ORAL HISTORY INTERVIEW WITH ROBERT DRUCKER
Duke University Libraries and Archives
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COLLECTION SUMMARY

This collection features an oral history I conducted with Robert Drucker on April 22, 2022. The 90-minute interview was conducted in Durham, NC. Our conversation explored Dr. Drucker's work as an advisory dean, the impact of COVID-19 on medical education, and his experiences working in pediatrics and pediatric infectious diseases. The themes of these interviews include pediatrics, medical education, and careers in medicine

This document contains the following:

- Short biography of interviewee (pg. 2)
- Timecoded topic log of the interview recordings (pg. 3-4)
- Transcript of the interview (pg. 5-35)

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
- Scan of a signed consent form

BIOGRAPHY

Dr. Robert [Bob] Drucker is Associate Dean for Medical Education in the Duke University School of Medicine. As Professor of Pediatrics, his clinical work has been centered in the Division of Pediatric Infectious Diseases. Previously, he was Director of Pediatric Student Education and Associate Director for Graduate Pediatric Education.

Dr. Drucker was born in Cleveland, Ohio, and spent his later childhood in Toronto where his father was Chairman of the Department of Surgery at the University of Toronto. Observing his father's work and friendships, Dr. Drucker gained an early appreciation for the field of medicine. "I didn't know what kind of doctor I wanted to be," he says. "But I really liked the idea of being able to help other people, and have those unique types of relationships." Dr. Drucker attended Harvard University, where he majored in Applied Mathematics and took pre-med coursework. He was accepted to Duke University for medical school, and after his second year was torn between a number of specialties. He bonded as a third year research student with pediatricians Dr. Catherine Wilfert and her spouse Dr. Samuel Katz. "Spending a lot of time with Cathy and Sam, immersed into the world of Pediatrics, [I] found that I really did like working with kids," he recalls. Dr. Drucker moved to Massachusetts General Hospital in 1979 as a Resident in Pediatrics, where he spent an extra year in 1982 as a Fellow in Pediatric Nephrology.

Dr. Drucker returned to Duke in 1983 as a Fellow in Pediatric Infectious Diseases. In 1987 he spent the year as Chief Resident in Pediatrics after an unplanned vacancy occurred, a role that coincided with his first year on faculty. "I had not done my residency at Duke, so [it was] very, very atypical," he laughs. "[But] for me, it was career-changing. Because it immersed me into the world of education, and I absolutely loved it."

His first educational role was working with the Residency program, and soon after, with the Pediatric Clerkships program. As a member of The Council on Medical Student Education in Pediatrics [COMSEP], Dr. Drucker helped to re-write the standard medical school curriculum for pediatrics and contributed a case to the CLIPP [now Aquifer Pediatrics] casebook. In 1991, Dr. Drucker became Associate Director for Graduate Pediatric Education, and in 1994 became Director for Pediatric Student Education. In 1991, he joined the Medical School Admissions Committee, where he has contributed for the last three decades. In all of these roles, and as an Advisory Dean, Dr. Drucker has relished in the fact that both medical school and the medical student population is "always changing", creating new opportunities to reimagine a comprehensive and inclusive educational model. He supports individuality, noting that "the worst thing a school could try to do is have a cookie cutter product." In his weekly lunches with first-year medical students, he makes a point to always ask "What have you done for fun in the past week?" to emphasize to busy students the need for work-life balance. Dr. Drucker retires from Duke University in the Spring of 2022.

INTERVIEW TOPIC LOG (robertdrucker.wav)

00:00 Introductions; full name and birthdate.
00:57 Current responsibilities as Associate Dean for Student Affairs in the School of Medicine.
01:52 Title in Department of Pediatrics; clinical responsibilities in Division of Pediatric Infectious Diseases.
02:31 Upbringing in Cleveland, Ohio; father's career as a surgeon at Western Reserve University [Case Western Reserve] and at the University of Toronto as Chairman of the Department of Surgery; early interest in science.
03:30 College experience at Harvard University majoring in Applied Mathematics [Computer Science] and taking pre-med courses; friendship with Steve Ballmer [later CEO of Microsoft]; father's move to University of Virginia and Drucker "looking south" at medical schools; applying to Duke.
05:15 Early life and personality as "the good kid"; hobbies in violin, sports management, and French.
06:42 Early influence of father; early interest in computers.
08:06 Social interactions with University of Toronto and visiting surgeons.
08:44 Visiting rounds with father; observations on doctor-patient interactions.
10:15 Visiting Duke during admissions process; early perceptions of Durham.
11:14 "Intensity" of first year at Duke; bonding of incoming class.
12:41 Basic sciences curriculum; example of learning about superoxide dismutase by Irwin Fridovich "way ahead of the curve"; initial talents and challenges.
13:57 Interest in pediatrics; positive interactions with children as a young person.
15:03 Third year research in Dr. Cathy [Catherine] Wilfert's virology lab; relationship with Dr. Wilfert and Dr. Sam [Samuel] Katz; decision to go into pediatrics.
17:09 Learning how to communicate with families; "most effective to teach the parents by teaching the children".
18:12 Move to Massachusetts General Hospital for residency; letter of recommendation from Dr. Sam Katz.
19:56 Residency experience; wife's [Joan Liversidge Drucker] internal medicine residency; extra year working in pediatric nephrology and work with Dr. John Herrin.
23:44 Fellowship in pediatric infectious diseases at Duke; clinical year working on pox viruses; collaborations between Clinical Infectious Disease Divisions and the Department of Microbiology.
25:52 Birth of children [Eric and Jenny]; experiences parenting young children while working on medical careers.
29:15 Year as chief resident at Duke, post-fellowship.
32:52 Concurrent first year as faculty, discussion with Dr. Mike [Michael] Frank about interest in education; opening for Associate Residency Program Director; relationships with Dr. Tom [Thomas] Kinney and Dr. Laura Gutman; creation of resident database.
35:44 Interest in education and views on student challenges and guidance.

37:20 Role as Pediatric Clerkship Director starting in 1994; work with The Council on Medical Student Education in Pediatrics [COMSEP].
40:03 Pediatric clerkship structure; COMSEP national curriculum for pediatrics; development of CLIPP [now Aquifer Pediatrics] cases.
44:31 Work as medical director of the 5100 Intermediate Care Unit; mentorship outlook for medical school and avoidance of the creation of a "cookie cutter product".
48:49 Current curricular revamp at Duke; changes to medical education model over time
51:05 Role as Advisory Dean;history of Advisory Dean system; mentorship by Dr. Debby Kredich.
53:47 Weekly lunches with first year students.
55:21 Reflections on current generation of medical students; daughter's experiences that led her to medical school.
57:53 Participation as Advisory Dean in student-faculty show and student-created videos for Second Look Weekend.
1:00:17 Guiding and supporting students through career planning challenges.
1:04:00 Work on Admissions Committee; leadership by Director of Admissions Dr. Brenda Armstrong; move to computer-based systems and diversity and inclusion work led by Dr. Armstrong.
1:08:01 Changes to application essays; introduction of Multi[ple] Mini Interviews [MMIs] and team station interview segments by Dr. Armstrong.
1:11:21 Building connections with a large portfolio of students; perceived impact of the Dean's Letter.
1:14:03 Work on Fourth Year Curriculum Committee; diversity of experiences in fourth year.
1:16:57 Work on Pediatric Undergraduate Medical Education Committee.
1:18:09 Impact of COVID-19 pandemic on responsibilities, admissions process, and relationships.
1:23:10 Mentorship and relationships with Cathy Wilfert, Sam Katz, Tom Kinney, Debby Kredich, Mike Frank, Joe [Joseph] St. Geme.
1:24:57 Collaborations with private practices - the Purcell Pediatric Clinic in Laurinburg, North Carolina, and with Dr. Joey Bell in Pembroke, North Carolina.
1:27:19 Reflections on collegial relationships and thoughts on retirement.

