ORAL HISTORY INTERVIEW WITH KEVIN SOWERS
Duke University Medical Center Library and Archives
Submitted February 8, 2018
Researcher: Joseph O'Connell

COLLECTION SUMMARY

This collection includes an oral history interview I conducted in two parts with Kevin Sowers on January 22, 2018. Sowers had recently stepped down from his role as President and CEO of Duke University Hospital. Our conversations trace his career as an oncology nurse and hopsital administrator. We discuss his upbringing in rural Ohio, the develop of his passion for patient care, and the evolution of his responsibilities as a leader in the Duke University Hopsital organization. We also discuss his decision to leave his current position. Some of our focuses include nursing and gender; oncology nursing as a specialty; mentorship and leadership dynamics; and the changing economics of academic healthcare organizations.

This document contains the following:

- 300-word biography of Kevin Sowers (pg. 2)
- Timecoded topic logs of the interview recordings (pgs. 3-4)
- Transcripts of the interview (pgs. 5-17, 18-29)

The materials I am submitting also include the following separate files:

- Audio recordings of the interview
- Scan of signed consent form
- A portrait photo of Kevin Sowers I took after the interviews*

*Please note that for any publication, Mr. Sowers prefers that the archives use his official press photo.

BIOGRAPHY

Kevin Sowers has served as President and Chief Operating Officer of Duke University Hospital since 2009. Sowers's career at Duke spans more than thirty years beginning with his role as a staff oncology nurse and culminating in his position as the hospital's most senior leader. In executive roles, Sowers has shepherded the organizaton through major changes, including safety and quality reforms and pressures on the traditional financial model for academic medicine.

Sowers was first inspired to pursue a career in healthcare by a part time job at a nursing home in his home state of Ohio. Along the way to earning his BSN, he overcame financial hardships and the social norms that surround nursing as a traditionally female occupation. An interest in oncology nursing drew Sowers to Duke, one of the major cancer centers in the country. During his time as an oncology nurse, he earned an MSN and helped develop oncology nursing as a specialty in the Duke system.

He moved into the position of clinical nurse specialist and continued to receive assignments beyond his clinical care routine. In 1992, Brenda Nevidjan, the Director of Oncology Nursing, tapped Sowers as Nurse Manager for a pilot Hematology/Oncology/GYN Oncology unit. Hesitant at first to accept a management position, Sowers soon embraced the opportunity to apply his values to the role. He set up shared governance within the unit, a management model that was not yet embraced by the hospital as a whole.

As Sowers's role evolved, he took on even more sophisticated projects such as designing and implementing new care delivery models and consolidating clinical laboratories. The leadership positions he has held include Chief Operating Officer of Duke University Hospital and Chief Executive Officer of Durham Regional Hospital. In 2018, Sowers leaves Duke University to become president of the Johns Hopkins Health System.

INTERVIEW TOPIC LOGS

Interview 1, Part 1 (January 22, 2017)
File: 1008.WAV

0:00 Introduction
... Name
Birth
Family and community
Early interest in nursing
3:58 ... Gender and nursing
5:30 ... Story about working as orderly
7:44 Mother's influence on interest in nursing
10:00 Attending college
10:31 ... Changing major to nursing
... Economic challenges during college
13:18 Gender and nursing issues during clinical rotations
17:30 Oncology nurse position at Duke
... Decision to pursue oncology nursing
18:56 ... Choice to accept job at Duke
19:45 ... Observations about oncology nursing during grandfather's illness
22:13 Status of oncology nursing at Duke at the time
... Need for oncology nursing specialty
28:24 Master's thesis on GRID/HIV support groups
32:31 Transition into administration
... Story about receiving nurse manager assignment
38:08 ... Reasons chosen for management responsibilities
39:53 Influence of Mary Ann Peter
... Receiving assignment to develop oncology nurse specialty

Interview 1, Part 2 (January 22, 2017)
File: 1009.WAV

0:00 Leadership of new oncology/hematology/GYN oncology unit
3:38 ... Implementing shared governance
5:46 Chief nurse role
6:28 ... Moving into full time administration
7:39 "Human side" of management
10:25 Developing clinical service unit model for care delivery
Being put in charge of half the hospital by Mike Israel
14:38 Receiving assignment to consolidate clinical laboratories

18:48 Transition into COO at Duke Hospital
... Jesica Santillan case
20:17 ... Participating in all areas of the hospital during first 120 days
21:43 ... Concurrent financial crisis
22:15 ... Difference between nursing skills and leadership skills
26:40 ... How others perceive president role
28:13 ... Approach to economic decision making
30:28 Contributions to field as writer and lecturer
... Sociodramas
35:10 Accepting position at Johns Hopkins
... Succession questions at Duke
38:34 ... Leaving behind Durham
39:20 Current challenges in academic hospitals

TRANSCRIPTION, INTERVIEW 1, PART1
PROJECT NAME: Oral History Interviews with Kevin Sowers
PROJECT DESCRIPTION: A two-part oral history interview with Kevin Sowers focusing on his biography and career in nursing and hospital administration
INTERVIEWEES: Kevin Sowers
TOPIC: This is the first part of the interview, in which we discuss his upbringing, training, and early career.
RESEARCHER: Joseph O'Connell
DATE: January 22, 2018
LOCATION: Kevin Sowers's office, Duke University Hospital
CITY, STATE: Durham, North Carolina
AUDIO FILE: 1008.wav

Joseph O'Connell's questions are bolded.
Kevin Sowers's responses are unbolded.
Timecode is listed periodically.

0:00

Ok. This is an oral history interview for the Duke University Medical Center Library and Archives. My name is Joe O'Connell, and I'm interviewing Kevin Sowers, the outgoing president of Duke University Hospital.

It's January 22, 2018.

Thanks for making the time to do this interview, Mr. Sowers.

Please, Kevin.

Kevin.

0:00:26.4

I appreciate it.

You're welcome.

The first thing I would like to talk about is—could you tell me your full name?

Kevin Ward Sowers.

Ok. And where and when were you born?

I was born in 1961 in a small rural community called Cable, Ohio, which is toward the western side of the state of Ohio.

Ok. And can you tell me a little bit about your family and who your parents were and what they did?

So my mom was a housewife, and my father was a farmer, and we grew up below the poverty level. I always say that I didn't know we were poor. It was only when I got to college that I realized we were poor because everyone around us was poor, so I thought how we were living at the time was just the way everyone lived, and it was only when I got to college that I realized that wasn't true. We didn't have--for instance, we didn't have indoor plumbing until I was eight years old. And so it was a very—I never felt like I went without anything because my mom and dad did an incredible job of taking care of us kids during that time. They had three of us. My brother and sister. I was the oldest.

Ok. What were your parents' names?

Martha Jane and Samuel Ward.

