—that's actually paid now. Before, you had to take it without pay. And now there is ability to be paid. We also worked on issues as far as stopping—being able to stop the tenure clock, and providing advice for that. And one of the other things I really enjoyed about being on the committee is the ability to—and being asked to interview potential

other leaders—such as department chairs that are coming in—and being able to talk to them about the way that they support women in their academic growth. And I think that's so important that that actually happened with each of the chairs that are being recruited. And I felt our voice was heard. So.

ROSEBERRY: So to specifically support women?

CLEM: Yes. So we were able to speak to the dean regarding that component of whomever they were working to recruit. That was good.

ROSEBERRY: Well, who are women that you see here that inspire you, or that would be important to mention?

CLEM: Well, of course, Nan. She was very, very inspiring. Ann has been there. I've enjoyed—Marilyn Telen has been somebody who's absolutely influenced me. Nancy Major, actually, as well. She's been good.

ROSEBERRY: I don't know that name.

CLEM: She's on the committee. The other group I have just really enjoyed working with is the group that I'm working with right now to get the Women's Faculty gallery up and running. What a great group to work with! And when I ask people to be in charge of a subcommittee to do something and I get the work back, I've just been amazed at the quality that has gone into it. It's just awesome. I think probably one of my biggest disappointments in leaving is that actually I'm going to leave before that gallery is a reality. And I really hope that it does become a reality. I think it will. I think the momentum is here. But it scares me a little bit that it might not happen.

ROSEBERRY: Can you just, for the recording, kind of give the vision of what that—?

CLEM: Yes. This actually—Ann had the initial vision. We were—as a Faculty Women's group, we were touring—at the MLK [Martin Luther King] exhibit. And Ann had said, "We need to have an exhibit for women in medicine at Duke." And I said, "Oh, that is a great idea." She said, "Well, would you chair the committee?" The task force—I guess it was task force. And I said I would be honored to do that. Well, as soon as I did that, all around the group somebody said, "Oh, I'll be in charge of fundraising." "I'd like to do design." Everybody pitched in. And the energy and momentum made it very easy. So we have been working on it. Right now, the roadblock we have is actually getting the initial funding for the planning, because it appears that architects and artists need some seed money to get started. So we're working through that little barrier. But I don't think that should stop this from occurring. And I—the vision and the work that people did—as far as planning the location, artists, who should be included, the description of the gallery—has just been awesome. I'm really, really proud of the work that's been done. And also of the information that I've learned about the women who've made an impact here at Duke—it's amazing.

ROSEBERRY: Well, who are some of the women that you've heard about, that you'd like to talk about?

CLEM: I'm not even sure I could give you all of the names. But I remember a lot of the stories, such as the first African-American female graduate from medical school.

ROSEBERRY: Jean Spaulding.

CLEM: Yes. And then I would say—also some of the first female graduates, and what their career was like, and how it was impacted by all the other societal demands—and what they did in spite of that. And I would say, also, the women who have been involved

with science and doing basic research here. And the way that they would do that and combine their families, early on, without mentors—just is incredible. And that, once again, speaks to the issue that the women who succeed do it in very non-traditional ways. And the sooner medicine—and those in leadership—get that, the more the entire country is going to benefit; because you're missing a lot of talent if you don't embrace the fact that it's not all one pipeline.

ROSEBERRY: How have you been able to, in your own division, support that idea?

CLEM: I have not even been as successful as I hoped I would be with everyone, but strides have been made. Let me give an example: I have a faculty member now who is—I see—as tremendous potential for her work as a bridge between the [Department of] Community Medicine and the Emergency Department. And she is very interested in that. She started off with a bang, and then she became pregnant and needed to back off a little bit. So I arranged for her to be able to work part-time, which is not an easy thing to do here, because you still have to pay full benefits, full malpractice, even if you work part-time. So that's something that took a lot of doing, for me to get that approved. But I didn't want to lose her. So I have been able to work her through that. She's now expecting her second child. I'm going to continue to support her. I've set it all up so she should be able to be supported through this. I fully anticipate—as soon as she's through with this little dip in her time that she needs to have intensive time at home—she's going to blossom. I expect her research and her work in that whole realm to take off. I saw her potential early on. And so I'm working with her. I would say I do that for all of my faculty. I try very hard to look at what their potential is, and then look for opportunities for them. Now, I can't make them do the work, but I can open doors for my faculty. And