TRANSCRIPTION (robertdrucker.wav)

JM 0:00
Yes. And so, I will start this recording on the phone as well, which is directed towards you. Okay. And I'll do a little preamble for us. So, it is Friday, April 22, 2022. I'm Josephine McRobbie. And I'm interviewing Dr. Robert Drucker. This is part of an ongoing oral history series for the Duke University Medical Center Archives. So thank you for being part of this project. Dr. Drucker.

RD 0:32
Well, thank you for letting me participate.

JM 0:34
And can I ask you, so do you go by Bob or Robert?

RD 0:38
I go by Bob.

JM 0:39
You go by Bob. Okay, that's great to know. And can you start by telling me your birthdate and your full name?

RD 0:44
Okay, so I was born April 20, 1952. And my full name is Robert Patrick Drucker.

JM 0:52
So a recent birthday.

RD 0:54
Recent birthday, the magic 70.

JM 0:57
Okay, and you're getting ready to retire, so congratulations. And so that is part of why we're doing this, to learn a bit about your contributions to Duke. So can you tell me a bit about your current role and responsibilities, before we go back and find out how you got here?

RD 1:11
So currently the majority of my time is spent in the School of Medicine. I'm one of the Associate Dean for Student Affairs. So, working with medical students. What that means is when a class starts, one fifth of the class are assigned to me as advisees. And they stay with me throughout their time in medical school. During the first year of medical school, I have lunch with them every week, in an attempt to get to know them. And then as they go through other years, it becomes more individual meetings, talking with them about career planning, life situations, academics, whatever comes up. So it's exciting and constantly different.

JM 1:52
And you are also a Professor in the Department of Pediatrics.

RD 1:56
Professor in the Department of Pediatrics, I actually stopped my clinical work about three years ago. When I was doing clinical, I was in the Division of Pediatric Infectious Diseases.

JM 2:06
So an interesting time to segue out of that, I'm sure.

RD 2:11
[Laughs] Shortly before COVID hit, so in some ways, fortuitous. But again, I've been involved in infectious diseases long enough. I was early in my career when the HIV issues rose for the first time. So [I've] seen a wide range of infectious disease issues over the years.

JM 2:31
And so I hoped we could go back and talk a little bit about your upbringing and how you got into the roles that you're in today, and talk a bit about your career development. So I read that you're from Cleveland, originally.

RD 2:43
Born in Cleveland, lived there for the first 14 years of my life. My father was a surgeon. He was doing his training when I was born, as a resident at what was then called Western Reserve University, now Case Western Reserve. He went into academic surgery, so [a] practicing surgeon but very involved with education. When I was 14, he was offered the opportunity to go to the University of Toronto, as the Chairman of the Department of Surgery. And so I moved there at age 14 and went through high school in Canada. Again, [I] worked in his laboratory for a couple of summers. So [I] got immersed into benchtop, basic science research, looking at the physiology of shock, and just fascinating work.

I went away to college having a good idea that I wanted to go into medicine. So I went to Harvard for college, and chose to major in this new field. Something called Computer Science. It wasn't even a major available, it was something called Applied Mathematics -- applied to computers. So that was my major, but I still took all the Pre-Med courses. It's looking back on the college years that I realize I was not very good at predicting the future. One of my colleagues, things we did together, we were both football managers showing our athletic prowess -- or lack thereof -- but someone by the name of Steve Ballmer, who went on to become CEO of Microsoft and owner of The Clippers. So [I] did not maintain that relationship after college, unfortunately. But while in college, again, pursued the Pre Med courses and then applied to medical school. By that time, my father had actually left the University of Toronto, and he was now at the University of Virginia as Dean of the School of Medicine. Since he was in Virginia, that was the first time we even thought about looking south at medical schools. And one of the ones I looked at was Duke. [I] really liked their curriculum, and the idea that they had a full year of research as part of the four years. And the fact you got into the clinical setting during the second year. So I applied to Duke, and was very fortunate to get accepted into the School of

Medicine. So I came here for those four years of medical school and worked hard. But it was just an incredible experience.

JM 5:15
So I'm interested in -- I often ask people this -- what kind of kid were you? What kind of kid, what kind of high schooler, college student?

RD 5:23
What kind of a kid. My parents would describe me as -- I was the good kid. I had [an] older brother, younger brother, younger sister. I was one who didn't cause trouble. So a rule follower, which has shown up throughout my career, I think, to some extent [laughs]. I enjoyed different things. Again, I've already mentioned my lack of athletic abilities. But I played violin, started that in fourth grade, and did that through high school. And one of the biggest regrets in my life is I stopped playing violin when I went away to college. I did well academically and really liked learning. As an example, one summer we weren't on vacation [and] I took an eight-week course in learning French, just because it was an interest. So that was the sort of kid I was. Going through high school I liked being involved in different organizations. I liked sports. And that's where I started my managerial career, manager in high school for football [and] soccer. But, I think that's a good description of my early years.

JM 6:42
And who were some of your early influences? You mentioned your father was a big one.

RD 6:47
My father very much so, and then contacts through him. And then through school, again, I was fortunate when I was in high school [it] was the first time the high school introduced computer science as a course. Interesting story there. We were all told that anyone who was even thinking about medicine as their future career had to take Latin as one of the courses. So there are about 20, there are 30 of us, who took Latin. The next year, they introduced computer science, but the only time they could fit that in was the same time that Latin was offered. That year, there were two people taking Latin and 28 who'd switched over to computer science. Again, found that something I really, really enjoyed, and had the opportunity to start some teaching that year, because they decided every student needs to know something about computers. And so the math teachers were all supposed to teach computer science. Well, one of the math teachers -- who also happened to be one of the physical education teachers -- just wasn't understanding it all. And I was doing well in computer science. So I got to teach his math class, about computer science. [It was] the best grade I ever got in physical education [laughs].

JM 8:06
And was there anything that you were interested in doing as a career aside from medicine in those early years? Or did you feel like you were pretty focused?

RD 8:14
I was pretty focused on medicine from early on, and that was the world I was immersed in. Again, during high school over in Toronto, when my father was Chair of the Department of

Surgery, we would have visiting surgeons from literally around the world. And so that was all the discussions. It really was about medicine. Good friends in medicine. My older brother had no interest in it whatsoever, went into architecture, and I couldn't understand why he wasn't doing medicine.

JM 8:44
And what did you like about the kind of culture of it, or what you learned from these different surgeons in your dad's orbit?

