

ORAL HISTORY INTERVIEW WITH DAVID LEE SIMEL
Duke University Libraries and Archives
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COLLECTION SUMMARY

This collection features an oral history Joseph conducted with David Simel on March 5th, 2021. The 67-minute interview was conducted in Durham, NC. Our conversation explored Dr. Simel's early experiences in and around medicine, his research in clinical exam and diagnostic tools, and his work at the Durham Veterans Affairs Medical Center and as Vice-chair for Veterans Affairs in the Department of Medicine. The themes of these interviews include veterans' health, medical training, hematology-oncology, and general practice medicine.

This document contains the following:

- Short biography of interviewee (pg. 2)
- Timecoded topic log of the interview recordings (pg. 3)
- Transcript of the interview (pg. 4-22)

The materials we are submitting also include the following separate files:

- Audio files of the interview*
 - Stereo .WAV file of the original interview audio
 - Mono .MP3 mixdown of the original interview audio for access purposes
- Photograph of the interviewee (courtesy: David Simel)
- Scan of a signed consent form

*Due to COVID-19 social distancing protocols and best practices, Joseph recorded the interview remotely via Zoom.

BIOGRAPHY

Dr. David Simel is Professor of Medicine and Vice-chair for Veterans Affairs in the Department of Medicine at Duke University, where he also acts as Chief for Medical Service at the Durham Veterans Affairs Medical Center. Simel was introduced to medicine as a potential career path at an early age, observing his father working as a physician at two (at that time racially segregated) hospitals in Greensboro. His father's friendship with dentist and civil rights activist George Simkins Jr. allowed Simel to see first-hand the long struggle to desegregate public facilities in North Carolina.

As he grew up, Simel was afforded the opportunity to visit his father at work, eventually joining the hospital staff as a summer worker while in high school. He recalls that in those "pre-regulatory days" he was able to participate in medical tasks including drawing blood and performing EKGs. A quick study, Simel was immediately passionate about medicine, and specifically the many tests, diagnostic tools, maneuvers, and conversations that could lead to a diagnosis or treatment plan for patients. As his path led him from an undergraduate degree at UNC to medical school at Duke, he honed interests in hematology-oncology, general practice medicine, and the rational clinical exam. As a researcher, a highlight of his research and educational work has been editing the "Rational Clinical Examination Series" published in the Journal of the American Medical Association, a series birthed out of a relationship he forged with JAMA at the age of 30.

Another passion of Dr. Simel's has been the health and well-being of veterans. While working as a staff physician at the Durham Veterans Affairs Medical Center, Simel quickly had an "awakening" on how working with this specific patient base would require specialized training and sensitivity. "Once you understand that things that happen in the military can have real daily life impacts on people, you begin thinking about things in a different way," he says. One of the initiatives he is most proud of is that of the VA's work to create one of the first comprehensive health centers in the country dedicated to women veterans.

INTERVIEW TOPIC LOG (david-simel-interview-audio.wav)

- 00:00 Introductions
- 00:25 Upbringing in Greensboro, NC
- 02:19 Father's work in segregated hospitals (Moses Cone Hospital and L. Richardson Hospital); father's friendship with dentist and civil rights activist George Simkins Jr.
- 04:02 Early experiences exploring medical library while visiting father at work; watching resident interpret vector cardiograms
- 06:15 Undergraduate education at UNC and initial impressions of Duke
- 08:42 Remembrances of Mudd Library
- 09:40 Collection of physical exam textbooks
- 13:00 High school job at hospital
- 16:09 Observations on early privileges, experiences, and opportunities
- 16:59 Mentorship by Bob Waugh at VA and Hal Silberman as fellow; early medical school interest in the physical exam
- 22:15 Development of research interests and early study evaluating physical exam findings for ascites; description of funding opportunities for physical exam research
- 27:18 Examining for ascites and early findings on signs during VA research
- 29:27 Development of analytical skills during Master's degree in Biometry (now Master's Program in Clinical Research); teledermatology study
- 32:04 Observations on own research interests in general medicine and creating a path as part of a married couple both in medicine
- 34:33 How Dr. Simel and Dr. Joanne Piscitelli (Obstetrics-Gynecology) approach discussing work as a married couple; advice for trainees in similar positions
- 38:05 Rational clinical exam and work with JAMA; meeting with Dave Sackett while at conference with Jack Feussner
- 44:44 JAMA editorial strategy and acute myocardial infarction article; debunking of maneuvers
- 51:45 Tenure at VA and development of Women Veterans Comprehensive Health Center
- 55:28 Perspective on working with specialized patient base of veterans; approaches to patient interactions and conversations at VA
- 1:02:47 Reflections on personal and familial loyalty to Duke

TRANSCRIPTION (david-simel-interview-audio.wav)

Joseph O'Connell 0:00

So it's March 5th, 2021. I'm Joe O'Connell. And I'm interviewing Dr. David Simel for the Duke University Medical Center Library and Archives and the Department of Medicine. And thank you, Dr. Simel for being with me over Zoom today. I appreciate you being part of this project.

David Simel 0:23

Thanks for inviting me.

JO 0:25

I want to start with talking a little bit about your family. I read that your father is a physician. And what did your mother do?