Ok. And was it unusal for someone from your community to go to college?

So, yes, it was very unusual. So, to this day I am the only one on either side of our families to have gone to college. It was typical—my graduating class probably had sixty-five people in it, so it was not a big community. Also not a diverse community. Mostly made up of farmers, and the expectation was that you typically graduated and worked your father's farm. Especially if you were a male. But I just had other ideas about what I wanted to do with my life.

Yeah. Where did those come from? If you were immersed in this farming culture, where did you get the idea that you might be able to do something else?

So, I was a musician. I was voice and piano and did all that through high school and did music theater and did all that, and I really thought that's what I was gonna do with my life. And because we were poor and my parents had to pay for me to go to college, in the summer months I had to work, and so I went to work in the mornings and did music therapy at a county nursing home in Urbana, Ohio, and then in the evening I went to work and was an orderly in a nursing home, and my job there was to feed people, bathe people, and put them to bed. And it was during those summer months that I fell in love with caring for other human beings and really developed a passion for caring for the human spirit, and that's when I decided I wanted to be a nurse.

And you have to remember this was back in the, gosh, the late seventies, early eighties, and that's not a time in which men really were becoming nurses. So when I went home and told my parents that's what I wanted to do, you can imagine my father's response.

0:03:58.0

My father, if you look up macho in the dictionary, you'll see a picture of him. His response to me was, "Son," he said, "if you want to be a nurse you can do that later. Finish your music degree." And not only that but, "being a nurse is a woman's job not a man's job."

And I'll never forget, my mom—in fact I wouldn't be here today if my mom had not taken the position she did. My mom said it is not about whether you're a man or a woman, it's about do you have the passion to care for another human being. And if our son wants to be a nurse he'll be a nurse.

0:04:33.1

And that's the only conversation that we ever had about me becoming a nurse.

And that's what I did. I became a nurse.

0:04:41.7

Wow. So you—in some ways it sounds like your interest in music kind of introduced you to the experience of caring for other people through this music therapy opportunity.

Mm hm.

Is that accurate?

It's the music therapy and also the orderly job because, you know, when you're an orderly and your job is to feed people and bathe them and put them to bed, you see people in some very vulnerable times in their life. And you get to know them on a very different level. And so it was those moments that really turned my heart and my head in a very different direction in life.

0:05:30.6

Can you describe a little bit of that orderly job? What were your responsibilities there, or were there any memorable cases--?

Well, yeah, there's an incredible memory that I have of that summer that I was an orderly. So I would go to work at three to eleven. So I would literally work in the mornings at the nursing home, change my clothes, and then go to work. So, Ohio is known for its tornadoes, and there was one summer night that there was a tornado coming, and of course what you did is you took all the residents and put them in the shower room in the wheelchairs because that was the safest place in the center of the building, and so we had done all that, and on that particular night, there was a woman who was dying in the nursing home. And I remember the charge nurse that night was Helen, and I remember very clearly she told me what we were gonna have to do. We were gonna pull the drapes to her room and we were gonna cover her with blankets in case glass came in. And I did that, and I just couldn't leave that woman alone, because there was just something in me that said if she dies in the midst of this, she'll die by herself. And so I stayed in the room with her, and Helen came and got me and said you can't stay here. And I said, no, I'm going to stay here. So I stayed with her, and she died that night. But it was another one of those moments where you realized what it meant to be there for people in a very vulnerable time in their life, and what that meant. And there are many situation that I look back on now where while people thought I was giving to them I was learning about life, and so I was getting back as much as I was giving.

Yeah.

0:07:44.2

And you said that your father was very macho.

Oh.

Is it the case that you were—you saw more vulnerability in your work at the nursing home than you did in other contexts of your life? Or do you know why that context was so—that you made that strong of a connection?

You know, I get this side from my mom. My mom has always been like that. And I think, you know, if my mom had grown up in a different situation and in a different time, she probably would have been a nurse. I mean, she's an incredibly compassionate woman. And so I would say that I probably got that from my mom.

Now what was interesting as my dad aged—my dad's been dead now three years—I saw a completely change in him. And he was very proud of me being a nurse. So there was this turning point of where it went from, no that's—and then he started having to go to the hospital himself for his own heart disease a variety of other things that were wrong with him at the time. And you began to see him change in his whole perception of what nurses did and the role nurses played in people's lives. So he would very proudly say my son's a nurse. He'd—but it was only later in life that he began to do that.

0:09:12.7

And after he had some contact with medical professionals.

Yeah.

Yeah. That's good. I'm glad you got that opportunity for his mind to change.

Can you tell me a little bit about how you wound up going to college? And why you chose to study music?

So I went to college at Capital University in Columbus, Ohio. I didn't think first of all I was gonna get to go there because I just didn't have the money to go there, and then I got music scholarships to go there, and so I was on scholarships, and then I took the money that I'd made in the summer months to buy my books and do that kind of stuff. So it was—I first went there for music.

0:10:07.2

Loved it. Did voice and piano. And then I had this life changing moment where I knew I wanted to be a nurse and Capital also had a nursing school. So I applied to the nursing school and began my nursing career there. And that's how I made the transition. Once again on scholarships.

0:10:31.2

Right. Ok. So you actually began studying nursing before you left Ohio.

Yeah, there was—yeah, I did, I studied—it's a very interesting story. So there was a semester that I knew I wasn't gonna have the money for the next semester because I also--so when I went to college I was working multiple jobs. You know, I was a waiter, I was a bartender, I worked in an art gallery, you name it I did it trying to make ends meet. And I knew I wasn't going to have enough money for the next semester. And I was in a fraternity and I remember being in my dorm room and there was a knock on the door and I opened it. And it was one of my fraternity brother's father, Don Brame, and he walked in the room and he handed me an envelope, and in it was a check for my next semester. And in it was an IOU note, and it said here's how much I'm giving you, here's how you'll pay it back, and his point was if you want to help pay it back while you're in college you can come over to my house and rake leaves, and here's how much that's worth. You can house sit for us and here's how much that's worth, but he said whatever's left over at the end you have to pay me back. And you can set up a payment plan. So he did that for multiple semesters for me. That wasn't just one semester, and once again there were these incredible people who came along because—I for all intents and purposes I was against all odds of not making it for lots of different reasons, but there were these incredible people who came along and really were there at moments that—it was—incredible looking back at that.

0:10:31.2

And that's why today, at Capital, every semester I fund a student who can't financially continue.

In any discipline or in nursing?

A lot of times it is nursing. But in any discipline because I know what that was like, and so I'm trying to pay it forward now.

Yeah. And so your fraternity brother's father, did he just happen to hear about your situation?

His son Dave actually told him what was happening. And of course I knew--Don and Vivian were their names-- was friends with their son--and he was just gracious and was a businessman and he just thought it was a good investement.

