ORAL HISTORY INTERVIEW WITH NANCY BATES ALLEN
Duke University Libraries and Archives
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Researchers: Joseph O'Connell and Josephine McRobbie

COLLECTION SUMMARY

This collection features an oral history Joseph O'Connell conducted with Dr. Nancy Bates Allen on June 1, 2020. The 107-minute interview was conducted via a Zencastr remote recording session. Our conversation explored Dr. Allen's early life and interest in medicine, summer jobs in medical labs, medical education at the Medical College of Virginia and Tufts, medical residency and fellowship at Duke, work in outreach clinics around North Carolina, Duke administrative and committee work, and Dr. Allen's experiences preparing for retirement during the Spring 2020 emergence of COVID-19. The themes of this interview include the development of the treatment of rheumatic conditions, medical training and career advancement, and clinical work in outreach settings.

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. 4-30)

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 (credit: Philip Chu)
- Scan of a signed consent form

*Due to COVID-19 social distancing protocols and best practices, Joseph recorded the interview remotely via the Zencastr web platform. At the end of the interview recording, we recorded a self-introduction and room tone for use in a production edit of the interview.

BIOGRAPHY

Nancy Bates Allen M.D. is Professor of Medicine in the Division of Rheumatology and Immunology at Duke University Medical Center. Her primary area of clinical expertise is in the care of patients with all vasculitis types. Allen's 42-year career at Duke has emphasized clinical practice, including serving as a primary care physician. In addition to practicing at Duke clinics, Allen has worked extensively at affiliated outreach clinics, serving local populations and training Duke fellows in locations such as Fayetteville, Roxboro, Oxford, and Henderson, North Carolina. As an instructor, Allen models listening to patients as a central skill: "I don't look at someone as, you know, just their arthritis. I want to know as much as I can about them, and what's going on in their life, and their family, and social interactions, and what medications they're on, what their expectations are, and meet the patient as a partner."

Allen was born in Philadelphia and grew up in Richmond, Virginia. She remembers vividly the imperfect treatments available to her younger sister, who suffered from childhood rheumatoid arthritis: gold shots, wax treatments, and even therapeutic footwear. Allen completed her medical degree at Tufts University and arrived at Duke as a resident in 1978. During that time, she persevered in a training environment intended to produce what she calls "the Duke Marine." She accepted a position as Assistant Professor of Medicine in 1984, and graduated to full professorship in 1999. Allen has served Duke in a series of leadership roles, pushing for change around issues of gender equity and diversity and inclusion. As a voice on DUMC's first and subsequent committees for women faculty and as Vice Provost for Faculty Diversity and Faculty Development, Allen has sought to "help Duke be a better place, not only for women, but for everybody."

INTERVIEW TOPIC LOG (nancy-allen-interview-audio.wav)

00:00	Current role and overview of work
03:57	Early life in Philadelphia and Richmond; sister's diagnosis of childhood rheumatoid arthritis and treatment experiences such as gold shots and paraffin
12:00	Career aptitude tests and early interest in medicine; summer grant in McGuire VA hospital cardiac catheterization lab
17:20	Interest in scuba diving and meeting spouse, Barry
21:38	Research in vasoactive intestinal polypeptide at the Medical College of Virginia with pulmonologist Dr. Sami Said
23:43	Work at the Karolinska Institute in Stockholm, Sweden in 1972
26:26	Work at Massachusetts General Hospital in cardiac biochemistry lab; digoxin research; Dr. Bob Lefkowitz
34:14	Medical school training at Medical College of Virginia and Tufts; culture at Tufts in the 1970s
39:00	Transition to Duke for post-doctoral education; culture of residencies and internships; interest in being a clinical internist
44:44	First day at Duke and time at outpatient clinic
48:48	Rotations on CCU at the VA; other rotations
53:22	Rheumatology rotation and development of career focus
56:11	Meeting with Dr. Wyngaarden; prioritization of clinical work
1:01:24	Outreach clinic experiences
1:06:43	Common conditions at clinics; culture of Duke outreach clinics versus Duke clinics
1:11:40	Changes in treatment of rheumatic conditions; ultrasound technology; joint aspiration
1:15:56	Clinical skill-set; changes in medical education
1:18:40	Administrative roles related to diversity and inclusion; women's leadership at Duke; death of George Floyd and 2020 protests
1:24:30	Advice for new rheumatologists and young faculty; medicine as a profession versus medicine as a business
1:29:03	Misconceptions related to field of practice; Duke's shift to managed care
1:33:45	"Whole patient" approach, primary care support system
1:37:50	Experience transitioning patients to new providers in anticipation of upcoming retirement and during COVID-19 pandemic
1:45:04	30-second room tone and production introduction for production purposes

TRANSCRIPTION (nancy-allen-interview-audio.wav)

Joseph O'Connell 00:00
And we are recording. And I'll give a little bit of an introduction here, just to be able to identify the recording later. It's June 1st, 2020. My name is Joe O'Connell and I'm interviewing Dr. Nancy Allen for the Duke University Medical Center Library and Archives, and the Department of Medicine. Dr. Allen is recently retired as Professor of Medicine in Rheumatology and Immunology at the Duke University School of Medicine. So thank you for being part of this project, Nancy.

Nancy Allen 00:39
Oh, you're welcome, Joe. Happy to do it.

JO 0:45
Yeah, I'm excited. Well, thank you again, I'm excited to talk to you today, and document some of your stories, and some of your history, of your long career at Duke. And to begin with, I wonder if you could tell me, just to gather some basics, what is your full name and what is your birth date and birthplace?

NA 1:10
Nancy Bates Allen, and I was born May 26, 1952 in Philadelphia, Pennsylvania.

JO 1:22
Okay, great. And when you retired recently, what was your position at that time?

NA 1:30
I'm actually not retiring until the end of this month.

JO 1:32
Okay.

NA 1:36
But, my position is Professor of Medicine in the Division of Rheumatology and Immunology.

JO 1:43
Okay, and just as a broad orientation to what you do, can you briefly describe what the different aspects of that role are?

NA 1:55
I'm primarily a clinician that is seeing patients in the Duke clinics. And also, I've had a long history of working at outreach clinics affiliated with Duke. In addition, I teach fellows and residents and medical students, in the clinic setting, primarily. I also give lectures occasionally, or our own grand rounds in Rheumatology or Internal Medicine. In addition, I've been involved in some clinical research and administration over the years.

JO 2:40
Okay, thank you. And as you approach your Emeritus status, what will you be continuing to do, or will you be stepping into any new roles?

NA 2:56
I likely will continue to have an affiliation with the division, in terms of attending our conferences when able or time permits. I also hope to continue to mentor and be available to our current faculty, fellows, and former trainees around the country. I don't have other specific roles at this time, although that may happen.

JO 3:36
Right. Okay. And so yeah, thank you for walking me through some of that. I want to be sure we talk upfront about sort of where you are right now, before we zoom out and discuss your previous experience.

NA 3:52
Thank you, Joe.

JO 3:57
Yes, of course, and so that's what I'd like to do now, I'd like to talk a little bit more about your early life, and kind of put together a picture of how you got to this point. Just in general terms, can you say anything about what your early life was like? Do you remember any influences that you connect with what you wound up doing in your career?