I've certainly done that. And I've also taken at least one of my faculty—who truly hit a brick wall here at Duke and probably would have had to leave—and managed to completely do an about-face with her career, put her in another direction, and now she's absolutely thriving and being nationally recognized as being one of the foremost in her field. A gift women bring is the ability to really look at a situation, a problem, or a challenge in a unique way, and then find different ways to work through it. And I think that's definitely been true of my leadership style here. And I just gave you a couple examples of how that works. And I don't see that as being as true for men. Men are given a lot of mentoring, and they're pushed, and it's in a very structured way. That doesn't work so well for women. You have to be open to lots of different ways to get from A to B. Of course, you have to have your board certification, your training, and your level of excellence. I'm not talking about that. But once you have your training, so that you're prepared to succeed—at that point, the world of possibilities needs to be exploded.

ROSEBERRY: Why do you think that the path is more circuitous for women?

CLEM: We have a lot of societal responsibilities that men don't have. We have different ways of looking at how problems can be solved than men have. Our mentoring is different. The way we interact with our colleagues is different. So I think you have to put all of that into the equation.

ROSEBERRY: Is mentoring an important—is that important in academic medicine?

CLEM: Oh, it's crucial.

ROSEBERRY: For both men and women?

CLEM: It is. But there aren't enough female mentors for the women coming up. Fifty percent of medical school graduates are female, but you don't have fifty percent of your colleagues in academic medicine as women. So there's not going to be an appropriate number of gender-matched mentors. So the way I see that being addressed currently is multiple ways. One is that you have more than one mentor for people coming up. And I think the people who succeed have multiple mentors. I would say that's definitely true of me. I have multiple mentors—not only here, but outside of Duke. And the other is to actually help men learn how to be better mentors. So I think that you have to do both. I think you have to have cross-gender mentoring, and then you have to spread the job of mentoring out. Otherwise, you overtax the women that are available as mentors. And then if you're overtaxed, then you really can't perform as a mentor in the way that you should for your mentee.

ROSEBERRY: Has the need for mentorship increased? Is that kind of a current-day phenomenon? Or is that something that was lacking but has—?

CLEM: I think it's always been there. I just don't think women even knew to ask. And now they're learning to ask. But then when you ask, finding the resources is difficult sometimes.

(*end CD 1; begin CD 2*)

ROSEBERRY: Well, are there mentors that you've had that we've not talked about? I mean, we've talked about some of the support that you've—.

CLEM: Yes, but they've not—they've not been here at Duke. They've been outside of Duke. And yes, I spend hours on the phone with them, or one-on-one with them.

ROSEBERRY: So even still, you're—?

CLEM: Oh, absolutely. And I actually—for this last move, I actually hired a professional career coach. So I think sometimes if you can't get the mentoring you need, sometimes you have to buy it.

ROSEBERRY: Well, has the kind of pull between career and family—is that still an issue for women? Or is that something—?

CLEM: Absolutely. And what isn't recognized is that the angst that women go through, trying to do that balance—is not recognized as the dedication that's there. Women will work through tremendous barriers to try to maintain a successful family life—with all of the different roles that they have there—and maintain their career. And the efforts associated are not recognized for the—for what they are. Having done it, I feel that I'm more able to appreciate that than, maybe, people who haven't.

ROSEBERRY: If you don't mind my asking how—kind of how that worked for you? What was some of—your mechanism?

CLEM: Well, because of the fact that I had to earn my way through college, and at that time I had just had two small children as well, I didn't start medical school 'till they were five and six. And then when I started medical school, I was certainly the only woman with children and one of the few people in medical school that had children. So right there, I was an anomaly. And while my classmates were out throwing Frisbees in between breaks, I would always be studying, because I knew when I got home, I wasn't going to have time. And I would study in between putting loads of laundry in, and you know, those kind of things. And I think that's what women do all over the country. They just don't talk about it. I do have a very supportive husband who is not afraid to do anything, and has definitely stepped up to all the childcare potential, and a lot of women