Yeah. And it turned out to be—

He turned out to be correct.

0:13:18.3

So you had a network of people who were at school with you who were supporting you and knew that you needed some help. That's really great.

I wonder if—the whole question of gender and nursing—what was that like as a college student? Did you still get some skepticism about the idea of being a man and being a nurse—

So, you know, in the early eighties when I first started my clinical rotations, there were difficult moments. You know I remember my OBGYN rotation and you know there's a cleansing procedure that you do on a female patient after a baby is born. And I remember the nurse that I was with at the time looking at me and saying no this is--you can't do this, this is a woman's job to do this. And I said no it's a nurse's job to do this.

I remember going to my clinical rotation in OBGYN and it was a hospital, it was a private hospital, and they had different uniforms for the doctors and different uniforms for the nurses and the nurse's uniform was this mauve flowered top and mauve bottoms. And of course they didn't have any male nurses and they went and got me a pair of mauve colored smocks and a mauve flowered top and that's what I wore. And there was never any consideration that—it was almost like this rite of passage that you had to go through.

But you know once I got into taking care of patients, patients just knew that I was there to take care of them. It didn't take long to break past that.

0:15:27.2

When your coworker said you shouldn't do this, this is more appropriate for a woman to do, what do you think she meant? What was she thinking--?

Well, you know, I think it was at that point in time it was there's a thing a male should be taking care of males and women should be taking care of women. And by the way, that's not true. You should be able to take care of anybody who needs your care. But I think in her head that's how she was conceiving how I was going to be as a nurse. That I was going to be a male nurse and take care of male patients but you don't have that luxury. You get an assigment and you take care of whoever needs your care on that day.

0:16:14.0

Ok. So you were at Captial and you were going through your nursing training, and you had some support from others around you financially and were able to kind of get by that way.

Now I think I saw on your CV that you had also trained at Duke.

I did my master's of nursing at Duke University.

Ok. So, and was that directly after you finished your degree at Capital?

No, back then you had to work at least two years before you could go back to graduate school.

Ok.

So I came to Duke in 1985 and started working as a staff nurse in oncology and then two years later started graduate school part time while working full time and studied to become an oncology clinical nurse specialist.

I see. So you had a job on staff at Duke before you started your master's training.

Mm hm.

And can you tell me about why you wound up at Duke and also in the role of an oncology nurse?

0:17:30.6

So why Duke and why oncology. So I was graduating from nursing school and at the time I was working my last semester. I was working in CT surgery ICU up at Ohio State and I was really trying to decide was I gonna stay at Ohio State and work at Ohio State or was I gonna go and do something different. And it was during that year, my last year of college, that my grandfather on my mom's side developed a neuroblastoma which is a brain tumor and became very ill. And the experience we had during his illness was not one that I would want any other family to go through. It was really difficult. And let's say we could have—the care that we received as—for him and the care we recieved as a family could have been much better. And so it was those—it was during that year that I really started thinking, gosh, I could really make a difference for other cancer patients and how they recieve care. So the passion from caring for cancer patients came from my grandfather's experience.

0:18:56.1

And then when I made that decision I said, gosh, I want to work at one of the comprehensive cancer centers in the country. So it was the very last vacation trip I ever took with my parents, and we started down in Florida and we came up the east coast and I interviewed at different places along the way. And Duke was one of those places, and it was one of those times that there was a nursing shortage and Duke said that they would pay for my graduate education if I worked for them for two years. And I told my parents I could do anything for two years. But the thought of because once again I didn't have the resources to pay for graduate school. So I told my parents I'll stay here for a couple years, I'll get my graduate degree, and I'll come back home to Ohio. Well that's now 32 years ago and I never went back.

0:19:45.6

And I'd like to back up just a little bit, and I wonder if you'd be willing to say a little bit about what the—when you were observing--the cancer care that your grandfather got, what did you see as some of the—what was lacking in it from your point of view, and what were those areas where you thought this is an area where there could be some improvement?

You know,

0:20:19.3

It was not that anyone was a bad person that treated him. But our family had no background in healthcare. He has a glioblastoma, he has surgery to the brain, so there was no education of what we needed to look for as a family, what we needed to plan for when we took him home, and he had a severe disease that really impacted his emotions and his way of thinking and so he was very, very needy

when we got him home. Very needy. And no one prepared us for that. No one really prepared us for what the end would be like. There was just, it was more of how do you engage the family so you can bring the family along in a loved one's illness so that they're prepared in many different ways, on an emotional a spiritual and a physical level, to care for that person. And that just didn't happen for us. And like I'm saying the people who treated him were not bad people. They were all good people. But there were—it's what I call wraparound services, that you put around a family to support them during those challenging times, and that was missing for us.

Ok. So you saw an opportunity to treat patients within the context of their social relationships?

Mm hm.

That sounds really important.

0:22:13.8

And when you started working at Duke, was that a better fit for you in terms of how you wanted to do nursing and how you saw it being practiced at Duke? Do you think that the oncology nursing here was more advanced than what you had seen before?

So when I came to Duke in 1985, I came to an oncology unit that was half oncology and half pulmonary and it was the early years of oncology as a profession, oncology nursing as a profession. So I would say that I was on the front end of really helping oncology nursing develop here as a specialty. I very quickly was pulled out of a role of a staff nurse and went into the oncology nurse educator role, developed the oncology nurse curriculum to teach other nurses to become oncology nurses here, developed an oncology nurse internship program, so there were things early on that I did here after being here two years that really began to kind of set the foundation for even making oncology more expansive in its specialty.

0:23:55.2

Ok. So when you first arrived here, it wasn't necessarily a specialty that had been very thoroughly developed.

Well, no, and that was true at the national level. That wasn't just at Duke, that was at the national level. It was only in the years that followed that that really began to take a lot more detailed work around curriculums and expectations of what you had to do when you delivered chemotherapy.

Yeah. Ok. And you were actively involved in that process, in bringing that to fruition.

Yes.

So can you tell me a little bit about why there was a need to develop that specialty, and what you saw as the key parts of, you know—when you were putting together the curriculum and develping that specialty, what—why was that important to have that, and not just a more general--?

So when you—if you remember when I became an oncology nurse in 1985, all chemotherapy was delivered on the inpatient unit and there weren't many chemotherapy agents. There were maybe four or five common chemotherapies that people were treated with. Unlike today where people get their treatment on the outpatient side. One of the reasons we couldn't do it on the outpatient side at the time is we didn't have the drugs, the supportive care drugs, to help with nausea and vomiting, to help with the side effects associated with the chemo, and so as the, as the number of agents grew, as the way we delivered care changed, as we began to have new medications, supportive medications, enter into the care model, it became more important for people to be educated about that. And so building that educational model for folks to understand so that they could be a part of that change and transofrmation was incredibly important.