NA 4:24
Oh, I do. I grew up in Richmond, Virginia, from the age of four. Before that we lived in Philadelphia till I was 18 months old, and Waynesboro and Martinsville, Virginia when my dad worked with DuPont, in those cities. And then we moved to Richmond when I was a child, so that my dad could go in business with his father. So I grew up in a neighborhood setting, went to public schools, had great friendships. And my younger sister had childhood rheumatoid arthritis starting at her age 13. So that ended up being a later influence to what I chose for a career. I remember her rheumatologist at the Medical College of Virginia, now VCU, who put my sister in the clinical research unit, and did some studies, and treated her with gold shots, which in the 1960s was a going thing. There weren't many approved, there were no approved treatments for RA at that time. So that did come back to, you know, my reality once I got to Duke as an intern in medicine.

JO 5:46
Yeah, absolutely. That must have made a huge impression on you.

NA 5:50
It did. So other other influences. Go ahead.

JO 5:56

I was just curious what else you remember about your sister's experience with arthritis and what you observed as a younger person?

NA 6:09
Yes, well, Peggy was, you know, [a] very energetic child and early teenager, had been chosen to be a cheerleader, was a dancer. And all of a sudden she developed painful joints and movement difficulties, and fairly quickly was diagnosed with [the] childhood form of rheumatoid arthritis. Our GP, which we called them then, general practitioner, treated her with aspirin, and referred her to the rheumatologist. I remember Peg using the hot wax treatments. My mom would take a block of paraffin, and put it in a pan on this stove with some mineral oil, and heat it up and Peg would dip her hands in that, to warm them up and give her some comfort. The doctor also prescribed some special shoes one time, and Peg took one look at those and said, "Mom, you can buy those for me, but I'm not gonna wear them." [Laugh].

JO 7:26
What were they like?

NA 7:28
Oh, they were clunky, you know, black, round toed shoes with a strap. And you know, were not the thing that young teenagers wanted to wear.

JO 7:42
Yeah. And did you notice what helped your sister through that illness? Did you notice anything that was effective for her?

NA 7:58
Well, whether the gold shots helped or not, her condition did go into remission after a couple of years, around the time that she also developed a rash to the drug. So it had to be stopped anyway. And actually throughout her life, she only had a couple of other flares. After pregnancies, which is not uncommon in RA. So she did fairly well from that standpoint, but sadly had other health issues and died at age 61 a few years ago.

JO 8:39
I'm sorry to hear that.

NA 8:40
Thank you.

JO 8:44
So I can imagine that that experience was very closely tied to your clinical work and your research over time. I am curious about the gold shots.

NA 9:00
Yes.

JO 9:06
What was the thinking behind that treatment, at that time?

NA 9:06
Oh, gold salts were used for other diseases at the time, and serendipitously you know, a few patients that did have arthritis, in addition, had some benefit, or it seemed to be beneficial. So, you know, it was adopted as a therapy, it was not an FDA, you know, approved therapy, never was studied double blind, randomized controlled trials, like today we accept treatments. So, you know, the retrospective studies that put together lots of patients' experiences in the 1980s and 1990s, looking backwards, [it] really did not have a statistical benefit. But at the time, those drugs were being used in the 60s and 70s, you know, the quote was that about two-thirds of patients would have benefit, and about half of those would have to stop the medication because of side effects. So we even had a gold clinic over at the VA for years. Patients would come in on Friday mornings, and get blood tests and a urine study, to make sure they didn't have low red blood counts or white blood counts, and didn't have protein in the urine, which were some of the big potential side effects. They had to have those tests, before they could get their weekly or monthly shot.

JO 10:47
And how long did that continue to be a common therapy?

NA 10:53
Into the late 80s, and I'd say early 90s. One drug company came out with an oral gold product but it also had a fairly high side effect rate, in terms of rashes, particularly. And that treatment faded out as we used methotrexate, starting in about 1982. And once that caught on, it worked faster, it worked better, there were fewer side effects. And, you know, interestingly, patients responded much better. There was less disability. We didn't have to use as much prednisone to control flares. We didn't need to put people in the hospital as often for flares. Which, when I was an intern at Duke, we still had an inpatient rheumatology service, and admitted patients to treat their flares, often for five to seven days at a time.

JO 12:00
So when you were in high school, and you were noticing your sister struggling with arthritis, were you already thinking about the potential that you might be able to do something with your life that would address that illness?

NA 12:20
I don't recall thinking about that specifically when I was in high school, Joe. I remember taking an aptitude test at Hampden-Sydney that said I would be a teacher or a social worker, because back in the 60s, girls were not being, you know, put in the category of potentially going to medical school. It was more if you wanted to do some form of medicine, you would go to nursing school, for example. But when I finished high school, I applied for and received a Richmond-area Heart Association grant to work at the McGuire VA hospital in Richmond. And I was assigned to a cardiac catheterization lab, actually worked with one physician who was a member of our church. So I knew him already. And he was wonderful. My main job was to

correlate data [in] veterans who had COPD or chronic obstructive lung disease, and what their vector cardiograms showed, and that was a sort of new-fangled way of looking at the heart's electricity in 3D back then.

JO 13:42
Okay, so that was a digital representation?

NA 13:45
It was. I did that project, but I also was fortunate to have Dr. [David] Propert and Dr. [Art] Gear as mentors, and they let me watch cardiac caths and pacemaker insertions, and took me to conferences. So that was really my first exposure to medicine other than, you know, having gone to the doctor as a child.

JO 14:12
How did that fellowship come about, what inspired you to apply for it?

NA 14:20
Well, I needed a summer job before I started off to college. I wanted to have a little pocket money. And I don't recall exactly how I found out about it, maybe from our church, maybe from Dr. Propert himself. Or maybe from our school counselor. I'll have to dig back in my memory to retrace those steps.

JO 14:45
Yeah, yeah. Well, I wonder, I did notice that you talked about the impact that made on you of watching the cardiac catheterizations, and the pacemaker insertions. And I wonder if that experience, that research experience, could be one of the things that we talked about in a little bit more detail. Do you remember what your daily life was like while you were doing that job?

NA 15:19
Yes, I had a little tiny desk that was right off the cath lab, and right near Dr. Propert's office. And so, you know, I would studiously do my work, whatever they asked me to do. And then if they had a case, and they had enough room in the cath lab for an extra person, they would invite me in to watch. So I do distinctly remember some of those events. I also remember that the pacemakers back then were huge and took up about, you know, a quarter of the upper part of the left side of the chest. They made a pocket under the skin to put it in, and didn't take very long to do that. And these were cardiologists, not surgeons, but they still had to make an incision in the skin. So that was exciting to watch.

JO 16:22
Yeah. Do you remember what about that experience, what about it was exciting? What were your thoughts about it at the time?

NA 16:34
I think I thought back to both my maternal grandmother having died of a heart attack. And my paternal grandfather, being in an oxygen tent in a hospital when I was eight years old, and I saw

him the morning before he died. So, you know, I knew that taking care of heart disease was important, you know, for so many people and had another, family influence for me.

JO 17:06
So you could you could sort of make a direct connection between the care, and the experience of the patients and the patients' families?

NA 17:17
Yes.

JO 17:20
Okay. And I know as a college student, you had several other unique research opportunities. And I wonder if you could tell me a little bit about just what you were like as a college student. How would you describe yourself?

NA 17:40
Oh, probably a hippie [laugh].

JO 17:45
[Laugh] Okay, how so?