don't have that. And I feel very fortunate that I did and do. But I will say, even when I applied to medical school, a couple places said, Well, what are you going to do with your children when you start medical school? Who's going to take care of them? And I remember thinking, You know, that's my problem. That's not for you to even ask about. They don't anymore. But I did get asked. And I will say that I remember one night, it was Halloween, and I wanted to get home and take my kids trick-or-treating. And I had worked really hard—I was still a resident—to get through all of my work, so that I could be off in time, by six o'clock, to be home. That was way before the eighty-hour rule. And I did. I got it all done. And I had come in early and done everything so I could get off. And I said to my attending that I wanted to go home, so I could—and he said, "Well, why?" And I was honest, and I said, "Well, I want to take my kids trick-or-treating." And he looked at me like, "How unprofessional is that?" But I'd done my work, and he let me go. But I will just say, I know I went down multiple notches in his estimation by my being honest and saying why I wanted to go home. But I would say I've made sure that that is not the case here. And if I have a faculty member who needs to leave at three-thirty when the faculty meeting is due to be out to go pick up their kids from school, go. That's okay. I can tell you that even my male colleagues appreciate that. They're much more open now. They're talking about it, whereas they wouldn't before. "I have my kid's soccer game today." You know. Or, "Could you come in an hour early so I can go hear my kid's piano recital?" Or what—and we do that. And I don't think before—I think that that's a difference that we've made for all of them. So I would say the men are appreciating the culture that's been made here as much as the women have.

ROSEBERRY: So that culture is changing at Duke?

CLEM: Yes. Well, certainly in my sphere of influence it is. I don't know how much it is in other areas, but—.

ROSEBERRY: Well, I know that when we started talking, you had kind of made a distinction in your mind about nursing and physicians. And I know that emergency medicine nurses are an important—play an important key role. And I wonder if we could talk a little bit about women who are nurses?

CLEM: Absolutely. I would say that in emergency medicine the lines between what we do in providing patient care are probably blurred more than many other areas. My nurses order things from triage, and it's okay. We both start IVs. They take histories, I take histories. We combine our stories together, because we're in a very tight environment where we both need the same information. We've worked side by side taking care of the patients, in a way that is very unique. I will say, though, that my male colleague will be walking down a hall, and the patients don't yell, "Nurse, nurse!" Whereas, if I'm walking by, a patient will yell, "Nurse, nurse!" And when I go in, they want a glass of water or a blanket, or—you know, something like that. And I'm happy to get it for them. And that isn't the issue. But I—if we're walking beside my male colleague, and the same thing doesn't happen for them. And let's say that I really am too busy to go get a glass of water, because I am truly on the way to helping the next heart-attack victim or something. I do it when I can. If I decline to do something like a simple patient comfort measure and say, "I'll get a nurse for you," I get glares—from nursing and from my patient. Whereas if you're a male that doesn't happen. It's just expected. And I would say that's probably just the reality of our gender.

ROSEBERRY: So are women still predominating in nursing? Or predominant in nursing?

CLEM: They are. Although in emergency medicine we do have more men who are male nurses. We see more.

ROSEBERRY: Have you had to work with the nursing service or with the school of nursing, in your role in the Emergency Department?

CLEM: Yes; in fact I meet with all of the new nurse recruits here. We have nursing students who we train in the Emergency Department. I—we invite our nurses to our—all of our resident conferences, our grand rounds. And I would say yes, we work closely together. I think it's a very symbiotic relationship.

ROSEBERRY: Well, what are those lines—I mean, you once were—you were a nurse, and you chose to be a physician.

CLEM: I was a nurse. Most of us in the Emergency Department work collaboratively—if we have one trauma that we just cleared out, and we have another trauma coming, and housekeeping is in there sweeping the floor, and I know that ambulance is coming through the door, it's not—I'm not above taking the squirt bottle and spraying off the gurney and putting the sheet on. You wouldn't see that in the OR [operating room]. You're not going to see the surgeon who's scrubbing off the bed and putting a sheet on there to make a bed for the next surgery. But we just do in emergency medicine whatever it is that needs to be done. And if I have a nurse who orders an X-ray of an ankle, or a chest X-ray from triage, or an EKG, I'm grateful. Yes, sometimes they over-order or under-order, but most of the time, they know our practice. They know what we need. And it's okay. It helps our patients.

ROSEBERRY: Well, are there women here in this institution that we haven't mentioned that you would like to talk about, or whose names you'd like to put on the record?