RD 8:51
A lot of it was just the interaction with patients. I would commonly join my father on weekend rounds. He would take me in [and] we would just talk to patients. And just seeing the relationships he had with them, in retrospect, even as a surgeon [he was] in great relationships with his patients. And just hearing them talk about their experiences with the surgeon was something that really appealed to me. So I liked that concept. Didn't know what kind of doctor I wanted to be. But I really liked the idea of being able to help other people, and have those sort of unique types of relationships.

JM 9:28
Well, thanks for sharing that. And so you mentioned that, you know, you weren't sure about these southern schools, and applied to Duke. So when did you first visit Duke, and Durham?

RD 9:40
So it's interesting because at that time, Duke was doing regional interviews. So my interview for Duke was actually in Boston. But on spring break, so this would have been the spring of 1975. I was visiting my parents for spring vacation, and so took the opportunity to drive from Charlottesville to Durham, just so I could see what Durham looked like -- which wasn't a whole lot to say about, at that time -- but also was able to have a tour of the Duke campus and talk to some people here. So that was my first time, and it was after I'd been accepted.

JM 10:15
And what were some of your early impressions of the school and were there people that you connected with right off the bat?

RD 10:22
Probably not so much that one day, except the admissions office [was] incredibly accommodating. Here's a strange person out there [not] for interviews or anything, but wanted to be able to see the school. They bent over backwards, they gave me campus maps and told me places to wander around. The timing wasn't great for meeting with any students. But that was okay, I still got to see the campus. And I loved the campus, loved the people at Duke. They said Durham itself did not offer a whole lot. I was used to big cities -- Cleveland, Toronto, Boston. And at that time, Durham was probably at its low point. Downtown was completely abandoned, there was no American Tobacco, it was surrounded in barbed wire because it just wasn't safe. But it was the school I was far more interested in, and again, the curriculum.

JM 11:14
And so you arrived on campus, and who were some of the people that you initially connected with, be it students or professors?

RD 11:23
So, definitely classmates. One of the things in retrospect thinking about the Duke curriculum, the first year where all the basic sciences are put into 11 months is a very intense year. And I remember going through different phases. At orientation, it was sort of, "Wow, I'm in med school." And then the second week of classes it's, "Wow, I'm in med school." [Laughs]. And then it reached the anger stage, "How dare they try to make us learn all of this?" And then it was sort of the recognition, "Okay, other students have done this successfully, therefore, it has to be possible." And recognizing it was so much easier to do it, working with my classmates. And it really helped form a strong bond within the class, as we were all fighting against the enemy, in a sense [laughs]. But it worked out beautifully that way. And so it really formed a tight bond. And those are my first early memories, it was the bonding of the class. It got rid of that whole pre med competition atmosphere. Because we were all after the same thing.

JM 12:34
And how big was the class?

RD 12:39
About 115, so it then got smaller, and now has gotten bigger again.

JM 12:41
Okay, got it. And so you came into this new kind of education, [and] what was your skill set at that time? What things were challenging for you, what did you take to easily?

RD 12:56
[Laughs] Basic sciences were challenging, just the amount that is there to learn. I remember, there was one -- we had two lectures given by a professor on his research, and really getting angry, saying "This is not in the textbooks. Why is he making us learn all of this information?" And then later on, okay, what we were learning about was superoxide dismutase by Irwin Fridovich, which has become such an essential part of medicine. So yes, we were learning things way ahead of the curve. I could appreciate [the] value tremendously, in retrospect, but at the time it was just more overload. So, that was a big part of the challenge. Some things seemed to come more easily. Microbiology, I really enjoyed learning about bacteria and viruses. And that ended up being a very important part of my career.

JM 13:57
And did you have an idea at that point, what specialty you'd be going into, or subspecialty?

RD 14:03
I was thinking about pediatrics, I always loved working with children. So that's what I was thinking coming in. Not knowing a whole lot about the field, other than my own experiences as a child seeing my own pediatrician. During the second year, when I rotated through all the

specialties, I loved everything. The only thing I knew was not going to be in my future was surgery. Again, I'd been exposed to that world, and seen what that was, and that was not what I really wanted for my career. My lack of dexterity skills also made it probably as good for patients that I did not go into surgery. But I loved everything else. And at the end of second year, I really was very confused as to what career path I was going to follow.

JM 14:50
And you mentioned that you had worked with kids before?

RD 14:53
Just interacting with them at school. No formal working with them. Summer camps and things, babysitting, but nothing more than that. Just [that] I liked being around children.

JM 15:03
Got it. So you're at this sort of impasse after your second year, is that right? And where did you go from there?

RD 15:09
So [I] jumped into third year research. For my research I chose to work within microbiology, working in a virology lab run by Dr. Cathy [Catherine] Wilfert. Cathy was a pediatrician in pediatric infectious diseases, and an absolutely incredible person. Huge influence on my life, my career, everything I've done. An added benefit was that her husband was Sam [Samuel] Katz. Sam, at that time was Chairman of the Department of Pediatrics, [he had] also trained in pediatric infectious diseases. One of his claims to fame was that he was one of the co-developers of the measles vaccine. So here's this giant in the world of pediatrics, giant in the world of pediatric infectious diseases. And as a third year medical student, I was calling him Sam. Because he wouldn't talk to me if I called him Dr. Katz. That again had a huge influence on me. I recognize the importance of using first names. It gets rid of hierarchies, and just makes everyone colleagues, [it's] so much easier to get work done.

Well, during that year, spending a lot of time with Cathy and Sam, immersed into the world of Pediatrics, [I] found that I really did like working with kids. I was worried about working with really sick children. So one of my early clinical electives in fourth year was working in the intensive care nursery, where I would have to work with sick children. At that point, I was torn between pediatrics and internal medicine. The rotation that finally decided it for me was actually dermatology. Because on that rotation, I saw children and I saw adults. And in the clinic, I just found myself gravitating to the rooms that had kids in them. And it was sort of, "Okay, what am I doing? I've already made the decision. Let me just acknowledge it." So [I] went into pediatrics.

JM 17:09
And what skills were you learning about how to interact with children, when it came to talking about their health or them being sick?

RD 17:17

So it was, again, exactly that. Talking with children, learning how to get to their level, communicate to them, while also communicating to the parents. I found it was most effective to teach the parents by teaching the children. That way I could be talking at the level of a child, and not have to worry about what's the education level of the parents? Am I talking down to them? Well, maybe, but I'm talking to a child. And so the parents forget that. And for the parents who were at that level, they didn't have to acknowledge, you know, "I really don't understand everything." Because I'm talking to their child. And that was incredibly valuable, and helped form wonderful relationships with almost all parents.

JM 18:00
Is that something that you intuited, or was that a strategy that was taught to you by one of your [mentors]?

RD 18:04
It wasn't taught to me, it just sort of came to me. Trial and error, and that seemed to work very well.

JM 18:12
So you moved to Mass[achusetts] General [Hospital] for your residency, is that correct?

RD 18:17
So I left Durham. Again, I've described what Durham was like at that time. And I didn't even apply to Duke for residency. I had to get back to a big city. So I went back to Boston, and went to Mass General Hospital. What I liked about their residency program is that it was so similar to the Duke program. Relatively small, there were only nine interns in my class at that time. It was a pediatrics department within a big general hospital, where pediatrics is the poor cousin, after surgery and medicine ran the show. But I really, really liked that atmosphere.