DS 0:38

So my mother was trained as an interior designer, but mostly just took care of us at home. So I grew up in Greensboro, North Carolina. And I would say in reflection on that, that those were really interesting times. My dad had been in the military. And we moved to Greensboro, the summer after the Greensboro sit-ins. And I distinctly remember, my father was a jazz musician, and during the 1940s when he was a teenager, he had a band, and one of the members of his jazz band was black. And they weren't allowed to play a lot of gigs that they wanted to play. And so my dad, in the 40s, as a teenager, started a lifelong membership in the NAACP, which was interesting for a kid growing up in Brooklyn. And so we moved to Greensboro, and my dad used to take me with him to go on rounds and he would leave me in the library, and there was Moses Cone Hospital, which was the white hospital, and L. Richardson Hospital, which was the black hospital. And my dad would go back and forth between hospitals. And I thought it was really cool. I never questioned why there were two different hospitals. But it was interesting times. And Greensboro evolved into being the focus of desegregation of hospitals, later on.

JO 2:19

Do you remember your dad talking about that experience of serving patients in this segregated system?

DS 2:31

I don't remember him talking about it a lot. It was just something that he did. And I was just a kid. I was pretty young. So I didn't question him very much. I was proud of my father. I remember being proud of my father for working at both hospitals, because not every physician worked at both hospitals. But there wasn't a long discussion. There wasn't much discussion about why there were two hospitals. My dad befriended a dentist in Greensboro, a black dentist, George Simkins [Jr.]. They were tennis partners. And George is quite well known for figuring out how to use the law when there's federal investment of dollars to desegregate public facilities. He started first desegregating Gillespie Golf Course, which was a public golf course in Greensboro that was built on federal dollars. And he desegregated that. And then he had the brilliant idea to begin to desegregate hospitals using that same law. So I grew up during those

times in Greensboro, and saw a lot of things that I wish I had understood better at the time, what was going on and why.

JO 3:50

That's amazing. So your father was actually friends with him at the time that he was working on desegregating the hospitals?

DS 4:00

Yes.

JO 4:02

So you were really seeing medicine in a social justice context from an early age?

DS 4:12

Totally. I didn't realize that at the time. But I totally was. My dad would leave me in the library of each of the hospitals while he would go do rounds. And I would sit in there and sort of read books, and look at books. No one told me not to look at books, I was in a library. But I do, ironically, or it's probably related, distinctly remember reading physical exam textbooks. And just looking at the pictures, and reading explanations of them. And I don't know if that's why I developed a career doing research in the physical exam. But it is a fact. It did happen. And it was probably in grade school, that was the beginning of my medical career.

JO 4:56

[laughs] And that would be the time when you were looking through just the stacks in the medical library?

DS 5:03

Yes.

JO 5:05

What do you remember seeing in particular? Do you remember any particular volumes?

DS 5:14

No, I don't remember particular volumes. I do remember, I couldn't have been more than 10 or 11 at the time, sitting in the Moses Cone Library, and the chief resident for Medicine came in. And he was studying and learning how to interpret vector cardiograms, which is not something we do now. But I always remembered, not just about vector cartograms, but that he took the time to talk to a little kid about what he was learning. And I was fascinated by it.

JO 5:49

So vector cardiograms, would that have been an image?

DS 5:54

No, it was sort of the precursor of -- it was a way to sort of step up electrocardiograms. It was an image, but it was sort of a line tracing on a piece of paper.

JO 6:05

Well, that does sound kind of cool from a kid's perspective.

DS 6:09

It was totally cool.

JO 6:15

And I read that when you were looking at medical schools, you didn't really think seriously about going to Duke.

DS 6:28

Right.

JO 6:28

Can you say more about why that was?

DS 6:32

So growing up in Greensboro, it felt like if you were in the top [or] near the top of your class, or upper third of your class that your sort of go-to school was UNC in Chapel Hill. And so, I applied to two schools [for] undergrad, I applied to UNC and I applied to Dartmouth because that's where my father went. But I was going to UNC. So I went to UNC. And I never really gave Duke a second thought. Duke wasn't like a thing, at my time, when you were growing up in high school. I mean, there was a basketball rivalry, but I mean, no one went to Duke. And even while I was at UNC, I never drove over to Durham never went to see Duke. And so as I started applying for medical school, I thought, "Well, I'll apply to Duke. And I mean, it's only like, 10 miles from here. It would be a good place at least to get in a practice interview, if they interview me early." So, I got the interview, and I came over here, and I took a tour with the director of admissions. And they took me to the library, the Mudd Library had just been built, recently built. And it was surrounded by forest. And it had this weird lighting system that just made it -- those windows made it look like, you can't really tell now, but it looked like a spaceship in the middle of the forest. And while I was at UNC as an undergrad, I loved studying in the library. And I walked into that library and I thought, "Man, this would be a really cool place to study." And then the second thing was they described the curriculum to me where, in the second year, I could start seeing patients. I didn't have to wait till the third year. And I was sold on it. And like a week later, I had an acceptance, before I'd interviewed anywhere else. And so everywhere else wound up... I don't even know why I went to interviews at other places, I'd already decided I was going to Duke at that point.

JO 8:25

So it was kind of out of nowhere.

DS 8:30`

It was totally out of nowhere. I literally came here thinking this would be a practice interview, so I could see what med school interviews will be like.

JO 8:42

I read where you refer to the Mudd Library as architecturally bizarre.

DS 8:53

It was. I mean, it's hard to imagine now, but that thing was in the middle of the woods. There was just nothing around it, other than trees. So it was like it had been dropped from space into the forest.

JO 9:10

And did you find studying there to be as exciting as you had hoped?

DS 9:18

Yes. During the first year of medical school, there was a core group of us that would be in the library every night. And that was our place to study. I mean, some people studied in their apartments, but I liked to get out of my apartment. And it forced me to concentrate. So I spent a lot of my first year medical school in the evenings in the library.

JO 9:40

I also read that you're collecting physical examination books around this time?