NA 17:49
Oh just, you know, long hair, and I don't remember wearing jeans all the time. But that was fairly common. I also had taken a chambray long sleeve shirt and embroidered it with flowers and other things. I met my husband that year. He taught me how to scuba dive my freshman, first semester.

JO 18:19
Wow.

NA 18:20
And called me up a few months later. Presumably, I thought, to arrange an open water dive in the spring. But he called in February and asked if I was busy on Saturday. And I said, "No", because I didn't have anything on my plans except to study, and by the end of the conversation, I realized I had accepted a date when he said to meet him in Harvard Square at six o'clock. So I felt I had to do that, I had to go, and he fixed dinner at his place for me, and then we went to a friend's engagement party, and ended playing Scrabble, and he beat me by two points. So I knew I had to see him again, to do better than that.

JO 19:09
That's such a great story.

NA 19:12
Yes.

JO 19:14
What made you want to learn scuba diving?

NA 19:17
Oh, I always loved to swim. When I grew up in Richmond, we had a recreation center right down the street. So I swam a lot, and swam on the swim team and love to swim in lakes with cousins, and things like that. And of course, we had to have one PE credit for our entire college career. So I said, "I'll just get it out of the way, so this sounds interesting." So I did that. And Barry was teaching diving at Harvard, BU, and Wellesley, you know, where I had attended. He also taught several other people who were at Duke, so that's interesting. But anyway, I helped him with dives later, and we had great experiences diving in cold water off of Gloucester and Rockport, the North Shore, Cape Ann of Massachusetts. And did that through my college time.

JO 20:28
Yeah, that sounds amazing. Did you and your husband connect over your research interests, and your academic interests as well?

NA 20:40
Well, we certainly shared those interests. He is older than I, so he had graduated from Harvard 10 or 11 years before I finished college. We got married right after I finished college in 1974.

JO 21:00
Okay, yeah. I think I read that he is a physiologist. Is that correct?

NA 21:07
Yes, he got his Ph.D. in Physiology at Duke. So it was great that he was accepted to that program, like a day before I had to put my match list in the real mailbox. You know, for internships. And then it was great that I was matched to Duke so we could come to the same place.

JO 21:38
Right. Well, you mentioned that your first research job was, kind of, you needed a summer job, and that was something that was on your radar. What other jobs did you have during your education? And did you ever have jobs that were unrelated to what you do now?

NA 22:01
Well in high school, I would help at my dad's business. I'm not sure he paid me. Probably did in some ways, but he had a materials handling business where they sold steel lockers, bins, and shelving, and had a big warehouse. And so I would help with inventory or secretarial duties. But then once I worked at MCV [Medical College of Virginia] that summer, each summer in college, I had another research job. So in 1971, I worked at MCV with a pulmonologist, Dr. Sami Said. And he was researching vasoactive intestinal polypeptide. So I did some research with him. And then at the end of that summer, he said to me, "Well, I'm collaborating with a biochemist in Sweden. So if you ever want to go there to work, let me know." So as soon as I got back to Wellesley to start my sophomore year, I wrote him a letter, and actually my college roommate

also wanted to go, so I asked him [Dr. Said] if she and I could both have jobs working with his biochemistry colleague. And so that worked out. So the summer of '72 I spent in Stockholm working at the Karolinska Institute with Viktor Mutt - M-U-T-T.

JO 23:43
That must have been amazing.

NA 23:45
It was, it was. I spent 10 weeks there and we lived in an apartment that was available to U.S. students and researchers and it was just lovely. I would get up in the morning, and take a walk around a lake, about a one-mile walk. And then I would go to the pool that was up the street and swim, and then go to the sauna, and then walk another mile or two to work. And then work in the lab, mostly doing gas chromatography, biochemistry-type work. Met all kinds of wonderful people who took us on trips around various parts of Sweden. My roommate Nona and I took a ferry over to Gotland, which is a little island that's been owned by almost every Scandinavian country at one time or another in history. And it was just wonderful. She and I did some diving there too.

JO 24:52
Wow. Well, it sounds like a pretty great way to spend... a great place to work!

NA 25:00
Yes, it was and then at the end of the summer I used my Eurail pass to go to Greece, or as far as I could, to go to Greece, because Barry was the chief diver on an underwater archaeology expedition in Gythion [alternate spelling: Gytheion], Greece in the southern Peloponnesus, below Athens, below Sparta. And so I took boats, buses, trains, hitchhiked for about a week to get from Stockholm, all the way down to Greece. You know, my parents didn't know where I was, and there were no cell phones back then. For people out there listening to this at some point in the future, right. We could just write letters back and forth, and phone calls were actually too expensive. So yeah, my parents were very supportive of my having a good experience at that point.

JO 26:06
Yeah. And I read in your previous oral history transcript that some of the work that you were doing that summer had a very practical application. I wonder if you could describe what that entailed.

NA 26:26
Joe, you might be thinking about the next summer when I was at Mass General.

JO 26:34
Oh yes. Okay, well, maybe we can skip ahead to that experience, but it was altogether different than the the research you were doing in Sweden. Yeah, I apologize for that mistake.

NA 26:44

Oh, no, that's fine. It gets confusing! So the next summer [1973] I wanted to stay in the Boston area. So I managed to apply for and get a summer job at Massachusetts General Hospital in the cardiac biochemistry lab, mostly working with Thomas Smith, who later was a Chief of Cardiology at the Brigham. And also with Ed Haber, who was the Director of that lab. And that lab is probably.

Jr 27:39
We've lost the connection.

[Beginning of new recording]

NA 27:46
Alright, Joe, let's try again.

JO 27:49
Okay, we were briefly interrupted. But I think we were talking about some of your additional research experiences during the summers of college, and I think you were talking about one that you did in a hospital in Massachusetts.

NA 28:09
That's correct. At Mass General Hospital in the summer of 1973. I worked in the same lab that Bob Lefkowitz had just left, to come to Duke for a faculty position. And of course, he's famous at Duke because of his research, and his Nobel Prize a few years ago.

JO 28:36
If anyone is listening to this, who doesn't know who Bob Lefkowitz is? How would you summarize who he is.

NA 28:47
He's a famous cardiac biochemistry researcher, who has had great influence over certain pathways and medications to treat heart disease.

JO 29:04
Okay. And so you were working on a project that he had been part of before he left?

NA 29:11
No, I was not working on one of his projects. But I did work with one of his lab techs and got to be very good friends with her. So I was working with Tom Smith, predominantly, on a project that already had been started to purify an antibody against digoxin, which was then a common heart medication to treat heart failure. And it had a very narrow therapeutic window, meaning that you needed enough medication to do the good things, for that medication, but If the dose was slightly too high and blood levels got too high, there could be dire consequences including arrhythmias, heart rhythm problems, and death. So we were trying to make an antibody. So that was one of my introductions to immunology, in a roundabout way. They had previously worked out the techniques of immunizing sheep with a cousin of digoxin called ouabain, and the sheep

would make antibodies to that drug. And then we would take the sheep's blood, and purify the antibodies from the blood, to theoretically utilize those to treat dig[oxin] toxicity. And so my project was to make that whole process, into a sterile procedure, so that the drug could be packaged in small vials, in almost powder form that would be reconstituted and used in the situation of an intentional or unintentional overdose of the drug.

JO 31:34
And I gather that was that was a successful experiment?