JM 18:56
And were you encouraged to go there? Or were you encouraged to stay at Duke? What was the feeling among folks here?

RD 19:03
So Sam Katz was the advisor that we all went to if we were going into pediatrics. And Sam was great. He was just very, very open, listening to what I wanted, or what my interests were. So he did not try to talk me into staying at Duke, he was very supportive of me looking at multiple other programs. Later on, for various reasons, I was able to see the letter of recommendation he'd written for me at Mass General. They probably weren't supposed to show me, but I did get to see it. And it was a very, very nice letter. But what really stood out, he put on a handwritten note. Because he and the chair at Mass General were very close friends. His handwritten note was "This one's a winner." So very appreciative to Sam for many, many things.

JM 19:56
And what else can you tell me about your residency years? These are notoriously difficult, challenging years [laughs]?

RD 20:05
They were busy, just like any residency. I will not fall into the trap of "Way back then when we had to work 36 hours a day" [laughs].

JM 20:16
That's not something to glamorize, I suppose.

RD 20:19
No not glamorize at all [laughs]. But I don't hold that out as, "Hey, we were giants. We could do all this. And today, you know, they're only working 24-hour shifts." It's such a different world. Patients are so much sicker today. So it's apples and oranges. You can't compare them. So yes, it was working hard. Residents today work very hard. But you learned so much. And again, the relationships. Later on, we can talk about one of the relationships I formed there. I stayed there an extra year. So I finished residency, and then my wife -- now my wife, actually we got married when I finished medical school -- she was at UVA [The University of Virginia] for med[ical] school, but a year behind me. So I needed an extra year while she finished her internal medicine residency in Boston. So I spent a year working in pediatric nephrology. Not that I was going into nephrology, in fact, I had already accepted my infectious disease fellowship. But our pediatric nephrologist, Dr. John Herrin, was an absolutely amazing clinician. And I said, "If I can spend a year learning clinical skills from him, it is so worth it."

JM 21:29
So was it unusual at that time to stay for an extra year?

RD 21:33
Not completely unusual, people were doing it. Not as much as they do today, where they need that one year. So this was just a fortunate opportunity. He was thinking about starting a pediatric nephrology fellowship, and just wanted to try having someone for a year as a clinical assistant working with them. It worked out very well for me, worked out well for him. So it was a nice relationship.

JM 21:59
And what sorts of clinical skills did you learn from him?

RD 22:02
So just learning again, more, how to interact with families, and especially those with chronic illnesses. He had some children that I'd taken care of during my residency and got to know them a lot better during the fellowship with him. And again, his relationships with them, his interactions with them, how to give bad news, how to support them through difficult times, and then how to share the celebrations with them, as well. I learned some clinical tricks from him that aren't in the textbooks. One example there, I got a phone call -- it was around Christmas -- from Cape Cod. And a child had gotten into the family's holiday punch, and had consumed a ton of alcohol, dangerous levels of alcohol. And the child needed to be dialyzed. So they wanted to send the child from Cape Cod up to Boston. Dr. Herrin said, "Okay, here's what I want you to do.

Just put some normal saline into the peritoneal cavity, just put an angiocath in, put some saline in there, and then take the catheter out. And that will start the dialysis now, rather than waiting until he gets to Boston. I hadn't seen that written anywhere, but it was wonderful, and definitely helped that child.

JM 23:24
Was that something that you would then use again, or was that a unique case?

RD 23:27
I never used it, but it was the concept of thinking out of the box. Physiologically, it made great sense. Why do we need to have the formal dialysis set up with all the paraphernalia, when this can get things started rapidly?

JM 23:44
So after this, you were returned to Duke as a fellow in pediatric infectious diseases. Is that correct?

RD 23:53
That's correct, yes.

JM 23:55
What were you working on during this time? And were you excited to come back to Duke?

RD 23:57
Oh very, excited. I've already told you my feelings about Durham at the time. The way I phrased it to my wife is that I couldn't pass up the opportunity to work with Cathy Wilfert and Sam Katz again. And that we could survive Durham for a time period. She was coming to Duke to do an adult infectious disease fellowship. So it worked out very well. We had bugs covered all the way through ages. So I came back [and] worked here. The first year is a clinical year, and then I went into the laboratory working on pox viruses and inserting DNA into the genome of pox viruses. Working within the microbiology department, with PhDs and graduate students and postdocs. A fascinating, fascinating experience. I loved what I was doing, and I really saw that potentially as my future career. Mainly research with a little bit of clinical infectious diseases.

JM 25:00
And so it sounds like there was some kind of cross-pollination of departments at that time?

RD 25:06
There was, yes. The Clinical Infectious Disease Divisions and the Department of Microbiology were very closely connected.

JM 25:14
And why do you think that was?

RD 25:18

I think a lot of that was the beginnings of Microbiology at Duke, and some of the original people. And then the need to work with the clinicians as well. There's a textbook in microbiology that was written by Duke authors, primarily, Zinsser's textbook of microbiology. [It was] edited primarily by basic scientists. But a lot of the authors were clinicians who could talk about the clinical diseases, while the microbiologists could talk about the organisms themselves. So it was a great relationship.

JM 25:52
And I think I read at this time, you and your wife had two children.

RD 25:57
So our first was born during our fellowships. Eric was born during fellowship. And then our daughter Jenny was born shortly, a couple of years, later.

JM 26:13
And how did the two of you balance parenting while also pursuing your medical careers?

RD 26:19
[Laughs] Got to be interesting. But Eric was born after the clinical years. So when we were in research, where there's a little more flexibility. Also, he was born after my wife had finished her fellowship and had a remarkable opportunity. She went to what some people would have called "the dark side", at the time. She joined a pharmaceutical company. But they were recruiting someone who was trained in infectious diseases, to help guide a new drug through clinical trials, something called AZT, the first drug used for the treatment of HIV. So she was running a lot of those clinical studies. In that world she, again, had a little more flexibility. It was chaotic times. Really, really busy. But between us, we were able to juggle. So yes we could pick Eric up from daycare, and "Whose turn is it today?" And "Gee, something came up, can you go get him?" There are times I know he spent in her office at the company, and they were incredibly tolerant of that.

JM 27:25
And how did the two of you support each other during these really busy years?

RD 27:30
The evenings, you know, once the child goes to bed, I think there are reasons we make sure kids have early bedtimes [laughs], it was the time for us to spend our time together. But we were both doing interesting things, and things that we love doing. And I think that helped tremendously.

JM 27:47
Did you talk shop a lot? Do you talk shop a lot?

RD 27:50
Not a whole lot. One great example of that later on, we're both believers in science. And so yes, we enrolled our kids in different research studies. Eric was actually in one of the early chickenpox vaccine studies. So we got the chickenpox vaccine. My wife, part of her work at

Burroughs Wellcome was helping oversee one of their other medications, something called Acyclovir, which is a treatment for herpes viruses. Chickenpox is a herpes virus. About a year after Eric got the vaccine, he broke out in chickenpox. My reaction is, "Fantastic, [a] breakthrough infection really helps confer the longest immunity. Likely that it'll be a mild attenuating course and he will do fine." At that time, a study had just come out about the use of Acyclovir for the treatment of chickenpox in healthy children. And Eric ended up getting the worst possible care. When my wife stayed home with him, he got Acyclovir. When I stayed home with him, he didn't. So we do not talk about chickenpox at home. So other topics are safe. Chickenpox we just don't discuss at home.