0:26:20.4

Ok.

And you know the modalities for diagnostic work ups changed too. I mean, you started seeing petscans, you started seeing a lot of different modalities for working up a cancer patient and so a lot of new technology came into play and making sure how nurses were educated on what those things were and how they helped in the diagnostic work up, because our role was to educate patients when they went down for studies, and so it was important for them to understand all aspects of care.

0:26:58.5

So as the methods of care evolved, there also needed to be a corresponding development of the training for the nurses to administer that care.

Yep.

That makes sense.

So after your two initial years on staff, you enrolled in the master's in nursing program. So what changed at that point? Were you a student full time at that point?

I was a student part time and working full time. Which was a very full life. But I always tell students who are doing this, someone said this to me, it's only for a short period of time, it's not for the rest of your life, and so you just gotta work through that and get to the other side, and that's what I did.

And about how long of a time period was that?

Two years.

And back then when I was in graduate school you still had to do a thesis. Of course that's not required for many master's programs today, but you still had to do a thesis, a thesis study.

Ok. And what was your thesis on?

0:28:24.1

It was—it was very interesting. So if you remember back to the 80s, the other thing that happened in the 80s was something called GRID, Gay Related Immuno Defficiency syndrome. And at that point in time, of course we now know it as AIDS, but back then they didn't know what it was. And many of the patients that were presenting at the time had different types of cancer, either T-cell lymphoma, kaposi sarcoma, and so those patients in the early years often wound up on cancer units. And I was a clinical nurse specialist at the time, or I was studying to be a clinical nurse specialist at the time, and John Bartlett was the head of infectious disease and took care of these patients with HIV and John called me one day and he said I would really like for you to see the patients on the inpatient side, because back then you know it was, we went to extraordinary barriers to protect people, because they weren't quite sure how the disease was actually transmitted at the time. And so I did. And so I started a support group for people with grid. And I did it, you know, back then we had to do it in a location that was a private location, the only way you could find out the location was by calling me and or Sue Avery who was another person who helped with the support group. We would interview the people to makes sure that number one they had HIV because there were times we had bomb threats or death threats and so we had to, there was a lot of fear around the diagnosis and around a group of people coming together. What I learned during that time which was, getting to my thesis, I was doing cancer support groups but I was also doing support groups with HIV and AIDS, and what I learned was back in the 80s when someone's diagnosed with cancer, people really rally around that person. People talk about the fact that they have cancer. Their families support them. But people who had HIV back in the 80s, they often couldn't tell anyone, often they had to keep it from your employers. I saw people lose their jobs because of their diagnosis, that got found out. And they couldn't tell their family, and if their family found out, often their family would isolate them. So I did a comparative study on looking at social isolation in patients with HIV and AIDS versus patients with cancer and really did a comparative analysis looking at what were the variables that drove the social isolation between, or—first of all was there a difference and secondly what were the variables that drove the social isolation, and it really it was true. It really played out in the HIV population. They didn't feel socially supported. And so the support group became the only place where they could talk about it. And it was very interesting.

0:32:06.4

Yeah. And were you able to get the word out in the medical community more broadly that this was a group of people that needed more--?

Yeah. We actually presented, I presented the findings at multiple national meetings at the time. And began to help people look at how do you set up these support groups in their communities.

0:32:31.1

Yeah. So, I know you've had quite a few different roles—that your career has evolved through many stages at Duke. And I wonder, how would you—what were some of the key turning points in that progression. And how did it go towards the administrative role and ultimately the president of the hospital role that you're in now?

You know, Joe, this is always very interesting. So every semester I have six students from Duke Fuqua School of Business that spend the semester with me here at Duke Hospital. And these are people who are going to business schools because they want to be a CEO. When I went to nursing school nurses weren't allowed to be CEOs of hospitals, so I never went to nursing school to be the president and CEO of Duke University Hospital. Because that was not even a possibility. So let's start there as a baseline.

I went into nursing because I wanted to take care of people. And I wanted to make a difference in people's lives. When I was a clinical nurse specialist, I loved being a clinical nurse specialist but there was a turning point. I had a boss at the time. Her name was Brenda Nevidjon, and she was the director of oncology nursing here. And we were getting ready, it was back in the early 90s, and it was a time of managed care encapitation and the balanced budget act from the federal government that cut graduate medical education. There was a series of things that began to create economic crises for healthcare systems and hospitals. And so they were getting ready to open up a pilot unit here at Duke Hospital to try to understand how they would run a unit without graduate medical education, residents and interns. And it was gonna have NPs and PAs and very interesting that the nurse manager who was going to open the unit, the month the unit was a month away from opening and she had to leave the organization. It was her choice, but she had to leave for personal reasons. And so the staff had been hired, they had not been trained, the unit was under construction, and I was called to my boss's office and Brenda said Kevin listen Jan's gonna need to leave and I need you to go down and start figuring out how you're gonna train the staff, make the schedule out, the policies and procedures for the unit need to be written, you need to complete the construction punch list, I mean she just kept going down the list of all these things. And I looked at her and I said Miss Nevidjon I really appreciate the fact that you think this much of me but I like being a clinical nurse specialist and I think you'll find somebody else to do it. Here's where she taught me a valuable lesson.

0:36:03.7

She asked me if I was being insubordinate. And you know no one had ever asked me that before. And I said no ma'am I'm not not but I just I like being a clinical nurse specialist. And she said well Kevin in the life of an organization there will be times that the organization needs you to do something that you may not want to do but the organization needs you to do it. And I'm telling you the organization needs you to lead right now. And if you're telling me no, then you're being insubordinate. So that's how I got into leadership. I didn't raise my hand and say—now the interesting thing looking back on it, because I left that office and I thought, oh gosh, I don't want to do this. I liked being a clinical nurse specialist. I'll tell you the two years of being a nurse manager for that unit, as I look back on my career, they were two really incredible years, you know we set up a shared governance model, it was nurse-led protocols, there were many fun things that I did with that staff, and they were an incredible staff.

0:37:13.9

The lesson in leadership I learned is that there will be people who see things in you that you don't see in yourself. And they push you. And when they're pushing you it doesn't always feel good. Cause you're trying to figure out why are they pushing me like this? And you really are like kind of stop it. But looking

back on it now I wouldn't be sitting here today if Brenda hadn't pushed me that day. And really made me learn more about myself and skills and the talents that I have in bringing people together and leading people that that was a turning point for me.

Yeah. So you think she had an insight into your potential as a leader?

Oh if she was sitting here today absolutely she would tell you that.

What do you that was based on?