NA 31:39
It was. I stockpiled enough to be used in maybe one or a few patients. Another tech took over for me when I left to start medical school in 1974. And later that year, right after I'd gone off to school, a patient came in with an intentional overdose, and was treated successfully with the drug. And that got written up in the New England Journal in 1975. And the other tech and I were thanked at the bottom of the paper for participating. But that was exciting [crosstalk] to see something go from bench to bedside so quickly, and of course, back then, I think there were institutional review boards, but there was not as much scrutiny on how that all would happen. It's a much more sophisticated process today, and a lengthier one to get from, the bench, or the sheep, to the bedside.

JO 32:56
So after having these experiences, what were your feelings at that point about the possibility of a career in medicine? Where did you think you were headed at that point?

NA 33:09
Well I think, my first experience in the cardiac catheterization lab at the VA in 1970, when I finished high school, I think that's where I started on my path of wanting to pursue medical school, and thinking that that would be a wonderful career. So I built on that by getting a degree in biology and doing those summer experiences that would help me towards that goal. So I wasn't sure at that point exactly what kind of doctor I would end up being. I liked the research experience. I hadn't had significant clinical experience, except for watching those caths and pacemaker insertions. So I kind of held it open as to what I might want to do eventually.

JO 34:14
And I know you wound up doing most of your first part of your medical education at Tufts.

NA 34:26
Yes, I did one year at Medical College of Virginia, which was right after Barry and I got married and I was accepted at MCV. So we both decided it would be good for me to go ahead and start there. So I did one year there, lived with my parents for that year, studied with the cocker spaniel on the bed [laugh], and then was able to transfer to Tufts, which had a similar curriculum, so I didn't lose anything. At that point, most medical schools had classroom work and basic sciences in the first two years. And then the clinical experiences were in the third and fourth years.

JO 35:16

Okay. And what do you remember about the time period when you started your clinical experience, some of the the first experiences you had with patients? Are there any stories that stick out from that time, or things that made a big impression on you?

NA 35:33
Yes, in my internal medicine rotation, which I believe was six or eight weeks at St. Elizabeth's Hospital in the Boston area. I remember that I had learned how to draw blood. We learned how to do that on each other, as medical students. And so the first day I walked into draw blood from a real patient. I remember the gentleman asking me "Well, have you done this before?" I said "Yes", which I didn't think was a lie. He didn't ask me if I'd done it on a patient before. So, I remember being a little nervous about that, but it worked out fine. He had good veins, and I was able to get the blood, you know, get out of the room without too much trouble. I remember some of the specific patients I took care of. I remember, I think it was my fourth year when I was doing an internal medicine sub internship rotation. Had a patient who had been a mayor in a small town in Massachusetts and he had stomach cancer, and probably didn't have a long time to live, but I enjoyed our conversations, and he once shared his recipe for clam chowder with me, and I still have that in my recipe box.

JO 37:04
Oh, wow. So it was a good recipe.

NA 37:08
Yes. I also remember one of my attendings, on that same rotation, who told me he did not think I would be... I forget exactly how he put it. But the implication was I would not be material for internal medicine. He didn't think I could, I was up to the job. So, proved him wrong.

JO 37:39
What was the culture of Tufts like for that training? Was that common to receive that kind of negative feedback? Was that typical of the atmosphere?

NA 37:57
I don't recall that being typical. I think why it stands out was that it did hurt my feelings at the time, and gave me pause to think well, is that a career that I can manage? But I quickly thought back to my experiences with individual patients and you know, I think there and some of my early experiences on other rotations, and even at Duke, there was still a culture of the attending physician being the one who was right, almost all the time, and the trainees, you know, were there to answer their questions in ways they wanted them answered. And there was not as much support of learners as there is today.

JO 39:00
And I think that that kind of ties into what I want to ask next, which is beginning to think about Duke, and your transition to Duke. I gather from your previous oral history that Duke had a certain kind of reputation, would that be fair to say?

NA 39:24

Yes, it did. So when I was a fourth year medical student thinking about where I was going to apply for internships and residency, Duke had a reputation of being, you know, quite vigorous. There were still rotations that were for interns being on-call every other night. So 24 hours on, 24 off if you were in an ICU or an ER experience. There were even some rotations that were five nights out of seven. So, there was a reputation of the "Duke Marine". If you wanted to use an analogy to the Army or Marines. Oh, that gave me pause. But when looking at other North Carolina programs, there were some that had transitioned to every third night, or even every fourth night, I think I remember UNC had some rotations that were every third, and Wake Forest Baptist had a few rotations that were every fourth night, but in looking closely at those, the intern would be taking care of four nights' worth of patients. So up to a hundred patients at night, as opposed to 15, 20, 25 if you were on every other. So I just figured at Duke, I would get to know the patients much better. And there wouldn't be as much risk to the patients I was caring for, if I had that big load. Because I didn't see there was a way you could care for that many people at one time. So, one of the experiences I had in my fourth year, which also led me to internal medicine was a rotation out in the community with Henry Valliant in Acton, Massachusetts, near Concord. And I just had a wonderful two months there working in his clinic, at the hospital, also, and in a nursing home. So I saw the full array of internal medicine clinical work. Took care of some amazing patients. I gave a grand rounds at the hospital on fat emboli syndrome, from a young man who had had an auto accident and a femur fracture and the fat from the bone went to his lungs and caused sudden respiratory distress. So, you know, I was given some responsibility and recognition for doing that. And I just loved the patient interactions, and the teaching that he provided me. So that was a good introduction to medicine. And when I got to Duke I thought, "Oh, I'd like to be like that. I'd like to be a general clinical internist, in the community. I could see myself doing that.

JO 42:47
So that was when the clinical work really started to emerge as maybe your strength?

NA 42:56
Yes.

JO 43:01
Well, so it's coming up on 11 o'clock. Do you want to take a brief break?

NA 43:09
It's fine with me, or since we got interrupted, I'm fine to continue, if you are.

JO 43:18
Well, let's see. Maybe if we could take just 10 minutes or so. Okay, and come back at 11:10. Right. And we can just pick up around the time with where you're starting your residency at Duke.

NA 43:36
Yeah. Great. Okay, thanks, Joe. I'll just leave my window open and hope that the power doesn't go off again.

JO 43:45
Okay, and I'll stop the recording, and I think the phone call will disconnect and then we can reconnect it when we come back at 11:10.

NA 43:55
Okay, thank you.

JO 43:57
Okay, thanks, Dr. Allen. Bye.

[Beginning of new recording]

JO 44:02
This is Joe O'Connell and this is a continuation of an oral history interview with Dr. Nancy Allen on June 1st, 2020. And I should have mentioned earlier, we're doing this remotely on account of the social distancing related to the Coronavirus. So we're connected via a phone call. And we had began talking about your transition to your residency at Duke. And I wonder if you remember your first day at Duke.

NA 44:44
My first day at Duke I was assigned to the outpatient clinic. So I remember meeting the clinic director, and just a few patients that day. I've remained in contact with Nina Upchurch, who was the clinic director, a wonderful administrator and person. The clinic was in the basement of Duke South, I think in the orange zone. And I believe I did three weeks on that rotation. Because Barry and I moved from Massachusetts, I might have started a few days after some of my colleagues, so that I was a little bit off schedule, if you will. And then my second rotation was in the cardiac care unit at the VA, threw me right into five nights out of seven. I remember the first patient there, who actually should have been in the medical intensive care unit. And the junior resident who was just finishing his last rotation as an intern, passed that patient along to me. It was a gentleman unfortunately who had a GI bleed, and was having withdrawal from alcohol. So it was a challenging first experience, I expected to be taking care of people with heart problems. But we just did what we needed to do.