JM 29:15
Fair enough. So I think I read at this time, you came back to Duke, and then you were chief resident in pediatrics. So I'm from the humanities [laughs], but is that a little unusual?

RD 29:26
Very unusual.

JM 29:27
Okay. Can you tell me how you ended up on that path?

RD 29:30
So again, here's where I'd say serendipity came in. I was finishing my fellowship, and I was getting ready to join the faculty. And Sam Katz came to me with a problem. Normally, the pediatric chief residents are right out of our residency program. The person who was going to be chief resident had decided to go on to something else instead. And Sam did not have a chief resident to start that summer. And this was spring. He came to me and asked if I would be willing to be the chief resident while I was in my first year on faculty. Well, two things, okay? I was already finishing my fellowship. Normally the chiefs were right out of residency. And I had not done my residency at Duke. So very, very atypical. I think Duke learned from that in that they have never repeated that experiment. For me, it was career-changing. Because it immersed me into the world of education. And I absolutely loved it. And my father had been an educator and that was interesting, but not where I really saw myself going until that year. A lot of time spent with the residents, working with medical students, and found it was just something that clicked. So yes, it was very atypical for me to be a chief resident in that sort of setting. But boy, am I lucky.

JM 30:59
Did you have trouble sort of getting back into the culture there, or leading that group of people?

RD 31:04
A little bit of trouble, but a lot of it was because I didn't know them as well as the chief resident normally knows the residents. Where that comes up, is what I think is still the worst part of being chief resident, is the sick call -- when a resident calls out sick and you need to find a replacement, which means you're asking someone else to fill in, which is never popular. It may have helped that I didn't know the residents as well. So no one can accuse me of favoritism. But

it was, I think, maybe more of a challenge than it might be for others. Not that it's easy for anybody.

JM 31:43
And what kind of educational activities were you participating in in this role that made you find that passion?

RD 31:50
So it was more on the wards, so the rounding with residents. Time there instructing them, bedside teaching, some of the more formal lectures. Same thing with the medical students, sharing [with] them the excitement of pediatrics, but also teaching them about the care of children.

JM 32:08
Okay, and do you remember any activities that really stuck out to you during this time, any interactions with patients that were real teaching moments for you and the folks around you?

RD 32:20
During that year? Not in particular. In terms of teaching, again, it was morning reports and just talking with residents about patients. And how much I enjoyed doing that. And even though I wasn't directly involved with that patient, hearing about them [and] getting to discuss different ways to take care of them. So not one [in] particular, but just the concept in general. Much more immersion into the clinical world, without the one being directly responsible for the day to day writing notes, et cetera.

JM 32:52
Right. Okay. And so you joined the faculty the same year.

RD 32:57
Yes. So my first year on faculty, I was also the chief resident.

JM 33:01

Okay, and so what were your faculty responsibilities during that first year?

RD 33:05
Still I was trying to do some research. Again, it let me be the attending on the wards. So the clinical work. But where I had the relationship with the residents, they would just come by the office to talk. That was great. So after that year, I did go back into research for a couple more years, but the education thing kept nagging at me. So I then went to Mike [Michael] Frank, who had become Chairman of the Department of Pediatrics, and told him that if anything opened up in education, I would love to move in that direction. About that time the person who was our Associate Residency Program Director left to go to another institution, which created an opening. Mike came and asked if I'd be interested, and I jumped at the chance to work with the residency program. Tom [Thomas] Kinney was the Residency Program Director at that time,

Laura Gutman was the Residency Program Director when I was chief resident. Tom -- phenomenal person, hematologist, oncologist, great educator -- he and I had worked on some projects together taking advantage of my computer skills, creating databases. So it was just a wonderful relationship to work with him, and it got me into the education world.

JM 34:26
And were you coming into this thinking, "I have some huge restructuring ideas for residency?" Did you feel pretty satisfied with how things were at Duke?`

RD 34:36
Satisfied in the sense that there is no perfect system. So you have to constantly reevaluate, you have to constantly be willing to change, and that was very appealing. I didn't have any great ideas, because sometimes you have no idea what the needs are going to be. But sort of that willingness to be creative. And Tom was willing to be creative and adapt as needed and constantly look at what we were doing. Again, working with Tom one of the things we did [was] create a database for the residency program that tracked every resident to make sure they were meeting all of the American Board of Pediatrics requirements, to make sure we had the staffing needs, to make sure they were getting the educational things they needed.

JM 35:21
And that was in 1991. Kind of early to have a database going.

RD 35:26
Oh yes, personal computers hadn't been around all that long. So it was a unique thing which did let us have some workshops or other presentations at meetings. He and I created a database for tracking newborn screening results. So [I] got to present on that as well.

JM 35:44
So why was medical education so important to you at this time? What issues did you see students coming through with, or residents coming through with?

RD 35:58
A lot of it has to do with just the overwhelming amount of information. And different interests. One size does not fit all. Some students [or] some residents are great in one area but need support or guidance in other areas. So it was just a lot of fun helping them explore their strengths, their weaknesses, giving them suggestions, watching them grow during residency at that time.

JM 36:26
And did you did you start to see, I guess, sort of archetypes of students coming in? Did you start to figure out earlier, like how to guide them the right way? Or was each person a unique case?

RD 36:37
Each person is unique and the advantage of there not just being one person running the program [was] I could always talk with Tom and say, "Hey, what do we do with Joe Smith, he's struggling in this area, what guidance do we have?" Or also just the collaborative nature of the department.

If someone was interested in a career in infectious diseases, fantastic, I can help them readily with that. But if they want to go into neonatology, okay, I don't know the good training programs. But boy, I have phenomenal colleagues in neonatology. And so helping the residents tie in with the right people who can give them that sort of guidance was very useful.

JM 37:20
And at this time were you also developing courses and doing things of that nature?

RD 37:25
No, this really was just the residents. But in 1994, another opportunity came along. Dr. Shirley Osterhout had been the Pediatric Clerkship Director for the medical students for years. In fact, she was my clerkship director when I was a medical student. She announced that she was interested in stepping down from the position. And so they put a call out for anyone interested. I talked with Tom, talked with Mike Frank, and decided I was really interested in taking on that, moving a little bit more to working with students, while also working with the residents. So I was fortunate enough to become the Pediatric Clerkship Director in 1994. And [I] kept that position for 23 years. And it really became a career path, which was relatively new. It used to be clerkship directors were frequently that young faculty person who needed a boost, or something to help get their career started. Or the older faculty member, near the end of their career. But the idea of someone coming in and doing it for a long time was relatively new. What helped with that was actually a national organization, something called The Council on Medical Student Education in Pediatrics, or COMSEP, which was formed by the department chairs in pediatrics around the country. They felt there needed to be an organization of clerkship directors. And that was the original foundation. So I went to my first COMSEP meeting in 1994 in San Antonio, Texas, and just met people from around the country who had similar interests. It became my support group over the years, because we all faced similar problems. It was also a very, very collegial group. We were all interested in teaching medical students, so [it was] very collaborative. If someone came up with a great idea, something that was working well, they'd share it, and rapidly, the same idea would be used elsewhere around the country. It's a little bit different with residency program directors because at some level they are competing against each other as they are trying to recruit medical students to come to their residency program. For clerkship directors, that didn't exist.