CLEM: Brenda Nevidjon was a big help to me when I first came. And then I watched what happened to her when she was taken out of her role and was transferred to the school of nursing. And I learned a lot from watching what—how the institution related to her and her leadership style, and what happened. And it was more, "Well, if I do that, this is what's going to happen to me." But she was always helpful to me. She really helped me to learn how to network early on. And I'll say Kathy Finch as the nurse leader here. She understood the culture here so much at Duke. She gave me a lot of advice coming on about, "Well, you can play that trump card, but if you do, this is what's going to happen." And I listened to her, because she understood the culture here. And she was also really a stabilizing force as far as our ability to work side by side in creating this—and building this new emergency department, and the administration, and working through the issues, both with nursing and physicians. So even as a nurse, she served as a colleague and a mentor. So I don't think that all of your mentors have the same letters after their name that you have.

ROSEBERRY: Well, are there any questions that I haven't asked you today that I should have asked?

CLEM: I should look at your little sheet.

ROSEBERRY: Sure.

CLEM: I'll just have a look, and make sure that there wasn't anything—. Anything that emergency departments are always thinking about? Yes, I would say emergency departments are always thinking about patient flow. We really can't control what comes

in. And we can control what happens in the emergency department to a degree, but getting patients out, as far as being admitted, is something that emergency departments are always thinking about, and unfairly so. Patients who aren't admitted or aren't seen as fast as they think they should be—or we think they should be—unfairly blame the Emergency Department, when really most of what happens, as far as the patient flow in the Emergency Department, is out of the control of the Emergency Department. I can't control how fast the lab gets my results back. I can't control how fast Radiology reads or performs my tests. I can't control how fast a colleague comes down for a consult or how long it takes them to complete that consult. I can't control how long it takes the hospital to find an inpatient bed for my patient who needs to be admitted. We work really hard to be streamlined and efficient for those things that fall on the shoulders of emergency departments—I would say that we're the safety net for the community and the hospital. When people don't know what to do with any type of a situation, they think of the Emergency Department as a place to solve their problem. So I would say that that would be true. And then if we have difficulty figuring it out, people's response is often anger. For example, I have a patient who has a gastric tube—a feeding tube, and it needs to be changed. Well, the doctor at the nursing home can't find somebody to change the tube in a clinic. And so they send the patient to the Emergency Department to have the tube changed, even though it is not an emergency. The tube is still in, it's just time for it to be changed. And then when I have trouble getting a surgeon to come in and change this non-emergency tube, they become angry at me, because I didn't solve their problem. Even though it's not an emergency. So I would say that the expectations of the

community—and our colleagues—are sometimes unrealistic. And we do a lot to solve through those things. And that's hard.

ROSEBERRY: And do you—obviously, you're working very quickly, as well. You're having to make decisions very—.

CLEM: Yes. And then—and those are the things that weigh you down, because that takes a lot of time—because I'm on the phone with this, that or the other person, trying to convince them to come in and do whatever. And then—and you also have to deal with the emotions that are associated with that, because whomever it is that you're calling on a Saturday night isn't happy that you're calling them at home. And they become angry at you for calling them, when in reality you didn't have any say at all. The patient was wheeled in the door via ambulance, to have this non-emergency tube changed. So these kind of things happen all the time. Let's see. I think we've answered most of those. You asked me about my book, *Emergent Field Medicine.* That was something that I was invited to do even before I came to Duke, but I was able to finish it while I was here. It was something on my to-do list. I always wanted to write a book. So I did. And, actually, I wanted the title of the book to be *Where There Is A Doctor.* Because there's a book out called *Where There Is No Doctor,* which is how to practice medicine when you have nothing and there's no doctor around. Well, this is how to practice medicine when you have nothing and there is a doctor. But they wouldn't let me name it that. What I will just say in conclusion is that when I'm an old lady and I'm sitting on my front porch in my rocking chair, I am going to look back at Duke as some of the best years of my professional career. I have loved it here. I'm very happy with the progress that's been made. I feel that, although the issues are not—certainly not all ironed out for women in

medicine here—or anywhere—I feel like Duke, in many, many ways, supported me more than most places in the country would and allowed me to succeed in ways that I wouldn't have otherwise. And I'll always be grateful.

ROSEBERRY: And how would you describe the Emergency Department now?

CLEM: State-of-the-art, caring, professional, patient friendly. I would put it up against any emergency department in the country.

ROSEBERRY: Great. Well thank you so much, Dr. Clem.

CLEM: You're welcome.

ROSEBERRY: I really appreciate it.

(*end of interview*)