DS 9:51

Yeah, I sort of had a hobby of doing that. Med school at the time, I mean, relatively speaking was expensive, but in retrospect wasn't that expensive. And I had the good fortune of being able to go to school without a lot of debt. And so I could afford to buy books. And I still, I just love looking at the physical exam textbooks. Because I wanted to really be a doctor. And I wanted to take care of patients. And at the time, I thought, "Well, I've gotta learn this, because it's important." So I spent a lot of time looking at physical exam textbooks.

JO 10:37

So was it partly the sense that the books that offered instruction in physical examination, you thought of those as sort of fundamental to being a physician?

DS 10:53

Yes, absolutely. But when you're a first year medical student, one of the problems first year medical students have is figuring out what's really, really important, and what's not. Because, for the first time, compared to undergrad, you're studying something that really matters. In the sense that what you learn, you're going to apply to actually taking care of patients. It's not just learning for the abstract, and learning because, "This would be fun, to learn about German history." So you're really going to apply it. And during high school I had worked in a hospital. In the pre-regulatory years, I was drawing blood, I was doing EKGs, I was running chemistry machines. I was actually doing autopsies with the pathologist when I was in high school. And so I had a good sense of what was going to matter. And it seemed to matter, to me. The physical exam textbooks seemed to matter to me. So that's why I got interested.

JO 12:02

You mentioned that there was one that you particularly loved that was by DeGowin and DeGowin.

DS 12:11

That was my favorite one. It seemed encyclopedic. There seemed to be something about everything in there. And so I just kind of loved it. It was easy to read. It resonated with me. It was also small. We carried black doctors bags then as medical students, and I could put it in my bag, so it was my go-to book.

JO 12:39

Was there something about them as objects that was also appealing? And it sounds like in this case, it was the size?

DS 12:50

Yeah, it fit.

JO 12:53

The portability.

DS 12:54

Right.

JO 13:00

So if you don't mind, I really would like to know more about your job at the hospital in high school. And you mentioned pre-regulatory times.

DS 13:08

Now you could never do what I did. My first job in high school was I worked for the Carolina Cougars, that's the old American Basketball Association. And I was an assistant to the public relations director. Every game I got to sit at the scorer's table.

JO 13:30

That sounds fun.

DS 13:32

I saw some awesome basketball. And I still have a vivid memory of how large Julius Erving's hands were. I never saw bigger hands until Jahlil Okafor played at Duke [laughs]. So, but in terms of the hospital job, my father knew the pathologist at the hospital, who offered me the opportunity to just work there during the summers. So it was a summer job. At first, they taught me how to draw blood, as a 17-year-old. So I would go, as a phlebotomist I'd go out and draw blood as a 17-year-old for filling the doctor's orders. And then I learned how to do an EKG machine. And then I would work evenings. And it was a little bit like that chief resident I described. One of the lab techs there first taught me how to do blood counts. So [to] look at the microscope slide, and he taught me the different types of white blood cells. And so, as a 17 or

18-year-old I was actually doing the CBC differentials. And then they taught me how to do urinalysis, and then they taught me how to run the chemistry machines. And man, I was like, in heaven. And then the pathologists, when they did an autopsy, would take me down to do autopsies. It was pretty cool. I was the only one in high school doing autopsies. And it never bothered me. You would think maybe it would gross you out. But it just never did bother me. And so I was just in heaven. And it was just a great summer job. And then during school I was able to continue working there some, in the evenings. Turns out during medical school I also worked -- a lot of my friends, including my future wife, [were] working as phlebotomists in the hospital as medical student[s]. But I had an additional skill. So I actually worked in the Duke emergency room running the chemistry analyzers during the overnight shifts. So, I had a paying job during medical school.

JO 15:39

On the basis of all that responsibility that you had experienced earlier.

DS 15:45

Now, to think that someone who hadn't gone to med tech school was doing what I was doing is a little scary. But I think I was pretty good at it. So it was cool.

JO 15:56

It wasn't like your credential and running these, it was more like, "Yeah, I've done that before."

DS 16:04

[laughs] Correct. It was on the job training.

JO 16:09

I can see why this path was really inspiring to you. Because it sounds like people really, when you were young, they got you involved and let you participate.

DS 16:25

I mean, I'm very aware of my privilege, is the best way to describe it. I had opportunities, mostly through my dad, that most people just don't have. And I took advantage of them. I was comfortable doing what I was doing, I knew that I was advantaged at the time. But I worked hard, and I think I made the most of my opportunities.

JO 16:59

Since I know physical examination has become a centerpiece of your research, I'd like to talk a little bit more about your experience arriving at that focus, and that interest. And maybe we can continue to talk about your training a little bit more and we'll get there. I know Harold Silberman was a mentor of yours. I want to ask you about that relationship. And maybe we could start with, do you remember meeting him for the first time? Or do you remember first impressions of him?