JM 39:54
Because people are already in their programs.

RD 39:57
They're in med[ical] school, and the purpose of the clerkship director is to provide a pediatric education while they're in medical school.

JM 40:03
Can you tell me a little bit about the structure of a pediatric clerkship?

RD 40:08

So, most medical schools have a year or so of clerkships, which is students spending a block of time within different fields. So internal medicine, surgery. And for pediatrics, when I first started the clerkship, they would be with us for eight weeks. And we divided that up, they would have some time working in the hospital on the wards, some time working in the nursery, some time working in clinics. That structure changed a little bit over the years. For various curricular reasons, they shortened our clerkship to six weeks so that students could do other things. But we still had that basic structure, still have some time in inpatient, some time in clinic, some time in the nursery.

JM 40:58
And you mentioned discussing with your colleagues some of the problems of the clerkship, what were the common problems at that time?

RD 41:06
Well the common problems started from something that was very good. It started with a question -- what do we need to teach medical students, every medical student about pediatrics? For the student going into surgery, what do they need to know about children? And so COMSEP actually got groups of people together to come up with a national curriculum [on] what should every medical student should know about pediatrics. It took about two years, a phenomenal project, very exciting document. We were all excited when we finally got it finished, went back to our home institutions to implement it. And everyone struggled with how do we do this. People tried lectures, or tried to adjust where students worked, but no one had a good way to do it. There was a couple of enterprising people from Dartmouth, who came up with an idea of using computers, and developing computer-based cases to help teach the national curriculum. So they took all of the specific goals and objectives and found they could fit them into 32 computer-based cases. And then that was a project to write those cases. Another bit of serendipity, I was on a flight to a COMSEP meeting. And the person who ended up sitting next to me for the final leg of the flight was from Dartmouth, where they had just come up with this idea. And she was running a workshop at the meeting on creating cases. So I joined her workshop, wrote one of the original cases, and ended up working with the organization for 18 years, 15 years or so, whatever, a long time, and just watched it grow tremendously. So again, national collaboration. And virtually every medical school adopted the CLIPP, what were then called the CLIPP cases, now the Aquifer Pediatrics cases.

JM 43:11
Do you remember what the -- well, I'm sure you remember the case that you created.

RD 43:14
Oh, I remember it very well, it was case number 11. It was a five year old who presented with fever and rash, and ended up having Kawasaki disease, which is something everyone needs to learn about, fortunately we don't see as much of it anymore. But it had a number of other things they needed to learn about rashes during that case, and approach to a febrile child had to be built into the case. But I remember it very well.

JM 43:42

So this is an example of something that every medical student would need to know if they were dealing with children.

RD 43:46
Yes, it was part of the national curriculum.

JM 43:50
Can you remember any things that [COMSEP] had a lot of discussion about, does everyone need to know this particular piece of information or not.

RD 43:58
Oh, lots and lots of discussions. So the curriculum is divided into different components, like there's a section on the newborn. And so again, collaboration with other people, what does every medical student need to know about a newborn, as opposed to a very premature baby, and that's getting more specialized in pediatrics. But general newborn care, the reality is every medical student needs to know that. Whether or not it's for their career, many of them are going to have their own kids. And some general sense about how to feed a baby is valuable [laughs].

JM 44:31
That's a great point. And so that was around 1994. And in 1996 [your CV] says you were medical director of the 5100 Intermediate Care Unit. What is that unit?

RD 44:45
So that was just one of the general medicine units, or general pediatric units. And they always had a physician helping oversee how things are running in general. Tom Kinney had been doing it. He saw me as the poor sucker who was standing there. So I did that for a relatively short time. But just, how do we best care for children on the wards?

JM 45:09
And what kind of culture did you try to institute or maintain there in that ward?

RD 45:13
A big part of it was collegiality. We were still somewhat, you had the doctors, you had the nurses, you had the pharmacists, in their own little areas. And really working much more together was very important. It was also sort of early on in the stage of recognizing [that] errors happen. We should not hide them, cover them up. We need to find them, and find out why, and what do we do to prevent them. So I was trying to move away from the blame period of someone makes a mistake and you want to find out whose fault it was, to much more of how do we prevent it from happening the next time.

JM 45:57
And so you mentioned trying to work together as a team. And when I was doing research for this interview, I came across a quote from one of your colleagues, Kamara Carpenter. So she said, "Not surprisingly, some of the best advice I've ever received came from Dr. Bob Drucker. He told

me to be myself, don't change for the sake of change, or because others want you to be someone you are not."

RD 46:23
Which I think is so important. You can't force someone into doing something, you can help guide them and say, "Okay, they consider this." But to become a whole new person. Yeah, Kamara is someone I helped hire a few years ago to help be the Clerkship Coordinator for the pediatric clerkship. She's gone on to other things, and in fact, left pediatrics, went to psychiatry, and she now works in the School of Medicine. So I work with Kamara again.

JM 46:50
So this stood out to me because it sounds like you're trying to encourage and nurture the individuality of your colleagues, or the students that you work with.

RD 47:00
Oh, very much so. I think the worst thing a school could try to do is have a cookie cutter product, where every medical student is the same, or every resident is the same. They've got -- they are unique people, take advantage of their uniqueness.

JM 47:14
Yeah, one thing I've heard some of your colleagues say as advice for medical students is to make sure you're really passionate about it, because it is a difficult job. And it seems like a big part of that is helping guide people towards that specific, specific passion.

RD 47:29
And making sure they really are passionate about the right things. An example there with the medical students -- when they rotate to the clinical world, they are going to see a lot of brand new things. As an example, the first time they go into an operating room, it's sort of awe-inspiring, and just an amazing, different kind of world. And they get excited, and they say, "Well, I guess this means I want to be a surgeon." And I say "Well, step back, was it the environment, or was it because of what you got to do for the patient?" Or students will round on a team, and it's just a wonderful time because everybody in the team clicks. Phenomenal attending, residents, students. And they say, "That shows I must want to go into this field." And I keep saying, "Step back, focus on the patient." If what gets you excited to go in in the morning is that today you get to see Mrs. Jones, and you're going to do this for her, and see if that helps her, great, okay, that's telling you something about that particular specialty. As opposed to the group of people. Because you're not always going to have that same group of people. And I have seen some students actually change their career paths once they really explored the field itself.

JM 48:49
Do you feel like that the current medical education model gives students enough diversity of experiences to find that out? Are there things that you would institute if it were up to you entirely [laughs]?

RD 49:04

Well, the nice thing about medical education is it is constantly changing. Duke is in the midst of a big curricular change right now, bringing much more clinical exposure into that very first year. In fact, the first two weeks of our curriculum right now, the students are doing all clinical work. They're learning how to take histories from patients, how to use the tools for physical exams. They may not recognize what they're hearing in the stethoscope, but at least learning how to use it, and then continuing that training through the rest of first year, as they're learning the basic sciences. So I think that's very exciting, and really does give an opportunity for them to get more exploration. I am also very, very biased about the Duke curriculum, and I'll acknowledge that up front. I like the idea that they have that one year of basic sciences, second year they get all the clinical rotations. Once again, it's a core, they're not seeing everything. We have built in a couple of two-week opportunities that they each get twice, to explore different fields. But then they have their year of independent study, the research year, where they can go shadow and explore other fields. At most schools after the clerkship here, you're applying for residency. Our students have an extra year to reflect on what they experienced, and explore different opportunities before. A study I've always thought about doing but never did, was tracking our graduates compared to other school graduates. How many change career paths after they start residency? And I would hope ours is lower than other places, but I don't know that.