0:38:08.8

Well, when there were complex problems as a clinical nurse specialist, your job was to go figure out how to fix those complex problems and typically it was with patients and families. And if you look at often what you have to do in leadership, you often get faced with many complex issues and you gotta figure out how you're gonna fix it and bring teams together to do that. So I think she watched me—I don't think, I know—do that multiple times and she just thought this was the next opportunity that would, I would be able to grow my skills further. And she, by the way, she was absolutely right.

Mm hm. Ok.

0:38:52.0

And so it kind of changed overnight. Is that roughly accurate--?

It didn't change overnight. It took a while because I mean I had never been a nurse manager before so I didn't know what I was doing. I mean I had to figure it out. But I did.

And you were kind of presented with a list of where to start. Ok. And so did your position change at that point or was your job still the same on paper, but you had these added responsibilities?

No. My job changed at that point in time.

Ok.

I was no longer a clinical nurse specialist. Now, I tried to keep being a clinical nurse specialist on the unit and the nurse manager. So I brought both skill sets together during that two years, because I still saw the patients on the unit.

Ok.

0:39:53.1

Well, before we move on into the phase of your career when you were doing more adminsitrative work, were there other people or experiences that you know were formative in your work as a nurse that we haven't talked about yet? Any other mentors--?

There's another person. Her name is Mary Ann Peter. She was the director of medical surgical nursing at the time. And you know, this is another lesson, and I try to live by this, Mary Ann, after me being a nurse for two years, pulled me out and asked me to be the oncology nurse educator, develop an oncology nurse internship program. Now I was two years out of nursing school. And she took a chance on a young person. And she didn't have to do that. But she did. And I will always be grateful to her for that. But that's another moment where I go, that was life changing for me because she could have chosen someone who had ten years of experience. But she was, and I remember spending many private hours with her at the end of a day, a long day, and her walking me through her ideas and her thoughts about what needed to happen next, and she was another person who was instrumental in my growth and development.

Ok. So she's the one that actually gave you the opportunity to not just be doing nursing but also teaching it and doing training--?

Yep.

Ok. Well, we've been talking for about forty minutes, and I think we could probably take a break if you want to.

Ok.

Maybe we can take five or ten minutes and come back and begin again at this point where we are and talk for another maybe similar lenght of time if that works for you.

That's fine.

0:42:14.3

TRANSCRIPTION, INTERVIEW 1, PART 2
PROJECT NAME: Oral History Interview with Kevin Sowers
PROJECT DESCRIPTION: A two-part oral history interview with Kevin Sowers focusing on his biography and career in nursing and hospital administration
INTERVIEWEES: Kevin Sowers
TOPIC: This is the second part of the interview, in which we discuss his career as an administrator at Duke University Hospital.
RESEARCHER: Joseph O'Connell
DATE: January 22, 2018
LOCATION: Kevin Sowers's office, Duke University Hospital
CITY, STATE: Durham, North Carolina
AUDIO FILE: 1009.wav

Joseph O'Connell's questions are bolded.
Kevin Sowers's responses are unbolded.
Timecode is listed periodically.

0:00:00

This is the second part of Joe O'Connell's interview with Kevin Sowers on January 22, 2018.

And we left off talking about the work that you did from 1992 to 1994 as the unit manager of the new hematology oncology GYN oncology unit that was starting up and you were in charge of. And we were talking about how you kind of had to learn how to do that work on the fly, in a sense. Can you maybe describe what some of the things you had to learn to be in that, to do a good job as a leader of that unit?

Well, there's the technical things that I just had to learn like making out a schedule and how do you set up a process so that people feel that it's fair and consistent as to how they request time off.

There was writing the policies and procedures. I had had some experience in that. On the finances side I had absolutely no experience. You know there was a report at the time called the Bud Act Report [unsure of spelling] and I remember getting that report and not knowing what to do with it and realizing that if I was gonna learn how to do it I was going to need to spend time with the folks in finance, so I went over and met with the folks in finance and they were all very helpful in teaching me how to do that so there was technical things that you had to learn but then there was the human side of managing the business which was really around how do you manage people's performance? How do you manage people who are having performance issues? That's a very different skill set than making a schedule, so it was balancing the human side of being a leader and those types of issues with the technical things and you had to learn both of them at the same time.

0:02:17.9

Right. Did you have any help with that?

Oh yeah, there were all kinds of people around that really helped me with that. I never felt like I was by myself in any of those situations. There was always someone that I could, in a place like Duke there is always someone that knows how to do something that they can help you learn, and so people were very gracious during that time.

0:02:43.3

So you weren't having to figure it out on your own.

No. But the other lesson in leadership there is you have to know what you don't know. And ask for help.

0:02:53.4

And I've watched many a young leader feel like they somehow have to prove themselves and they have to just keep going even if they don't know it and that's not a good situation to be in.

Do you think your approach to running this unit, espeically since it was just starting out and there were probably a lot of decisions that you could make about what direction to set it in, do you think that you did things differently than somebody from a purely administrative background might have?

0:03:28.5

So, once I took it on, I knew I wanted it to be different. And at the time shared governance models were just kind of evolving in the nursing literature and so I thought I want to try that with this staff, so that was something that was new that had not been done on other units at the time.

What is a shared governance?

A shared governance is where you involve your staff in working groups that you put together on the unit and they help frame and shape how the unit's gonna run. They shape clinical practice standards. There's a variety of things that they begin to help you with so that it's not just about the leader it's about the leader shaping the team and the team's a part of governing the unit. And how it functions.

0:04:29.5

So everybody has some ownership. They feel like they have some ownership in it.

Yeah. Ok. So from the beginning you knew that you wanted it to in some sense be collaborative with your staff.

Yep.

Ok. And how did that go?

0:04:43.9

It was actually fun and like I said I had some incredible staff members at the time and in fact one of the staff members that I had was a new grad and today she's our chief nursing officer, Tracy Gosselin.

Awesome. And were there, you know, other structural or stylistic things that you did differently than someone else might have?

0:05:09.6

It was really the shared governance—that was the big thing on the unit at the time.

So this was a two year period roughly and you were still doing some direct patient care at that time. And then it looks like you moved into assistant chief operating officer? Is that accurate?

I think what I did then was, after that,

0:05:46.1

Brenda became the chief nursing officer and I moved into a role with her as chief nurse where I began to work with case management with the managed care contracting. I consolidated the advanced practice nurses within the hospital. There was a variety of things that I did around consolidation of registered dieticians, social work, at the point in time they had been so decentralized there wasn't a good accountability model for delivering those services and so Brenda brought me into her office to help with those things at that point in time.

0:06:28.2

I see. Ok. And that placed you directly in administration. And you were no longer seeing patients.

That's correct.

What was that transition like? Was that—what was it like to give up that direct care part of your responsibilities?