JO 46:39
It sounds like that's really stayed with you. Were you so you were surprised by the situation you found yourself in.

NA 46:48
And then I remember Dr. [Joseph] Greenfield was our attending on that rotation, and he came in, no name tag, hands in his pockets of his white coat, person of few words, but really a great teacher. And Tom Bashore was my fellow for part of that rotation. And Tom has not yet retired from Duke. He's older than I, and he's the person who led our PDC charge a few years ago to eliminate the age 70 rule. For a number of decades, faculty at Duke, on the clinical side had to

retire from their clinical duties at age 70. Which was really age discrimination. So that was overturned by a vote at the PDC members. But Tom was great.

JO 47:59
I'm just curious more about that first impression that you said [crosstalk].

NA 48:12
Dr. Greenfield? Very smart. As I said a person of few words, but his words were memorable. He later became chief of the Division of Cardiology, and beyond that the chair of Medicine within a year after I joined the faculty, so he had a big impression on me during my early faculty years, we can talk about that, too, later, or whatever.

JO 48:48
Well, I'd like to know a little bit more about those really intense rotations. Was it what you expected, was it difficult, and it's so, how?

NA 48:58
It was very difficult. So when I was on the CCU at the VA, there was one week out of the four, that I didn't leave the VA hospital from Sunday until Thursday. And I probably was close to being psychotic at that point from not enough sleep, and not enough to eat. My husband and I had one car, and I wasn't going to ask him to come pick me up in the middle of the night, even if I could go home in the middle of the night. So I remember working hard, I remember carrying the large code box because the people in the CCU and the MICU were responsible for codes in the hospital when people stop breathing and their heart stops beating, so we would have to run to that patient's room. I remember taking urine samples down to the lab to look at, myself. I remember drawing blood for the blood bank and carrying it to the lab, myself. We kind of were Jackie's of all trades, as interns. And I remember one night, one night on that rotation, Paul Klotman, who is married to Mary Klotman, who is our Dean of School of Medicine currently, Paul was a senior resident and he did drive me home once at about one in the morning, so that I could get some sleep at home. Unfortunately, my husband had locked the screen door to our house. And I tried walking around to the back of the house, and throwing something at the window, but that didn't work. So we just ended up cutting the screen, so I could put my key in the lock and go in.

JO 50:56
You had to break into your own house to get to sleep!

NA 51:00
Yes. One Sunday afternoon, I did take a nap at home and I woke up and you know, was obviously still thinking about work. Because I asked Barry if Mr. So and So Smith, I forget the name, and wouldn't say that anyway, if he had gone to surgery yet. And I wouldn't take no for an answer from my husband, who knew nothing about what was going on at the hospital. So it was, you know, that year was a challenging year, with sleep deprivation. But after I did the CCU, my next rotation was hematology oncology. Right after the Morris Building cancer unit had opened, so I had patients in two locations, and Duke South, not terribly far from each other in today's

terms since the place has gotten so big. But if a patient was having severe problems on the cancer unit, it was difficult. So I took care of patients for Dr. Joseph Moore, who was a wonderful teacher, and Dr. Wayne Rundles, who was a legend at Duke because of some of his early work in hematology and with allopurinol. So that was a great experience. But after that rotation, I was then to have a pulmonary rotation, and then two months on general medicine Olser Ward, which was the women's inpatient unit. And fortunately, serendipitously, one of my intern colleagues, Jamie Hines, who's now a cardiologist, I believe in Arizona, asked me if I would switch his rheumatology rotation for my pulmonary rotation. And I jumped at the chance. So that that also helped me make my decision about pursuing a career in rheumatology, because of the mentors I had there, because of the patients I saw, because of the challenges. Thinking back to my sister's experience with childhood rheumatoid arthritis.

JO 53:22
And why did you jump at the opportunity?

NA 53:25
Well, for one thing I was exhausted, and I thought that the rheumatology rotation would be a little bit less vigorous than pulmonary where our medical intensive care unit at the time, had only five beds, and there were two prominent pulmonologist clinicians, Drs. [Herbert] Sieker and [Herb] Saltzman, and they would have fairly ill patients on their own pulmonary services. So whether I was right or wrong, because I did work hard on the rheumatology rotation, I thought it would give me just a tiny bit of a break before I did two months of gen. med.

JO 54:17
And did you find that working in rheumatology just clicked with you automatically? Or was that more of a gradual realization?

NA 54:32
I think it did click. I enjoyed the patients that I saw, we had a census of 12 to 15 inpatients. Dr. David Pisetsky was my fellow, he had just come from the NIH and Dr. David Caldwell, Dr. Russ Rice, and Dr. Pete Pepe, were the clinical attendings, but several other people in the division had inpatients on my service that month. Even Dr. Mike Hershfield, who's a biochemist in our rheumatology division, and Dr. [Ralph] Snyderman, who was the division chief of Rheumatology, so I got to know almost everybody in the division when I was an intern.

JO 55:25
Were there any concrete ways that you found that you were drawing on your experience of having a family member suffer from arthritis?

NA 55:36
I think so, in connecting with patients, that was a help to me, to kind of know what they and their family members were going through, to have someone with the physical limitations and joint swelling and pain, I could empathize with that.

JO 56:11

And I know that around the time you transitioned into a faculty role at Duke, you had a meeting that you mentioned was important and informative. And I wonder, do you want to describe what happened in that meeting, and I'm thinking of when you were told that maybe you weren't going to be a long term hire?

NA 56:45
Yes. Dr. [James] Wyngaarden was our department chair throughout my training program, so I knew him from internship and from residency when I would go to morning report sessions with him. He was just getting ready to leave to be head of the NIH in 1982, at the time when one of our clinical faculty announced that he was leaving Duke to start a private practice in Durham. That was Dr. [Franc] Andy Barada. And so I was one of only two active fellows in that last six months of the academic year, which would have been January through June of 1982. And the other person was [William] Bill Gough, who had taken a position with a practice in Asheville, North Carolina, so he was getting ready to do that. So I think they looked around and said, you know, Nancy would be able to fill into a faculty position, and help with the clinical patients that Dr. Barada left at Duke, because Dr. Rice and Dr. Caldwell were already quite busy, and couldn't have absorbed those patients. So they offered me a position and before I accepted, I had to meet with Dr. Wyngaarden. So I met with him one-on-one, and I distinctly remember him, saying, "Well, Nancy, this is fine as a temporary position. But you are not exactly the kind of person we want here long-term." And he didn't elaborate, but what I thought might be the case was, [number] one I was a woman, and there were not many women faculty at the time in our department. The department had about 125 members and only four or five or women. So, I thought that was one reason he would say that. And the second reason would probably be that I had voiced the information that I did not plan to do bench research as part of my faculty goals. So that was clearly what he expected of most of the faculty, although there were this core of clinical faculty like Dr. Rice and Dr. Caldwell. So, you know, what he said to me was upsetting initially, but I think over the years, it was a good way for me to think about my own career and how I wanted to shape that.