DS 17:52

Let me just back up a little bit about mentors. When I was a second year medical student, my rotation was at the VA. And my medicine attending at the time was Bob Waugh. So Bob Waugh

was a cardiologist and did echocardiograms. And I just got lucky that I got matched up with Bob, because one of his passions was the physical exam. And what he told me on on rounds one day, very early in the rotation -- he didn't know that I had an interest in physical exam -- but he told me that his job was to listen to my history and physical the day after I admitted a patient, and to figure out from the history that I gave him what he could anticipate from the physical exam, and from my physical exam, what didn't make sense given the history. And at that point, I was totally hooked, because that's what my cardiologist was telling me was all-important. And so that really accelerated my passion. It validated kind of what I'd been interested in. And so I graduated from medical school early. My wife and I both finished medical school in three and a half years. So we graduated in December of what would have been our fourth year. Joanne started an anesthesia internship, which she did for six months before going into obstetrics and gynecology. And I started as a fellow with Hal Silberman, which sounds totally bizarre. How could you be a fellow before you were even an intern and a resident? And you just could [laughs]. They said you could do it, and it was really more [that] I was attached to Hal. He watched over me kind of like a hawk. And I worked as his sole fellow for six months. So I would do histories and physical exams of new patients coming to see Hal. I would round on the patients with him in the hospital. And I was mostly learning, at that point, by osmosis. But it was an awesome thing to be just immersed into hematology-oncology right after medical school. I was attracted to that because I had worked in the laboratory at the hospital, and love looking at blood films under the microscope. And I knew I was good at it. So to me the hematology part was just sort of fascinating. And Hal each year would take someone who graduated early and have them work for him as his fellow for six months. Hal paid me, and it was just an incredible experience. Hal had a pretty unique approach to taking care of patients. And one of the things that I learned from Hal is that he taught me that before you're a doctor, you're a human. And you have human reactions to patients, and you have feelings about patients. And you need to be able to recognize sort of what those feelings are and to deal with them. And it allowed Hal sort of the freedom to be frank with patients, and to express what he was feeling. Usually in a medically-appropriate way, but sometimes not. Occasionally Hal would get angry about patient behaviors, and he would confront them about that. He would call them out about that. And he would challenge them to sort of be different. And it was real important to me to be able to see that. But it was an incredibly exciting time for me. And then I started internship, right after my first six months of fellowship.

JO 22:04

So you were on a pretty accelerated path.

DS 22:08

I was. I didn't know what it was a path to, but I was on a pretty accelerated path.

JO 22:15

And it turns out that your research agenda in physical exams has become very important. And I would like to know what were some of the early experiences that you had, when you mentioned the conversation with Bob Waugh and that was a moment of insight. What else do you remember about realizing that there needed to be more attention to the way people were doing physical

exams and there needed to be more data collected on how people do that and more standards set for how exams are done?

DS 23:08

Well during that time I worked with Hal, I sort of was thinking I wanted to go into hematology-oncology. And then I started internship. And like many Duke house officers, I sort of wanted to do some clinical research. And so I started actually working with Dr. Cox in the Oncology Center, and I set up the myeloma database at Duke. And it was fascinating to go through that. But as I was going through that, in doing that, I started thinking that maybe an academic career in medical oncology with the type of research they do wasn't going to be for me. But I wasn't certain about that. And then what happened was, I got asked to be -- again, I guess, on an accelerated path -- chief resident right after my third year of residency, so most people are offered the chief residency to do after their first full year of fellowship. And so Dr. Yarger and Joe Greenfield asked me to do it right after my third year. And during that third year, Dr. Greenfield wanted his chief residents to do research that engage the house staff. And so my mentor at that point had become Dr. Jack Feussner. And we decided, based on an article that we had read in [The] Journal [of the] American Medical Association on the physical exam for ascites that it hadn't been done well, and I could do it better. And so during that chief residency year, I set up a study evaluating the physical exam findings for ascites. So ascites is excess fluid in the belly that is outside of the organs, so it's fluid that's just floating in the belly. And the most common causes are heart failure and cirrhosis. And so in the evenings, I would go around and examine people's bellies. And man, I was just having so much fun. And so it was at that point that I thought I [could] make a career out of it. I was pretty naive, because I didn't realize that physical exam was eminently unfundable. It's something you sort of do as a passion, sort of in your spare time, but no serious scientist was ever going to get funded to just study the physical exam.

JO 25:39

Why is that?

DS 25:42

Well, there's no money in it. It's not going to lead -- I assume that's the reason -- it's not going to lead to discoveries that can be monetized. It can lead to quality improvement. It can lead to better outcomes for patients. But there's no funding agency that's interested in studying the pulmonary exam. So what we had to do was figure out how I could study it in a way that was sort of plausible. And we did that. We did a few funded studies, but most of our work was kind of unfunded. But I took advantage of my opportunities at the VA, which was a little more forgiving, and would let you do sort of unfunded research. And I just started making a name for myself in that. And luckily two things sort of happened. I got put into another leadership role shortly after I joined the faculty, which meant I could decide how I used my own hours [laughs]. Being in control of your own hours was great. And then the other thing that happened to me was I got lucky and started working with The Journal of the American Medical Association. And then I was able to forge a path, by having control over my own time and working with JAMA.

JO 27:18

I want to ask you a little bit more about that time period when you were working on the research around, is it pronounced ascites?

DS 27:31

Ascites.

JO 27:34

Ascites. So the fluid in the belly. When you were doing those exam exams for that research, you said that was really fun for you?

DS 27:42

Yeah.

JO 27:44

Do you have any specific memories of sure what made that fun or made it click?

DS 27:51

Well, first of all, it was fun doing it with the house staff. Because what would happen is if they admitted a patient that they thought maybe had ascites, or they weren't sure, or they were really sure, they would pair it with a patient who they were certain didn't have ascites. And I couldn't know which patient was which. And I'd come in in the evening. And what they would do with each patient is they would take some Betadine, which is a cleaning solution that you use before you put a needle in the belly, to sample the fluid. And so they would Betadine each patient's belly and put a bandaid on it. So I would sort of be blinded as to which person they thought really had ascites, because they look to me like each of them had had a procedure where a needle was put in the belly. And so I would examine each of them. And it was just fun. There was one particular sign that was popular at the time called the "puddle sign", that required the patient to get on all fours with their belly down on the bed. And then you would sort of get underneath them, and you would percuss using your hands. Sort of like tapping on an empty drum to find out where the top of the drum is filled. And you would tap on the belly to figure out where that meniscus is. And there was one episode where the patient couldn't maintain all fours, and sort of fell down on me. And it was gross, and I quickly realized that the puddle sign, even if it worked, was just not a pragmatic, sort of safe thing to do. So we got rid of the puddle sign eventually when we published our data. That was memorable

JO 29:27

And so it was almost like the house staff was almost setting up this opportunity for you to test your assumptions.