You know, you begin to realize as a leader that when you're a care provider you can impact one life at a time. When you begin to get in leadership roles, if you are thoughtful about how you shape the team, and the values you place within the team, you can actually have a bigger impact on a lot more lives. And it was at that moment that I began to realize ok the care delivery models we set up, the values that we set that we're going to have as a team and we're going to embrace, that's gonna have more of a bigger influence on what happens to patients here than if I just continue to see one patient at a time. And that's when I really realized the value and the importance of effective leadership.

Ok.

0:07:39.6

So you could almost define leadership in terms of your experience with care.

Mm hm.

Ok.

And, yeah, I don't know. I guess I'm trying to get an idea of what do you think have been some of those areas where you've been able to make a difference on that level, in terms of leadership and in terms of the decisions you've made as an administrator here.

Well, you know, it's interesting. Duke will always have a special place in my heart. And you know the hardest part of my decision to take this new opportunity at Johns Hopkins--it was not about the opportunity because the opportunity is an incredible opportunity . it was about the people. And to make a place like this work it takes your abiltiy to manage relationships. And it's not just about managing relationships as it relates to is somebody doing their job at night--or doing their job right. That's only one piece of managing the enterprise. But do you know they have a kid in college. And or do you know that their mother just died. And do you acknowledge that. Do you know—there's a human side of managing the relationships that even make it more important as an organization that the leader knows me not just as I'm in this role but they know me and they know and care about me. And I think if I look back on my career I tried to do that because I saw great value. When I look at what we ask people to do here everyday in caring for patients and their loved ones, they need to know someone cares about them too. And as a leader that becomes very important.

0:10:00.5

And that was a lesson I learned early on. That if it's only about the work, it feels different.

0:10:12.1

Ok.

That's all they care about. They only care about the work. Well, no, I care about you, too. And so as a leader, how do you balance that, and how do you make people know that?

0:10:25.8

Ok. So, your approach to relationships might be one of the major areas where it feels like you've made a positive difference. And I know there's something like twenty plus years of time when you've had different admninistrative roles, and I don't know that we need to talk about each step necessarily, but what were the key turning points, and where did you see yoursel f going at this point in time. Early on in the early nineties. Did you know that you were going to continue in this direction?

So, it's interesting because looking back on it now there were some key milestones. So, there was one moment in time where Mike Israel was the CEO, Brenda Nevidjon was the chief operating officer and Rich Liekweg and I were senior vice presidents of Duke Hosptial. And Rich Liekweg is now the CEO of

Barnes-Jewish healthcare system in St. Louis. And what was fascinating for me to watch was Mike and Brenda locked us in a hotel and Mike said you know for Duke hospital to be successful in the future it's gonna take a different type of model, care delivery model. And organizational structure, and it was at that point in time we came up with the clinical service unit model where there's the triad of leadership to drive that partciular service line, so there was a medical director, a nursing director, nursing leader, excuse me, and also an administrative leader and it was those three people that came together to develop the strategy for the service line, i.e. heart, oncology, periop, but they also had the respnosibility and the accountabilty for executing on the strategy and driving performance through those areas. So we made that transition, came back and made that transition and that was a key turning point for the organization and for us as leaders. And the other thing they did during that time is they brough Rich and I into the office and they said ok Rich here's your portfolio you're gonna have this half of the hospital this year and Kevin you're gonna have this half of the hospital. And a year from now we're gonna bring you back in and you're gonna switch. And Rich and I, I remember we were walking out of the office because we kept saying, well, are we gonna have to apply for the positons, how's that—and they said, no, we're just gonna do this. They said at this point in time we need at least two people who know something about every aspect of this hospital because we have to worry about succession planning. If something would happen to one of us, who could step up and lead the organization . So I remeber Rich and I were walking down the hall and we thought, you know, this was anarchy. This is crazy. Here they are switching us and putting us around and looking back on it now, it was really a brilliant idea, because today I do know something about every aspect of the hospital because I managed every aspec t of the hospital during that two year period of time. So they were very smart and thoughtful and strategic and if you look at what's happened in my career and you also look at what's happened to Rich's career, that experience really did shape us. And really gave us a much better understanding as a leader of all aspects of the enterprise.

0:14:17.5

So the leadership above you at the time made a conscious decision to give you a variety of roles so that eventually you could rise up in the ranks and be the one to manage the entire hospital. Is that fair to say?

Yep.

So we did that.

0:14:38.6

At the time I was, I did that, and at the time I was interviewing to be the chief operating officer at Memorial Sloane Kettering up in New York City and the reason I was doing that was I was trying to think what I was going to do next with my career so I thought, oh gosh, if I can take my love for oncology and if I can take what I've learned administratively and apply that and go do that, that could be a lot of fun. So I was interviewing, I was in the final rounds of the interviews and I came back and Mike Israel was the CEO at the time, and I went into his office to tell him about where I was with the interview process, and he said, Kevin, listen, people don't want you to leave, they want you to stay here, so we need to talk

about what it's gonna take for you to stay here. And I said, well, Mike, it's not about the money, and it really has never been about the money for me. I said but I want to be challenged in a different way, there are things that I still have to learn. So he went over to the phone and he picked up the phone and he called this guy up in Toronto and it was a guy who they had been trying to work with to consolidate the labs for the clinical laboratories for the health system, because there was about a five million dollar savings we could achieve if we consolidated the labs, and multiple people had tried it and it had failed, they had built a consolidated laboratory up in north Durham, it had been sitting empty. They had bought an automated system that they were gonna implement that was sitting up in a warehouse in Toronto, and so he picked up the phone and he said, hey, listen, I need you to fly down here tomorrow, I want you to meet with Kevin Sowers. Kevin's going to help us consolidate the labs. Now by the way, Mike didn't ask me if I was gonna do that, this is how he handled it. And he looked at me and said well you have a new challenge. He said this guy's coming down tomorrow, you'll meet with him and you're going to consolidate the labs for the healthcare system.

0:16:52.1

And this was a project that had been kind of sitting dormant, had failed—

Failed. Multiple people had—and I did it. By the way, didn't know anything about clinical labs at the time. But at the end of the day looking back on it, the lesson in leadership I learned there was there was a lot of emotion around it, and it wasn't all based in fact. And so as a leader how do you take the time to listen and sort through what is emotion versus what is fact. And how do you bring fact back into the discussion, because you can't let emotion drive you, but you have to listen to the emotion to get to the facts and that's what I spent a lot doing during that period of time was listening to a lot of emotion but responding with fact, and we did consolidate the lab at that point in time for the health system.

So after I did that, Rich Liekweg had been the CEO at Duke Regional and Bill Donovan had asked me to go up and to be the interim CEO up there, and I was up there for almost 11 months, I believe, almost a year. And I got them through their joint commission survey. I was trying to decide at the time was I going to stay there as the CEO or not, or was I going to do something else, and I got a telephone call on a Friday afternoon from Dr. Fulkerson because it was back in 2003, I believe it was, yeah, 2003, and we had transplanted a mismatched heart in a young girl whose name was Jesica Santillan here.