JO 59:55
Yeah and I read that you described that a combination of activities as a triple threat, where someone has three strengths in one in clinical medicine, one in research, and one in education. And I got the impression from what you said that you thought that that was their higher expectations that people cover each of those bases at that time is that true?

NA 1:00:28
Yes, that was true. That was the understanding of the day. Because that had been the model. The clinical faculty, or the faculty of Duke, were majority men and they were people who did work in labs, and were active in research, and would teach on the wards, and would go to clinic, you know, sometimes a day a week. Sometimes more often than that, and they were expected to be excellent at all three areas. But research I think was still kind of the academic main theme.

JO 1:01:24
And can you describe how you wound up striking that balance yourself, and what allowed for you to shape your focuses the way that you wanted to despite that history of expectation?

NA 1:01:42
Duke was a different place at the time. There was not as much emphasis on the business aspects and frankly, whenever I asked questions about the business aspects, I'm not sure there was as much accounting of the business aspects back then. Certainly that became quite a bit more significant in the 90s with managed care and beyond. So I was able to set my own clinic schedule, and participate in whatever research projects that came along, or that I thought of, or writing projects with fellows or trainees. And I love the educational part, so I did round on general internal medicine in those early years. I also participated in outreach clinics where I traveled initially to Maria Parham in Henderson for my first year of fellowship a day or two a month, and then to Fayetteville to the Area Health Education Center there, and saw patients and taught family medicine residents at Cape Fear Valley a couple days a month. And then from 1987 till 2013, I went to Roxboro, North Carolina, just north of Durham, and saw patients in a small clinic there, and took fellows and did teaching with them. From 1990 until last year, 2019, I had outreach clinic in Oxford, North Carolina, and also took fellows there and worked with them. Those were all wonderful community experiences. So I did that, then got involved in a variety of administrative tasks and committees at the division, department, School of Medicine and university level over the years. So I felt like it was my way of trying to help Duke be a better place, not only for women, but for everybody. That was another theme of my career.

JO 1:04:31
And I want to ask you about the outreach clinics, since that has seemed to be a continuing thread in what you've done. Can you tell me a bit more about, maybe what would be a typical day, bringing a fellow to an outreach clinic, what would what would that experience be like?

NA 1:04:58
There were times early on where the fellows would meet me at my house and I would drive them there, it would usually be one person at a time. And we would get to the clinic, I'm thinking of Roxboro particularly. The clinic area was basically just a few exam rooms that were right outside the intensive care unit, which only had three or four beds. There was a nurse's station in the hall, and there was a small dictation booth. So we would have a list of patients to see, and over the years I would see the same person back every three to six months. So I got to know those patients, they were referred by the family physicians, and internists, and surgeons in the community. So I often got to see those physicians, and have in-person conversations, unlike like our conversation today, about their patients. We dictated in a little booth, and signed the notes later. The fellow would see their own list of patients, and I would go in with them after they had finished examining the patient, and we would talk over what needed to be done, in terms of testing or new treatments. Plus, I'd have time to mentor the fellows and get to know them.

JO 1:06:35
And who were the patients who were coming to those clinics, what were those communities like?

NA 1:06:43
We saw kind of "bread and butter rheumatology", you might call it, because maybe we saw patients with early rheumatoid arthritis, with lupus, with osteoarthritis, gout, other common

diseases. I did see some patients with more rare conditions. And they were people who worked on the farms, or in the warehouses nearby. I saw even some physicians over time, who developed rheumatologic conditions. It was a good experience, you know to have the patient right there. I remember one woman who had rheumatoid arthritis and lived right across the street from the hospital. And she had not been out of her house for several years according to her sister. She had severe rheumatoid arthritis and was quite overweight. And the first time I saw her, the ambulance had to go get her at her house and bring her to the hospital, for me to examine her. In retrospect, I wonder if I couldn't have just made a house call. But anyway, that's the way it happened. And I was able to come up with a treatment plan for her, and she was able to walk by the next year, after she had had a knee replacement and lost some weight. I took care of two of her sisters and one of her cousins over time, so it was like a family rheumatology practice, which I enjoyed.

JO 1:08:43
How was working in that outreach clinic setting different from working at Duke?

NA 1:08:51
Well, the clinic was way more efficient. It was more relaxed. The patients, you know, patients, always, are grateful. It was simpler because they just parked right out front of the hospital and walked in a few steps, and came right to the clinic. The lab was right there. The X-ray was right there. We didn't have as sophisticated of labs. So that helped our fellows learn to depend more on their history-taking and physical examination skills. We knew what limitations there were in terms of diagnostic studies. I think early on, we would have to send patients to Duke or elsewhere to get more sophisticated testing, until later they had a drive-up van for bone density studies and MRI. A tractor trailer brought the MRI, I think once a week, or every two weeks. So it was a different experience but also rewarding.

JO 1:10:11
So you were actually able to bring some pretty serious medical equipment to these remote [crosstalk]?

NA 1:10:16
Yes, well, we didn't bring them, but the hospital obviously interacted with companies to do that. But it wasn't like being at Duke where you could get more sophisticated testing any day of the week, and more sophisticated laboratory testing. So, I remember if I needed to take joint fluid out of a knee and wanted to look at it for gout crystals, I would save a little bit of the fluid and bring it back with me to use the microscope at Duke, to look for those gout crystals.

JO 1:11:00
What did you put it in?

NA 1:11:02
It was in a little tube, I just put it in a blank tube or capped off a syringe, and put it in my pocket. And bring it back to Duke. It's not the lab, the way the labs are done today, but we just did what we needed to do to take care of the patient.

JO 1:11:23
Yeah, it worked for the circumstances.

NA 1:11:26
Because their lab didn't have the type of microscope additions that you needed to do that test, particularly.

JO 1:11:40
So I'm wondering in the field of rheumatology, over the course of your career, what have been the major changes that you've seen, and that have affected the way that you treat patients?

NA 1:12:01
Well certainly improved diagnostic studies, so that we understand disease processes better, and can make earlier diagnosis. A lot of rheumatology, though, is still putting together many pieces of information, from your own history, your own exam, from a variety of lab tests, imaging, and even some tissue biopsies when needed. But there been more sophisticated tests. There's been a big change in imaging. I remember the first CT scan, when I was a medical student in 1975. When, in one of our classes, they showed us a CT scan of a brain, which looked very similar to what we were seeing in textbooks for diagrams for drawings of brain tissue. MRI came in much later, people are using ultrasound today, quite often. I decided a number of years ago that I was going to leave that to our younger faculty to carry out, and they have become proficient with ultra sounding joints and tissues.

JO 1:13:32
So you decided that the newer ultrasound applications were maybe not something that you are going to apply.

NA 1:13:41
I didn't feel I needed ultrasound in order to aspirate joints. I'd had enough experience that I knew right where to put the needle and which direction to orient it. So I didn't feel it would be helpful for me to add in that technology.

JO 1:14:18
That's really interesting, that the experience was enough that you were confident in, basically all the knowledge that you had already accumulated.

NA 1:14:38
I go back to one time I was a fellow. It was a Sunday afternoon, and I got called to the emergency room because a patient had a swollen temporomandibular joint, which is right where the jaw connects to the skull. And I had never done an aspiration of that joint. There were no faculty around, it was Sunday. And so I went to the Duke library, and looked up the landmarks of where I would need to insert a needle to get to that joint, and went back to the ER and was able to get fluid out of that patient's joint and sent it off. Fortunately, it was not an infection. But

it needed to be done, and I was happy to do that. It's part of the old "see one, do one, teach one", but the only way I "saw" the first one was in a book.