DS 29:45

Oh, absolutely. And we published that article. And then it led to lots of other things and made me realize that not everything was known about how to analyze data from physical exam studies. So we had to figure out our own sort of analytic strategy, which was really a blast. Jack Feussner got me funded, so that I could get a Master's degree in Biometry. Now it's the Master's Program in Clinical Research, but I was in the first class of the precursor for that, which was a Master's in

Biometry. So I developed some of the analytical skills. And then we moved on to some other topics. We studied sinusitis with Dr. John Williams [who] was our fellow in General Medicine then. And that was a lot of fun, too. And we studied the pulmonary exam for obstructive airways disease with Don Holleman. And then John Whited joined us as a fellow and we did one of the first teledermatology studies. The digital camera had just become a thing. And we thought we'd really arrived. We had an \$800, huge, Kodak digital camera. And so John was interested in studying consultation of dermatology patients, and how to improve consultation. And I told him I thought that was boring, and why don't we study it with pictures? Because until then consults were just sort of written out by hand. And you didn't send a picture to the dermatologist. So John got this \$800 camera, and we started taking digital pictures to figure out what was a good image and what wasn't a good image? And we started by saying, "Well, we don't even know how close to the lesion you need to get to take the picture." So we standardized our focal length by taking a couple tongue depressors, taping them together, and he's taping that to the camera, so we could standardize the focal length. It was just fun. We could go wherever we wanted with things.

JO 31:54

Wow, that's amazing. That sounds very hands-on and kind of do-it-yourself, in a way, repurposing the tongue depressors.

DS 32:04

Yeah, totally. And I think what I realized when I made the decision that I didn't want to do hematology-oncology research, which at the time, was clinical trials where Duke was a site for a cooperative study, and we were just one site that enrolled patients, but there weren't a lot of people developing the clinical trials themselves. That sort of made me want to do something different than hematology-oncology research. But I also realized that I was just a dilettante and totally eclectic. And what better thing than the physical exam for someone like me [because] you weren't constrained by the specialty you were in, you could do what you want[ed] to do. And once I realized that, I decided general medicine was going to be for me. The other thing is that I sort of my wife went into obstetrics-gynecology, and even though after my chief year, I did go back and do another year of hematology-oncology fellowship, at the time hematology-oncology was done by hematologist-oncologists who were not working in teams. So you had your own group of patients, and you were there for them 24/7/365 days out of the year. And I just started thinking [that] this probably isn't going to work with my wife as an obstetrician-gynecologist, if I'm always on call, including when she's on call, if we want to have a family. And so, with sort of my realization that I was a dilettante and eclectic, general medicine sort of rang to me. And yeah, I left my fellowship after that, that one full year, and then joined the general medicine faculty at the VA.

JO 33:55

It's interesting that you mentioned the influence of your wife's career path on those decisions. And your wife has had her own career at Duke, is that correct?

DS 34:13

That's right. She was a generalist obstetrician-gynecologist, and she was the first Chief of the General Division of Obstetrics-Gynecology at Duke. She was the first woman to be a Division Chief in the department, also.

JO 34:33

I think you're the first person that I've talked to in this project who has been partnered with someone who is also in academic medicine. And I wonder when you have trainees, for example, who are in that kind of partnership, what kind of advice do you give them?

DS 35:01

An [inaudible] thing to say would be that it's not easy, but the reality is, it's pretty easy to have a partner or a life partner with sort of the same interests with you [with whom] you can have easy conversations. You understand what happened at work, you understand that sometimes patients come first. So that part was really pretty easy. The hard part was just figuring out the time. And who's going to make a compromise, and who's going to do what. And it wasn't that difficult for me. I mean, it felt difficult at the time, to decide who's going to do what, and who's going to adapt their schedule. But in retrospect, I can't imagine not having a partner who was doing something different from me. So I don't think anyone went out of their way to make it easy for us. But through compromise we were able to figure it out. And we both wound up doing something that we loved. So it was great.

JO 36:20

Were there moments in your career where having your wife's perspective as another academic physician, where that had a big influence on the way you were looking at your work? Or were there insights that you were able to gain from her that you might not have gotten otherwise, if you'd been partnered with someone outside of medicine, for example?

DS 36:50

Well, I think if you talk to my wife's trainees, the people she's trained, the thing that they repetitively say about her is how calm she is under pressure in the delivery suite. And that isn't typically me. And so I think I learned a lot from hearing that about her, and I try to emulate that. But our fields are just so different that it really more is a personality sort of thing that we learn from each other, rather than kind of an intellectual thing. I was always fascinated by the things we did, and she did, and we did do a couple of papers together. [Aside: "Sorry about that. I thought I had my phone off here."] But mostly it's just sort of a shared experience and a shared understanding that [is] most important.

JO 38:05

I want to ask a bit more about the rational clinical examination. So I looked a little bit at the series online, and so one thing I noticed is that each article begins with sort of a hypothetical patient scenario. Am I getting that right?

DS 38:40

Yep.