JM 50:47
Because of that exposure and time to develop their own interests.

RD 50:51
And to think about it, yeah.

JM 50:53
So we're about 50 minutes in, do you want to take a short break, or get a drink of water or anything? Or keep going?

RD 51:00
I'm okay.

JM 51:05
Okay, great. I wanted to give that opportunity. I'm good as well. All right. So, we'll start in the year 2000, then. So this is when you were appointed Advisory Dean. Is that right?

RD 51:11
Yes.

JM 51:14
And can you tell me about that role?

RD 51:14
Okay, so the Advisory Deans. It's a system that started about 1986. The dean at that time was Dr. Doyle Graham. And he looked at the Duke curriculum, recognizing that with the third year research and the third year clinical electives there was a lot of elective time. And he felt that

Duke students really needed more advising, more individual advising, so he created the Advisory Dean system. At that time there were four Advisory Deans. Same structure I described earlier where a student is assigned to an Advisory Dean on matriculation who stays with them throughout their time in medical school. Most people who have been Advisory Deans stay in the job for a long time. In 2000, one of my mentors Dr. Debby Kredich -- who was an Advisory Dean, who had also become the Residency Program Director, so I'd been working with her both with the students and with the residents -- was stepping down for health reasons. And then two of the other Advisory Deans also decided to step down. So they had three openings. I was still new enough, eager enough, busy enough with the clerkship and working with the residency program, that I wasn't sure I wanted to take on something else. But I also knew that those jobs did not come around very often. So I applied for it, and was fortunate enough to be selected as an Advisory Dean. Now, I was doing it in a different way. What I gave up was some of my clinical time. I was working in the general pediatrics clinic, a half day a week, which was a great experience. But I gave that up to become an advisory dean. And I've continued with that for years. What I love is the interaction with the students. I mentioned before [that] pre-pandemic times the lunch we had with first year students would be in a small room with eight students on a Tuesday, another eight on Wednesday, eight on Thursdays. And every week throughout the year. I really get to know them well. And then working with them as they go through the clerkship, you're helping guide them where needed for their research activities, and then celebrat[ing] the match when they decide where they're going for residency. So it's just a tremendous relationship with the students.

JM 53:47
Can you recall any especially interesting lunch conversations, without breaking any privacy [concerns] of anyone?

RD 53:56
Any particular ones? Some of the most fun ones are them describing some of the places, or things they've done in Durham. I always start my lunch by asking the group "What have you done for fun in the past week?" I do that intentionally to emphasize to them [that] you need a life outside of medicine. So hearing about great restaurants, or some of the camping trips they've done, or just different things like that. I'll also build in some ethics talks, present different cases, love finding things in the news, acutely. A few years ago, there was an issue that came up, a young child with terrible cancer. There was a local pharmaceutical company developing a drug that may have been effective against the viral infection he had acquired. And it hit the national news. They were suing the company to get access to the drug and the company wasn't providing it, because there were things [inaudible] in their research studies. And that yielded a phenomenal lunchtime discussion with students who had a good idea of what drug development was, and what it meant to the company if they were to release the drug and there were an adverse event. And others who were saying, "Well, why of course they should release the drug." So it was a great discussion, very animated, where we all learned things. Those are fun lunches.

JM 55:21
What do you like about working with this current generation of medical students?

RD 55:26
The challenges. It is learning new things, it's [the] constantly changing things. A lot of it is -- it depends on their backgrounds. The students who've gone straight through school with no breaks or anything still need a lot more support. Whereas those who take even one year off come in with a different level of maturity. They know what it's like, they realize there are more important things [than] grades. So they know how to pay bills, they know how to live, and have a good work life balance. Those have gone straight through, it really created more of a competitive atmosphere that you had to fight against. Trying to emphasize, "No, we're all here together. Our goal is to help everyone become the best physician possible."

JM 56:18
So you'd encourage that year before [medical] school.

RD 56:22
Yes. And I sit on the Admissions Committee, and we're seeing that more and more. I use my daughter as an example. She decided she wanted to go into medicine early on, we kept saying, "Well make sure they are not other things that you might want to do instead." When she got to college, [she] majored in music, because I encouraged her, "This is your chance to explore other things." She did the pre-med courses, she became an EMT, and through that [experience] was teaching. And she found that she loved teaching. And she came home one time and said, "I've always wanted to be a doctor. But I love teaching. And you can't do both." And I said, "Well, there's my whole career thrown out the window." [Laughs] She has since realized the error of her statement. But after college, she joined Teach for America, and was a teacher down in Atlanta for two years [and] loved it. And people said, "Well, if you really want to decide, you need a third year." And she stayed for a third year and was lead teacher for the first graders. [She] had a great time, but missed the idea of things always being new, new challenges. And so she went back, did a Master's program, applied to medical school, and is now a pediatric resident, where education is going to be in her career.

JM 57:42
Oh, wow. That's amazing. And she has some interesting experiences to bring to it.

RD 57:51
Oh, very much so.

JM 57:53
That's great. So I mentioned this generation of students. And I also noticed while researching for this interview, that you're one of several faculty to be in some viral videos created by students in the last few years [laughs].

RD 58:07
Ah, yes. The students can do whatever they want to the Advisory Deans and we tolerate it. So there have been a number of things. There is an annual student faculty show, [that] is one viral video that's out there. That's a tradition that's been at Duke Med[ical] School since even before I was a medical student. But the quality of the shows today is so different. They're held in one of

the big auditoriums on campus. They're always a take off on some musical. The students write the songs, changing the words for the appropriate songs in the musical. Choreography, dancing, acting -- the talent among medical students is absolutely amazing. Frequently, there's a live band playing the music for the shows. Well, they always have a scene for the Advisory Deans. And there have been crazy things. One year they put all of us in Kiss makeup and put us out on stage like that. Just crazy things. One time I was a standardized patient named Lucy. And that was my role on stage. So just very, very creative.

JM 59:25
I don't think I was aware of this tradition. Is this unique to Duke?

RD 59:30
No, a number of med schools will do the same sort of thing. And then the other videos, um [laughs]. The students are our best recruiters for future students. So the past few years, they've done a video as part of what's called Second Look Weekend, students who've been accepted to Duke but they've been accepted elsewhere, and they come to campus just to see what the place is like. And the first year students create a video talking about the virtues of being at Duke. And again, they have frequently included the Advisory Deans in that, with us pretending to sing or dance or do something. Talents I do not have [laughs]. But we're on those videos. Oh, yes, I will be trying to live those down for a long time.

JM 1:00:17
Well, that's very game of you all to do that. So you mentioned in this position being able to do things like celebrate matches and other successes and goals achieved. Also supporting people through, maybe, disappointments. So I wonder if you could talk a little bit about that.