0:18:48.0

And it was horrific. It was horrific in the life of that child and the family of that child, but it was also horrific in the life of this organization because if you go back and Google it you'll find that it was not just a local news story, it was national and international news, and every day you would come to work at Duke Hospital and that front circle out in front of Duke Hospital, that entire circule was filled with tv cameras. We had to rope it off because they would try to grab our employees on the way to work and try to do interviews with them and so, it was a really difficult time on many different levels, but we made a huge medical error. We made a mistake, and so every regulatory agency in the country was in here looking at everything we did wrong, and by the way they should have because we made a mistake.

0:19:46.0

So what was interesting was Dr. Fulkerson was going to have to go in and testify before CMS down in Atlanta, and he called me on a Friday afternoon and he said Kevin I need you in my office on Saturday. He said I want you to look through these reports with me, and he said I'm going to announce that you're gonna be the next chief operating officer. He said I'm gonna go in to CMS and I'm gonna tell them I'm putting a nurse in charge of the operations of Duke Hospital and your focus will be on quality and safety.

0:20:17.3

That was another turning point in my career because I didn't see that coming. It was a complete surprise. I didn't raise my hand and say pick me. And so I did, I came here and spent the weekend with him, and I told him that if I was going to do it the first 120 days I would not go to any meetings. For the first 120 days I wore scrubs to work, and I spent time on every aspect of Duke Hospital. I worked in the cafeteria making food. I made beds, I cleaned rooms, I worked in the sterile processing. You name it, I was everywhere. And the reason being was the morale was so bad at the time that they didn't trust anybody, they being the employees. And why would they because how could you let something like this happen. And so I felt like I needed to see what the issues were first hand and hear from them, and then at the end of the 120 days I came back and did a big open forum and told people what I had learned. And told people what I felt we needed to do as a team to address those issues.

0:21:42.9

At the same time we had a financial crisis, and so I had a safety and quality on crisis on one hand and a financial crisis on the other. The good news is we were able to work through both of those, but it took incredible parnership with all parts of the hospitals to make that happen, and that's why I say this is a team sport, this is not about me just as a leader. It takes a team to make Duke Hospital successful.

0:22:15.7

When you were appointed into this role-- we're talking about the COO of Duke Hospital?

Chief operating officer of Duke Hospital.

You said that they in particular, they wanted to annouce in particular that were appointing a nurse, former nurse to that role. Was that part of the decision? Was that part of what made you the right candidate for that position?

You know, I get asked that question a lot. So, number one, I'm very proud of being a nurse, and when people ask me what I do at Duke, I tell them I'm a nurse, that's the first thing that comes out of my mouth.

You still identify as a nurse.

Because I don't go around telling pepole I'm the presicent oof Duke hospital. I just, that's not who I am , and people always chuckle when we're out and somebody says well what do you do at Duke and I say

well I'm a nurse because they're like you really didnt tell them what you—it doesn't really matter. Because this job can go away tomorrow, if I've learned anything, so, and where are you grounded, and I'm grounded in being a nurse. Did it make me a better COO and president? Well. Can I have clinical conversations with the faculty and the staff? Absolutely I can. And do I understand those clinical conversations. Yeah. At the end of the day does it make me a better COO or president, I've seen some very effective CEOs and presidents that aren't nurses. To be a president and CEO the question is can you manage relationships, can you take complex problems break them apart, understand and partner with key stakeholders as to what solutions might be, and then can you bring teams together to execute on those. That doesn't just take a nurse to do that. So I'm always mindful to know that the nurse in me gives me the ability to understand the clinical care we provide here from a first hand perspective but does it make me a better leader, I don't know if that's necessarily true. Because there's other human qualities to being a leader that anyone can have.

0:24:43.9

Beynod a nurse.

Yeah. And were there points in your time as an administrator at Duke where you felt like pepole were skeptical of you because of your nursing background, or was that--did you ever feel you were met with resistance because of that?

No. No. In all my years here I have felt supported, as a nurse and as a leader. And I think you know last night there was a, the clinical chairs of the departments threw a wonderful dinner for me and one of the things that was said was they always knew coming into my office that I would tell them the truth. And it wasn't always what they wanted to hear, but I would tell them what I was thinking and why. I would listen to their perspective, I would make a decision, but they always left my office feeling as if they were heard, maybe always didn't agree with the decision, but they understood my rationale for why I was having to make that decision. And you know at the end of the day if that's how people remember you I'm ok with that because it's about being fair and consistent and being respected.

0:26:18.8

It's not about being liked. I didn't do this to be liked. I did it because at the end of the day I feel ultimately accountable for the patients and the families we care for here, and so I have to make some difficult decisions that not everyone's going to like all the time.

0:26:40.3

Are there things that you think people misunderstand about the role of being president of a hospital like Duke Hospital? What do you think are the misperceptions?

I think that people think that I sit in my office waiting for the phone to ring and you know, I don't think people have a full appreciation of the complexity of managing the enterprise. You know in the life of the day, in one meeting you're dealing with quality and safety issues and performance issues around quality and safety, you can go into the next meeting and you can be dealing with a complex HR issue. You can

go into the next meeting and you can be dealing with a faculty performance issue. You can go into the next meeting and you can be talking about how you're gonna grow a service line in a particular part of the state. And so you have to be able to flip very quickly from one issue to another issue. But no day is the same. And I don't think people realize that all of that is coming at you at once. And oh by the way you have to perform well financially because the only way you keep this enterprise going is to make sure that we're financially successful too.

0:28:13.8

I think you've mentioned a couple times the idea of healthcare as a business. So that's always a concern as well, the economics of it. Have you ever felt like there was a time when there was a conflict between the economic decisions and the decisions about other values?

No, you know, one of the things I appreciate about the work we've done, probably in the last decade, is a focus on the values here of teamwork, integrity, diversity, excellence, and safety. And then the core value of caring for our loved ones, our patients, and each other. And do we have to make difficult decisions around finances? Absoltely. Because you know with the transformation of whats going on in healthcare and the new value proposition of quality equals, no, value equals quality plus patient experience plus cost and efficiency, and if you look at the national trends in terms of what healthcare means in terms of the gross national product, it's not sustainable, and everybody knows that. So how do you begin to make sure that you have a good quality product, but are you doing it in the most cost effective manner? So that's a hard discussion and there's hard decisions in there. The question you have to ask yourself as a leader is what's the process you're going to use to ask those questions and then how are you gonna benchmark where you are compared to other like organizations.

0:30:11.5

And how does that drive you in thinking about how you redesign care. If you do it that way you'll be ok. If you do it we just have to cut this much that's where you start to get in trouble every time.