JO 38:48

That really interests me in terms of you need to have some creativity or some imagination to come up with these hypotheticals. And I know you're collaborating with the authors on setting up these articles and bringing them to fruition. I wonder, can you tell me about the importance of why you choose to begin with those sort of specific hypotheticals in the articles and how you come up with them?

DS 39:22

So let me go back even further about these. So it's reasonably interesting how I got started working with JAMA. So I had been doing the research on ascites. And we had just started doing research in sinusitis. And I went to the Society of General Internal Medicine meeting, I believe it was in Washington, with my mentor, Jack Feussner. Jack had been a chief resident at Duke and was also really interested in [inaudible] clinical epidemiology. And at the end of his chief residency year -- Jack was tough, boy he was a hard chief resident, and he'll agree to that -- the department chair at the time told Jack that Duke needed a rest from him. And he sent him up to McMaster University in Canada to study with Dave Sackett and the group there. David was maybe one of the two fathers of clinical epidemiology in North America. And so Jack went up there to get clinical research training with David Sackett, came back to Durham, and was tasked with starting clinical epidemiology and research here. So when we went to the meeting in Washington, Dave Sackett had negotiated with JAMA to start a series called the rational clinical exam. And Dave was there to announce the kickoff and to look for prospective authors. He had invited Jack to the meeting to talk about this, and Jack had completely forgotten about it. And here I was, doing research in the clinical exam. And just by happenstance, Jack and I got into the elevator at the hotel with Dave Sackett. And Dave said to Jack, "Jack, you coming into the meeting?" And Jack said, "What meeting?" and Dave said, "On the rational clinical exam." At which point my eyes got huge. And Jack said, "Yeah." So we go to this meeting, which was just lucky that I learned about it. And Dave presented the topic and the format, which included these hypotheticals. And he was asking for people to volunteer to write articles for him. So at the end of the meeting, I sort of implicitly knew that I was probably ahead of most people, because most people weren't doing research in the physical exam. Dave was just asking for kind of review articles. So I went up to Dave Sackett, I introduced myself to him. I was pretty young. I was probably 30, at the time. And Dave was, you know, this legend. And I said, "Dr. Sackett, I'm Dave Simel from Durham, North Carolina, my mentor's Jack Feussner, who's been working for you. I'm real interested in doing this. I think if you let me go, that not only will I have the first article ready to submit to you, but I probably would have the second article ready to go also." And it was like, brash and bold. And Dave said, "Sure." So I did. I got him the first article in the series, and then, and we quickly turned that around and got the sinusitis article. Dave published a total of six articles as the editor with JAMA. [It] was the first publication that really described it using the words "evidence based medicine" in JAMA, which is just what we do now. And then Dave left to go from McMaster to England, and told JAMA that this kid Dave Simel probably could take over the editorship. Because I'd gotten him two of the first couple of articles, and I'd been aggressive. So the JAMA editor flew down to Durham to meet with me, which was amazing. And I was offered the editorship. So all I did was continue with the format that Dave had set up. And then over the years, tweaked it. Dave felt that the review articles needed to be pragmatic, and oriented towards how a physician would think. And since we're always using the

physical exam to answer a question about the patient, they felt that starting with sort of a patient scenario to get the reader to think about how they would use the physical exam was the way to go. And so that's what we've done. And we've just maintained that.

JO 44:07

Wow, that's, that's such serendipity.

DS 44:13

It was. I was not happy with Jack that he had forgotten about that meeting. But clearly, it made my career to be on that elevator and here there was a meeting.

JO 44:24

So prior to overhearing that you didn't even know that this gathering was happening.

DS 44:29

No, no [laughs]. And Jack had forgotten about it. It was totally luck that we got on the elevator at the same time.

JO 44:36

And it sounds like it was perfectly aligned with what you'd already been working on.

DS 44:42

Yeah, it couldn't have worked out better.

JO 44:44

And it sounds like you kind of came up with a fairly original editorial strategy for bringing out these articles in that you are involved in soliciting them and developing them, was that something that was your idea as well?

DS 45:12

Well, Dave Sackett early on wanted people who were junior faculty to be the primary movers of these, supervised by mentors who could guide them. And Dave had this interesting idea that he didn't want experts doing articles on the physical exam, because he felt like experts were biased by their expertise. And that really is true. There are a lot of biases that go into physical exam, and there's some people who are obviously better at it than others. And Dave wanted to see if he could bring science to the clinical exam, and not sort of the art of just the clinical exam. So we looked for junior faculty who had time, were aggressive, and really could be objective in developing their topics. A lot of the articles in the early years, the ideas were ours. But then as we evolved, people would come to us with ideas, and then we would sort of appraise them and decide whether or not an article was feasible. And I wound up being a mentor to these writing teams as the editor, all over the world, which has been great.

JO 46:38

Would you be willing to talk about maybe a favorite article in the series that you have, or one that you feel like made a huge impact in the way people were thinking about examination?

DS 46:58

I get asked that question a lot. "What's your favorite finding?"

JO 47:03

Well, maybe it's one that's memorable to you, or one that has a really interesting hypothetical.