JO 1:15:44
So it was really hands on.

NA 1:15:47
Most of the other joint aspirations, I learned how to do from one of my mentors.

JO 1:15:56
In addition to the joint aspirations, are there other skills that you find yourself falling back on again and again that feel like the core skills that you bring to seeing patients?

NA 1:16:14
To me it's mostly listening to the patient. It's mostly in the history and the physical exam, not so much procedures, like the joint aspirations and injections. So, that's what I try to pay attention to, and to model for students and trainees. Because you pick up so much, just from listening to what the patient is saying.

JO 1:16:45
How do you teach that kind of listening skill?

NA 1:16:49
That's a good question. Some of it is by modeling. I think our medical schools do try to impart that at the earliest stages of medical education, before students have contact with patients they have a variety of sessions to learn how to interview each other, or interview standardized patients. That's a technique that I don't recall we had in medical school, but I think is likely valuable to the young people today.

JO 1:17:36
Is there anything that your mentors told you when you were training that you try to repeat to your trainees? Any specific instruction or advice?

NA 1:17:52
I think it would be that listening skill. I mean, for the ones that I really respected and learned from.

JO 1:18:08
So, Dr. Allen, we're getting close to noon. And there's still a bit of territory I'd like to at least touch on, too. Are you free to continue a little bit longer than noon?

NA 1:18:33
I'm fine to continue, Joe.

JO 1:18:40

Okay, great. I just want to make sure that you would be okay with going a little bit longer than planned. And I think that the previous oral history that you did in 2006 did a really good job of documenting a lot of your leadership and advocacy at the Medical Center and at the university. And I'm curious sort of what happened in those areas since then, and how you've been involved in thinking about issues surrounding women and minorities. What have you seen change in the past 10 or 15 years at Duke in those areas, and how have you been involved in that change?

NA 1:19:34
Certainly, to see more women leaders has been one of the changes. So we have the second female department chair. So Mary Klotman was chair before Dr. [Kathleen] Cooney, and Dr. Klotman moved up to the Dean of the School of Medicine as the second woman Dean after Nancy Andrews. I actually had served on Nancy Andrews' search committee, and Victor Dzau's search committee, and President Brodhead's search committee, all during the time that I was chair of the Academic Council, which is Duke's Faculty Senate for the entire university. So it's been, I think, very helpful for younger women to see women in leadership positions. So that's been an evolution. We also have had more faculty of color in leadership positions, which is quite wonderful as well, with Chancellor Washington. He actually was hired on April the 1st, April Fool's Day, just like I was, except I was many years before him. Oh, so I told him that it was OK, it was not really a joke, it was OK [laugh].

JO 1:21:11
That's interesting [laugh].

NA 1:21:13
One of the iterations of the women's committee in the Department of Medicine that I was the first chair of in 1987, when I came back from maternity leave after having twins. The current committee, the Program for Women in Medicine is led by one of my rheumatology colleagues now, Dr. Lisa Criscione-Schreiber. So women have many opportunities for leadership training, for collaborations, for getting together, sharing strategies that have worked for them. And I see that all as being very helpful in my younger colleagues' careers. So in the last five years or so I've not been as deeply involved. I felt like it was time to turn that over to other people, and that there was a solid base on which they can build.

JO 1:22:23
Are there areas around equity and inclusion where you still see room for growth right now at Duke?

NA 1:22:34
Oh, I think so. I mean, just look at what's going on in the world around us, particularly related to race in this past period of time, this past week, has been very difficult. So we've had a series of emails from our Dean, from the Chancellor, from the President of the university, from the hospital leadership all just pouring out hearts and heartfelt sadness about the events of the current time after George Floyd's death last week and uprisings in cities. So there's much work to do, not only locally, but nationally.

JO 1:23:31
And as someone who's been working around these issues, do you have any sense of what that might look like, or what that should look like?

NA 1:23:40
Well, I would just like to see there be justice in the sense that people of color aren't treated so differently than those of us who were privileged to be born white. That the health disparities would get as much attention as possible, since there's a higher percentage of people of color who are suffering from the Coronavirus and dying from it. I think there's certainly so much that will need to be done to make things better.

JO 1:24:30
And I wonder, just looking at younger people coming into your field. What kind of advice do you give people who might be starting as rheumatologists or in academic medicine more broadly? What sort of advice would you give those people right now?

NA 1:24:56
I would like to give them the advice that they should follow their passions. That they should look at what interests them the most in terms of the possibilities of patient care, education, research, administrative roles. It's nice when you can knit those together in some ways, or have a balance of different skills that you learn, and different ways that you can be helpful. So when your research and your clinical responsibilities are in a similar area, then that helps with your career goals, and also is good for patients. So I fell into the area of vasculitis very early, actually, when I was a fellow, and carried that through in my faculty years. And I think it was wonderful to have an area or a niche where I could be helpful teaching others, I could be helpful taking care of those patients, I could work with the support groups to help educate patients and help physicians understand the diseases better, so that they could treat patients better and diagnose them earlier. So I think that's helpful. It's a little harder today for young faculty to get their foothold, partly because of the financial constraints. Not only of clinical care, but of applying for grants. I recognize that It's quite challenging to do that in today's world.

JO 1:27:13
So getting into the profession, there may be some obstacles that are specific to this time period.

NA 1:27:24
You know, I know medicine has to have a business support to it. But I don't accept the premise that medicine is a business, in totality. Medicine is a profession. It's a way that we bring our knowledge and care to populations and to individual people to help them. So just looking at the bottom line is, I know someone's job, but it does pose some challenges.

JO 1:28:16
And it's probably fair to say that that has become a greater focus for medical institutions over the course of your career.

NA 1:28:24

Yes, and academic medical institutions have big challenges because of the array of work that they do. And that's understandable that the finances need to underpin what is done. But there needs to be humanity in all of it when helping young people decide what directions they're going to take.

JO 1:29:03
Yes, that makes perfect sense. And anytime I'm interviewing someone about their job, I like to ask what they think others misunderstand about their job. Are there particular things that you think are kind of generally misunderstood about being a rheumatologist or about being in academic medicine?

NA 1:29:33
Well, I think being a rheumatologist, it's a long word. I think many people in the community don't really have a complete appreciation for what we do. So there are over 100 different kinds of arthritis. So when a patient comes in, and say they have arthritis, I will say we have to figure out what kind, or kinds, and then try to decide what we need to do to help you. So it's a great field, I mean, we deal with not only arthritis, but with illnesses that can involve almost any part of the body, or many parts at one time. There are serious illnesses like lupus that can cause brain, heart, lung, kidney involvement, that can be life threatening. And same for many of the vasculitis conditions that I have treated in my career. On the other hand, we have osteoarthritis, which is common to almost all people by the time we're 50 years old, at least in one or more joints or areas of the body. And there's a whole array of conditions in between. So as rheumatologists, we help educate our patients about what we do and what we can do in working with their other clinical providers, their primary care docs and other specialists that are needed. So we can be a coordinator of care also. And in my career I've, since Duke went to managed care in 1995, I also had a group of primary care patients that I cared for, within my rheumatology practice. So that's been fun too [crosstalk] Back in '95 when Duke started its managed care plan, I think with Sanus-New York Life was the initial insurance umbrella for that. That was a project of Dr. Snyderman's. Our [rheumatology] group decided that we would be both specialists and primary care providers for our patients or others in the community, because it didn't make sense to send a person to another primary care internist to get what I called a "Mother May I" slip to come see a specialist. So think at my peak I had about 150 patients in my practice for whom I was their designated PCP, primary care provider. And towards the end of my career, in the past year, I needed to transition about 60 people to other primary care providers.