0:30:28.5

Right. So it's all about understanding the big picture not viewing the economics in isolated--.

That's correct.

One thing we haven't talked much about is some of your work, some of your writing and your lectures, because I know you've contributed a lot on some of your areas of interest. I found some publication that you had on things like burnout and mentorship, leadership. Where does that piece of the puzzle fit in to your work, of contributing ideas and contributing as an intellectual?

So if you look back I've done that my entire career and its been through lectures and it has been through writings. I really felt a calling to really begin to talk about things that I saw happening or ideas that I had or things that I had tried and how it had worked and to share that with others. And to do it in a way that was fun at times, to do it in a way that was non-threatening and to do it in creative ways where you can

get people to see something that if you just do it through—you'll see that I also wrote a lot of sociodramas.

I saw that term and I didn't know exactly what that meant.

So I took a lot of the things I saw in the clinical area, either interactions with patients or specific patients and had those turned into plays, and then created discussion sessions after the play so that people could begin to think about, had they been in a situation like that. It was a very different way of teaching at the time.

Did you come up with that idea on your own or was that an established model?

I had learned about it, I had done it you can see at the national level for many different organizations, as a tool to make points about ways that they could change the way they delivered care to patients or to better understand issues that patients are facing. Like the one sociodrama, I took the evidence based literature on breast cancer patients and evidence based literature on patients with GYN cancers and in that partiuclar play there was a woman who was diagnosed with GYN there was a woman who was diagnosed with breast cancer and what happened on stage was the evidence based literature came alive and immediately people could see the differences in some of what they were struggling with. Now I didn't have slides and powerpoints and go through a lecture but people saw it come to life and so the findings of the reasearch, I partnered with a a researcher out at the City of Hope, Betty Ferrell, and she's done a lot of the psycho-social research on women and cancer and partnered with her so that she was part of really making sure that I was thoughtful in how I intergrated the evidence based research into the sociodrama as a way to teach people

0:34:21.3

Wow. It sounds like a way to not just tell people about a particular insight but to actually show it to them.

Well for me it was an opportunity that allowed me to intergrate my love for the arts and my love for the work I did in music and that creative side and bring together with my nursing side and so it was a great opportunity.

Did you ever write music for any of the sociodramas?

Mm hm. Yeah.

Wow. Are any of them on YouTube?

No, but I've got CDs of them.

Ok. I'll ask the archives if that's something they'd want a copy of.

0:35:10.8

Ok.

So, I think before we wrap up I do want to ask you a little bit about the leap to Johns Hopkins and what brought about the decision to leave Duke and accept a new opportunity?

So first of all I was not looking to leave Duke, but if you go back to 2003 to the present I will have been if I stay another year I will have been COO and president of Duke Hospital for 15 years. That's a pretty long track record. In fact if you look across the country the average lifespan of someone in my role right now is about 3 and a half years. So I had been talking to Dr. Fulkerson that my biggerst concern for the organization was me staying as long as I've stayed is not normal. And by the way it's been an incredible run. These 15 years. So I don't really have any bad feelings about my time here but I was also worried about the succession plan for the organization because there are these moments that are critical as a leader that you realize you can stay too long, too. And that was one of my biggest fears was in another year it will be 15 years and what next. What happens. To be the president, yeah, I could sign up for another five years and do 20 years, that's probably not good for me and it's probably not good for the organization. Because the organization needs to prepare itself for a different leader. And so that's the conversation I had been having with Dr. Fulkerson and then the folks from Johns Hopkins called and asked if I would have lunch with Dr. Rothman who is the chancellor and who at the time by the way I did not know I was being interviewed. I did not know. I've always wanted to meet Dr. Rothman. I flew to Washington DC, had lunch with Dr. Rothman and really liked him as a person, but it was like the conversation we're having now. Just tell me about who you are and your career. He did the same thing for me.

0:37:42.4

And then I learned about the position. And I actually got excited about it because it's probably my last career move but to leave here and to be able to go to another world renowned organization and lead what is their health system. They have six hospitals in this country they have two hospitals in Saudi Arabia. They have a children's hospital in Florida. And so to work with another great team of people to really try to figure out what are the care models that we have to create with those types of assets in the future to be successful, I got exccited by that and the hardest part of the decision was not about the job, it was about the people.

0:38:34.8

Can you explain that more?

Well you know when I say people it's not just Duke. I mean, having lived in Durham for 32 years I integrated myself into this community, too. So I made sure that I, you know, helped build houses with Habitat for Humanity, I volunteer in our community in many different capacities. My friends are here in this community and so it was the decision I didn't take lightly on the people side.

0:39:20.2

Right. That makes sense. And it sounds like your new role will be even a bigger scale—it will be overseeing multiple hospitals instead of just one. Is that accurate?

Mm hm.

I'm curious just to wrap up, what do you think the key challenges in academic hospitals are right now, and are there particular areas where you're thinking about, where your work is gonna be focused going forward or particular things that you have in mind that you want to change before your career is over?

So I think that the challneges in academic medicine or academic healthcare is there's multiple layers but I'll start at the 30 thousand foot level . And that is how do you create a sustainable economic model to support all three missions. Historically the way academic medicine got funded was off of the clinical revenues. When you start to see the clinical revenues shrinking across the country the question is how do you now continues to sustain at the level you have around research and education, and so that's a big challenge for all of us especially when you also see changes to NIH funding in the country. There's multiple variables happening all at once that's causing that to be a challenge. The second one is if you really step back and think about what you have to do to be successful in the future, not all care will be in the academic medical center so you really don't need to come to a Duke Hospital or a Johns Hopkins hospital. To get an apendectomy. You might need your appendix out but you can get that done in a cheaper setting. So if you start to look at a distribution model that really begins to position certain patients that do not require tertiarty, quaternary care in lower cost settings that forces you to think about how you use the entire enterprise. That also forces you though to start thinking differently about how you educate the next generation of providers. Because the model of everything took place here and learners learned here, that's gonna be different in the future and so what's that look like?

Also as you start to think about research, the value and the importance of basic science from bench to bedside in transforming healthcare outcomes is incredibly important. What's even going to be more imporant for us in the future is health, you know, studying healthcare models so that we can understand the impact of how we change care delivery systems on populations of people and healthcare outcomes for populations and population research so that's going to be even more incredible for the academic medical enterprise to focus on in the future.

0:43:09.2

Ok. Yeah. That makes sense. It sounds like a really dynamic situation where you kind of always have to be making a lot of changes to keep things in the same place.

Yep.

Ok. Is there anything that we haven't covered that you think would be important to document for the archives?

Alright, well I think we're at a good stopping point. And thanks again for working with me on this.

You're welcome. You're welcome, Joe.

0:43:46.4