DS 47:10

Well, I think one of the ones that was really interesting was to be involved with trying to figure out whether a patient had an acute myocardial infarction. Because we were doing that article, at the time there were no biochemical test, no blood test, to figure out if you had a myocardial infarction, although they were coming out, they were not always available at the time. And so it was really interesting to look at the physical exam, and the historical maneuvers or the historical findings, in light of this sort of emerging technology. And one of the findings that just struck me as just being totally bizarre is that, we were all taught that chest pain that radiates to the left arm was a really good predictor that the person was having angina pain, pain from the heart, and that it might be a myocardial infarction. And what we found was there was this strange finding in a number of papers, that actually chest pain rating to the right arm was even more important. And I've never understood that, and it's always bothered me. It's certainly less frequent than pain to the left arm. But it may be chest pain that [inaudible] the right arm may be a more accurate finding. I've never been able to totally figure that out. And so that's one that has always kind of struck me. Some other things that were kind of fun is when we debunked sort of maneuvers that [people] previously thought were important. And one of those had to do with tuning fork for hearing loss, where you would put a tuning fork on the forehead and ask the patient if they heard it more in one ear than the other. And that's a great test. Actually, I shouldn't say it's a great test. It's not a very good test for hearing loss. But if you have hearing loss, it's a test for figuring out whether the hearing loss is more on one side than the other. But quite honestly, it's just not something that you need to be doing during screening exams as a generalist physician. And, I haven't been to an ear, nose and throat physician in a long time. So I don't even know if they still use tuning forks on your forehead to do those. So that was kind of fun, evaluating that. But there have been a lot of really sort of interesting findings as we've gone along. But those were just two, sort of simple things that struck me. They haven't changed the world. But the myocardial infarction thing has continued on. And so it's a nice example of something that's evolved over time, where now it's not just your history. It's mostly your history and the patient's symptoms, a little bit less the physical exam. But it's the history, in combination with the blood test, that now rules the day. And so we were publishing that kind of from the beginning. And I'm pretty proud, actually, that those articles that were by Duke house officers who had mentorship from one of our cardiologists. So that was really nice. That was a great article. A lot of fun.

JO 50:32

Thank you. Those are really interesting examples, I think, especially the tuning fork, because it's almost kind of mysterious why that caught on in the first place.

DS 50:44

There have been some other ones that you wouldn't have thought were really important. One of them was does this patient have influenza? Which was also sort of a fascinating article, and relevant to the current times of COVID, in that, we learned that the clinical diagnosis of influenza really depends on what's going on in the community. And it's not so much your history and physical exam alone, but it's the patient's symptoms in view of what's going on in your community. And that's true during this COVID pandemic, too. It's your symptoms in view of what's going on in the community. So that was a pretty durable finding.

JO 51:34

So basically you need contextual information from outside of the visit with the individual.

DS 51:43

Absolutely. That's a good way of putting it.

JO 51:45

We haven't talked much about your clinical work, or your leadership at the VA. And I know there's a lot to talk about there as well. I wonder if we could touch on some of the aspects of these other parts of your career. What one thing that struck me was your role in setting up the comprehensive Women's Veterans Health Center? Is that something that you'd like to talk a little bit more about?

DS 52:20

I've loved the VA, the VA has been a great home for me. I started as a staff physician at the VA. And I stayed as a staff physician for two years before I got put into a leadership role at a pretty young age. And so I was chief of Ambulatory Care for 19 years before I became chief of the Medicine Service. And while I was in Ambulatory Care, when I started in Ambulatory Care, we had a total of six physicians, one of which included me. Which in retrospect, I can't believe how small we were. But at the time, so my wife was an OB-GYN, [and] we had a trivial number of women veterans. But I knew that at some point, we had to get serious about being able to provide care to women's veterans. And I didn't think there were going to be fewer veterans and women veterans, I thought they were going to be more in the future. And so I started discussions with Joanne's department chair about some day having an obstetrician-gynecologist on the staff at the VA. And I maintained a relationship with him socially through meetings that I went [to] with Joanne, their department meetings. And I just kept talking to him about [how] someday we needed to have that. And then eventually [the] VA put out a solicitation to create comprehensive women's health clinics, and I was able to jump on it. And we were one of the first three in the country to have a comprehensive women's health center here. So we started that. And, it's proven fantastic. It's been a great clinic here, and we're still one of the leaders in the country, I think, in women veterans' health.

JO 54:17

And so prior to that time, there wasn't an OB-GYN physician at the VA.

DS 54:25

No, there wasn't. If we needed something we would send the patients to Duke.

JO 54:31

It wasn't integrated into the VA.

DS 54:34

No, it wasn't. And shortly after that, VA came out with a solicitation for a primary care residency program. And so we were one of the first six in the country to get one of those also. And it was just taking advantage of the opportunities, the funding, that was available to us, and our relationship with Duke. And it served us well.

JO 54:56

This could be related to the women veterans Health Center or another aspect of your work at the VA, but are there ways that you've needed to kind of gear the way you're thinking about medicine toward the experience of specific veteran groups?

DS 55:28

I'm so glad you asked that. So my experience as a medical student was that people decided they were going to like working at the VA, or not, before they even stepped foot in the VA. And I never totally understood that. I recognized it. I was one of those people who really looked forward to working at the VA, though I didn't really know why. I was just a little bit too young, to my good fortune, to be drafted to go to Vietnam. I was part of the draft lottery. And we knew that if you stayed in college and went to medical school, that there was very little chance of getting drafted. And so I kind of wanted to know what veterans were like. But even then, so this would have been in the late '70s, early '80s. When I came to the VA, I was pretty narcissistic. I was about myself, and about learning how to take care of patients. And to me, at the time, a veteran wasn't a veteran, they were just patients for me to take care of, and to learn how to practice medicine. And so I just did not have the perspective that I needed to take care of veteran patients. They were just patients. And I suspect that I wasn't unique in that. And I suspect that there was a lot of dissatisfaction from veterans all across the country about the attitudes of people taking care of them, who didn't think of them as veterans. And it wasn't until about six or seven years working at the VA when I had this sort of "aha" moment. And that "aha" moment was sort of like, "holy crap." When I was the age of these guys who were in Vietnam -- crawling in rice paddies, keeping their head down so they don't get blown up, not knowing if they were going to survive one day to the next -- at that age, I was walking down Franklin Street with a beer. And it was like, "Oh, my God, these guys were soldiers." And I had this sort of true awakening, that I needed to think about them differently. I just could not think of them anymore as just patients for me to enjoy practicing medicine on. I had to figure out what they were like as people, and what they had been through. And that sort of "aha" moment transformed the way that I talked to them, and transformed the way that I think when I have house staff with me that I model how to speak with veterans. Factoring in that they've had a military experience and a life that was just very different from those of us who weren't veterans.