JO 1:32:38
So in general, is it your preference to work with someone as a primary care provider?

NA 1:32:45
I could not do that for all patients. Because it does require a different skill set and over the years as as our numbers dwindled, there was an increased emphasis on primary care. And so Duke now has many, many, many more primary care physicians spread out through the community. So there are more people to take that on. But I took care of people who worked in nutrition, and physical therapists, and deans and other faculty, and their family members, as well as my own

rheumatology patients who had started with me, you know, to help manage their rheumatoid arthritis or lupus or another rheumatic condition.

JO 1:33:45
From what I can gather about your work, it sounds like that sort of direct work with patients, the clinical care is just something that is very important to the way that you view your work. And I wonder if you could tell me a little bit more about those relationships. Maybe there's an example of a relationship that you feel like has been a successful one. But yeah, I would just love to document a little bit more of how you approach working with patients.

NA 1:34:21
It is what I love to do. As an internist, we take care of the whole person. As a rheumatologist, I also take care of the whole person. I don't look at someone as, you know, just their arthritis. I want to know as much as I can about them, and what's going on in their life, and their family, and social interactions, and what medications they're on, what their expectations are, and meet the patient as a partner. So, you know, that means a lot to me. So I think a rheumatologist has to start out being an excellent internist and be able to look at that patient from the whole person perspective. So some of my patients, yes, I have taken care of for 30 or 40 years. And those experiences have been quite important. It did become clear probably 10 or 15 years ago, though, that we didn't have the same primary care support system as our colleagues in primary care. So if a patient of mine had a sudden sinus condition, they would contact me and I would take care of it. But if I were out of town, most of my younger colleagues are not doing primary care, so that just became a little more challenging. Fortunately, Duke established some urgent care centers that allowed patients who had an urgent need on a weekend, when I was away, they could be taken care of there.

JO 1:36:16
So you didn't you didn't have the same backup initially.

NA 1:36:19
Well, initially all five of my or four of my colleagues and I decided we would do the primary care. You know, we had a pact. One of us was always on call as the faculty. So we would take care of others' primary care patients, also. But as one retired, and another changed focus, and another person left Duke, then, the two of us who were left were not able to cover everything in the same way. In terms of one particular patient, long term experience, I guess partly what's fresh on my mind are the patients I've had to say goodbye to in the past two months by telehealth, rather than in person. And so some of them we've been through many ups and downs over the years, hospitalizations, infections, and various things as they have aged with me. And so turning them over to another person is difficult, but I know that they will be in good hands. There are a lot of wonderful young primary care folks in the Duke system at this point.

JO 1:37:50
If you don't mind me asking, what were those telehealth conversations like, parting ways with some of those patients?

NA 1:37:58
Many of them are difficult, since I have known them for so long, so I would take care of what they needed, in terms of asking them what's happened since our last real visit. And what was going on that they were concerned about, what medications they're on, what refills they needed, what tests we needed to arrange. So I'd get all that out of the way. And then we would, you know, say goodbye to each other. And sometimes we both use humor if we could. I said "well, here's my virtual hug, since I can't give you a real one." And many of them expressed their gratitude for everything that I had done to help them through some difficult times or through the years. So, some of the people who live nearby and are actually friends as well as patients, I said "contact me after I retire and we'll arrange a time to go have lunch together, when that's possible again." When you can sit in a restaurant and talk to somebody, that will be lovely. So we can catch up on their families and what's happening. And I arranged for each patient to be set up with an appointment with a new physician, whether it's in rheumatology, or primary care, or both. So I know that they will be well taken care of, our triage nurses know that once I am retired in a month, if the patient has not yet seen their new rheumatologist, they'll help them with whatever they need in terms of a prescription, or a test result, or whatever's needed. I feel good about that. I'm leaving them in good hands.

JO 1:40:06
I'm sorry that you had to do that remotely. That's so hard.

NA 1:40:09
I think so much has been changed in the last few months. And we've all just tried to do the best we could, under the circumstances to take care of patients. And to help things along. It's certainly not the same as being able to see them and examine their hands, or elbow, or knees, or listen to their lungs. But pretty much we can tell what's important. Patients can now send us photographs of a new rash, or a swollen joint, through the electronic medical record. And rheumatology in general is now starting to have in person visits, so my colleagues will be able to hopefully meet the person in real time soon and be able to move forward.

JO 1:41:18
That's good, that's great. Thanks for sharing all of those rich details. I think that's really that's really great to have some of your thoughts about that.

NA 1:41:30
Oh thank you, Joe. It's not exactly what I planned. I'm working on a memoir, and a chapter I started two months ago, right after we started doing telehealth visits, is planning for retirement under the cloud of Coronavirus. Everybody's having interesting experiences, if you want to put it that way, and challenges.

JO 1:42:02
Yeah. Well, kudos to you for writing it all down, that's really cool.

NA 1:42:08

Yeah, the days sort of run together, so I'm not sure what happened last week or yesterday sometimes [laugh].

JO 1:42:16
[Laugh] I know that feeling. Well, I've asked you to talk a whole lot and I so appreciate you sticking with me, and helping guide me through some of your story. I know there's probably a lot that we didn't capture, but I think that we did record some really great reflections and important information. So is there anything else that you want to make sure to include in this interview?

NA 1:42:56
Oh, we could talk forever, I guess, but that's a lot. You know, I think particularly since you have access to the previous interview with Jessica [Roseberry] that's in the Medical Center Archives. Hopefully at some point both of these will be available to people who might want to learn more. So, I'm grateful for my patients and for my colleagues and for the opportunity to have been at Duke for 42 years, starting with internship and finishing up with transitioning my patients. I'm not sure exactly what the next few years will look like, but I probably will keep my rheumatology interests up, and still work with young people in some way. And also try to be active in the community to make things better in my own small way.

JO 1:44:21
Excellent. Well, we could leave the recording there.

NA 1:44:24
That's fine, unless you had other questions for me

JO 1:44:28
Okay. Yeah, that's fine. I'm gonna press stop. And I'll go ahead and do that now.

[Beginning of new recording]

Now, and I am ready when you are, if you could just say who you are, just your name and a statement of who you are.

NA 1:44:50
Hi, I'm Nancy Bates Allen, and I am Professor of Medicine in the Division of Rheumatology and Immunology at Duke University Medical Center.

JO 1:45:04
Great, thank you. And then the very last piece that we will use for the edit of the interview will be what we call room tone, which is actually just the sound of the natural ambient sound in the room. So what we have to do to record that is just pause for about 30 seconds, so if you don't mind we'll sit here quietly for about 30 seconds *[pause for room tone]* Okay, that should do nicely.

NA 1:46:14

That's good.

JO 1:46:16
Thank you. Thanks for your patience today.

NA 1:46:20
You're welcome.