JO 58:34

Do you want to give any examples of when you're working with veterans what the differences are or things you've learned to adapt?

DS 58:57

There's a difference between the phrase that I've come to dislike, which is "Thank you for your service," because it's almost like telling a waiter or waitress "thanks" when they bring your food. It's just too dismissive. It's not real. It's just something that you just say in common language. So instead of "Thank you for your service," I ask my patients, "Tell me what you did in the Army." "Tell me what you did in the Navy." And I try to find out what their experience was like "Where were you stationed?" "What did you like?" "Do you wish you'd stayed in?" And so I explicitly ask them about their military time and we talk about it. It's interesting. They think that I'm a veteran because I ask them that, so they start dropping a lot of jargon on me. And I've sort of learned through some of that. But I've gotten great history lessons. And I've just learned fascinating things about people.

JO 1:00:12

So even just asking a question about their experience puts you in the culture of working with veterans, where they start to maybe talk to you a little bit more as an insider?

DS 1:00:34

Well I mean, you can imagine, at 18, walking down Franklin Street with a beer didn't really affect my future life that much. At 18, crawling through a rice paddy is going to affect the rest of your life. So it does help you get to know them. And it helps you build trust. And you can sort of figure out where they're coming from. I think after Gulf War One, it really opened people's eyes to the veteran patients we saw with post-traumatic stress. And so I'll give you an example. A patient is late for their appointment. And a person who doesn't understand why that young person is late for their appointment may get angry that they're inconveniencing them in their clinic, and they may refuse to see them because they're 30 minutes late. But the experience that that veteran may have had, who was someone, let's say, had been around improvised explosive devices in Afghanistan, their experience in getting to the hospital may have been terrifying if they had to stop at stoplights. And if they stopped at stoplights, and they saw suspicious pieces of trash, or garbage cans next to their car. Or if they got here sort of panicked and sweaty from a difficult drive, because it replicated what they did in Afghanistan in terms of stopping, and unclear vehicles, and people getting too close to them. And then you say, "You're too late for me to see you." That isn't a great experience for the patient. And so once you understand that things that happen in the military can have real daily life impacts on people, you begin thinking about things in a different way.

JO 1:02:47

Thanks for spending some time explaining that point of view. I know we're kind of getting towards the end of our time, but I wanted to make sure that I asked you, given the fact that you've been at Duke for I believe, over 40 years, is that accurate?

DS 1:03:16

Let me think about that, because 40 years is a long time. So I started medical school in 1977. Yeah, I have been.

JO 1:03:32

I'm just interested to know, do you have a sense of loyalty to Duke, or what have been the factors that have made you want to stay in this institution?

DS 1:03:49

That's a great question. I've never been much of a risk taker in my jobs. I've not been one of these type of people who just goes and does job interviews, and does serial job interviews, and is always looking for where the grass is greener. I just always felt that I had a pretty good life here. I like my life in Durham. I didn't want to ever go through the hassle of both my wife and I having to find dual jobs together. My kids loved it here. They became passionate dark blue fans in a sea of light blue. My daughter played soccer here as an undergrad for four years and then was a medical student and an OB-GYN resident and then worked with my wife for a couple years before moving away. My youngest son also went to Duke, and my middle son who didn't go to Duke is still the biggest fan of the three of them. And so, life was pretty good here and I didn't see any reason to change as long as things were going well for us. So, yeah, it's been great. And I'm happy I've done what I've done.

JO 1:05:07

Is there anything that you want to make sure to include in this record before we wrap up the official part of the interview?

DS 1:05:18

I think the VA has been -- as much as I feel for Duke -- the VA is really where my academic home has been. And the Duke-Durham VA affiliation is probably the strongest in the country. And Duke has a real passion for the VA and has always supported it. I've always had the sense that the VA was just as good as Duke. And I never wanted people to make excuses for the VA. And so I always had the sense of challenge to see if I can make things better here than at Duke. Which is a little sort of paradigm-shifting. But still there's this presence here of Duke that has helped make the Durham VA great. And when you get right down to it, it's potentially a house of cards. And that if Duke ever lessens their commitment, or lowers their commitment, to excellence at the VA, I feel like we're at risk of crumbling down. And so I've always treasured and valued the relationship and tried to nurture it between Duke and the VA. I think we both have things that we can learn and benefit from each other. And I think for training, for education, for the growth of faculty, that there's this symbiotic relationship that is both essential and necessary. And so I'm just glad that I've been able to work in that type of collaborative environment between the two facilities.

JO 1:07:13

And so you see Duke benefiting from that relationship, as well, in terms of that experience available to trainees, and I'm sure there are other aspects of that partnership that Duke faculty really benefit from as well.

DS 1:07:33

I hope so.

JO 1:07:38

Well, great. I think we can end the interview there, if that works for you.

DS 1:07:44

Yeah, that's fine.