RD 1:00:36
Yeah, because with the good, there's always the unfortunate. I feel very fortunate to be at Duke, because the students we get are very, very bright, very good. But it also means our students are really shooting for the top in terms of residency programs. And there are times where someone's great, and they're going to be wonderful, but they're not quite as competitive for the field they think they want to go into. And so it's helping them sort out, why is that field of interest and what really excites them about it. And can we achieve that same level of excitement, potentially with a different career path. An example of that, we have a lot of our students coming in who want to go into orthopedic surgery, which has become a very, very competitive field. And there are times if a student hasn't done well with clerkships, and their research has not gone terribly well, they may not have the credentials to really get into a good program. And so a lot of times in talking with them, [I ask] what is it that excites them about orthopedic surgery? And it's the idea of working with athletes. And it's not necessarily the operating room aspects, but just being able to help athletes take care of problems, prevent problems, and introduce them to other fields like sports medicine. Which may be a little bit more of a preventive side, but is also, after injury, very, very helpful. Or for others, physical medicine and rehabilitation is another phenomenal field that most students don't know about. And so helping them look at these as potentials. So it is working through those disappointments. Other disappointments -- the first time they get a low score on a test. This goes back to when we had grades in our first year, which was terrible. Because again,

these are all outstanding students. They're used to being the top of their class. For the first time in their lives, half of them are in the bottom half of the class. Mathematically they have to be. But they've never been in that position before. And getting them to realize that, yes, you may be in the bottom half of this class, but recognize you're starting in that top one percent echelon to begin with.

JM 1:03:06
And how have you made sure that you could stay on top of all of these different potential career fields for students over the years? I'm sure there are new things happening all the time.

RD 1:03:18
New things are happening, and recognizing we don't do this in a silo. So working with the different specialists. We have connections in every specialty. So if a student says they're interested in radiation oncology, I know who to send them to. Also being involved with the national committees, the national organizations, and just hearing what's going on nationally, is very, very helpful. That's how you learn a lot of what's going on, what the hot fields are. Just comparing notes with colleagues at other institutions. Another advantage of having been in the positions for a long time -- you get to know people. And those connections are invaluable.

JM 1:04:00
I wanted to ask you about some of your committee work as well, if that's alright, starting with some of the internal Duke committees. So you've been on the Admissions Committee for about three decades. Is that right?

RD 1:04:10
Yes [laughs].

JM 1:04:11
And how has that changed over time?

RD 1:04:14
Oh, it's been fascinating watching the changes. I remember [in] 1991 when I first joined, working with the residency program. I knew that I was sort of subject to the will of the department, to some extent. Because in education, you're a cost center. You're not bringing money into the department, they're spending money on you. And therefore I needed to be a little more willing to say yes to things. So when the Chair came to me and asked if I'd be willing to join the Admissions Committee, I said, yes, I'd do it. He said, "Don't worry. It's a three year appointment." As you said, it's now been 31 years. When I first joined, Dr. Lois Pounds was Chair of the Admissions Committee. Lois was a pediatrician. She was an Advisory Dean. So a great role model, doing a lot of things I was interested in. So working with her was a natural extension. All applications were on paper. I remember they would deliver 20 folders to my office at a time from applicants. And I used to go through them, and out of my stack of 20 I was told that given the number of applications, only one or two of them could be invited for an interview. So learning, going through all of that, and doing all of that was a challenge. And then the committee meetings, sort of presenting my applicants as to why these are the ones who should be

interviewed. Being involved with the interview process. So very, very time consuming, laborious.

When Lois stepped down, Dr. Brenda Armstrong came in as the Director of Admissions. Brenda was a pediatrician. She had been the Pediatric Clerkship Director at one point. So again, a common theme. Brenda was a pediatric cardiologist, African American, and a dynamo. Very, very, very invested in diversifying. And that really became a prime mission of the Admissions Committee. And Brenda was a star. She went out, she would go on recruiting trips to different schools. And so we saw different applicants coming in, which was phenomenal. Still a lot of work, though. During her 10 years we were able to move some more [systems] to computer-based, which helped with a lot of the paperwork. And so, a change in the students we were seeing. Still all outstanding, outstanding students. But really bringing in the diversity, emphasizing that a lot more. And that was long before diversity and inclusion was the critical importance we know it is today. And I credit Brenda with that. She just did a phenomenal job with it. So I stayed on. I stepped off the Admissions Committee the year I became an Advisory Dean, because I did not know the time commitments. But I found I missed it. Not only did I miss it, I felt it was really helpful to me, as an Advisory Dean, to know the students who were coming into the class. Not as individuals, but the discussions that had gone on. And just, it was so much fun looking at different aspects. I had been very proud of the fact that Duke had not based admission solely on MCAT scores, or GPAs. Ask students, they'll tell you that the Duke application is one of the hardest ones in the country. Because we ask for about five or six additional essays. And those essays tell us so much more about each individual. And that's what we rely on, tremendously.

JM 1:08:01
And what are those topics?

RD 1:08:04
It may be evidence of leadership skills, or tell us about your background, where do you come from, what's your story. Things like that. Or a challenging experience they've had. They change over the years. But it really is much more, "Tell us about things you have done." Not, "I was president of the glee club," or things like that. You want to talk about, "What did you get out of it? How was it meaningful to you?" And so we really, I think, get to know the students much better than from the core application. And Brenda takes a lot of credit for a lot of the way that developed. She changed the interview style by being innovative. Where was it? Up in Canada they were starting something new called Multi[ple] Mini Interviews, MMIs, where rather than two half-hour interviews, students may have 10 mini interviews. But based on a specific question. And they were questions that didn't have right or wrong answers, but it was much more aimed at how does the student think, and can they justify their answers. It was up at McMaster [University] that started this, and they showed evidence that it really brought in a different type of student. We did see some of that, when we went to MMIs. For me, one of our favorite stations is actually a team station, where one applicant instructs another applicant in how to do something, whether it's drawing a picture [or something else]. And it changes, they each get to be in each role with different people, and different tasks. But we don't care how well they do on the task, but [rather] how's the communication between the two of them? And part of it is giving

feedback at the end, so what kind of feedback do they give to each other? And that, again, has helped with admissions tremendously.

JM 1:10:04
So this is part of the interview process, so they're watched, maybe by one or two people?

RD 1:10:10
There's always one person. And for the other stations, they're interacting with a faculty member or a student or staff member. They don't know who it is. When we started the MMIs our Dean actually was doing some of the MMIs. Students had no idea they were talking to the dean. Because it just had her name, Nancy, on it.

JM 1:10:31
That's fascinating.

RD 1:10:34
Oh, it was great. And MMIs have become very, very popular around the country. And Brenda was one of the first ones to bring it into med school admissions. There were several other schools at the same time. So very, very innovative. And that's been a great change.

JM 1:10:46
Yeah, it sounds like there's been a lot of creativity involved in that part of your work.

RD 1:10:51
Yep. And then Linton Yee is our current Director of Admissions. Another pediatrician. He's pediatric emergency medicine, but also very invested in education.

JM 1:11:02

Why do you think [there are] so many pediatricians [on committee]?

RD 1:11:05
I think it's the interest, the recognition, of people. And frequently, pediatricians are the ones who can give up other things, maybe a little more easily to take on, I guess. That's a huge job to be the director.

JM 1:11:21
Absolutely, yeah, it sounds huge. And so also your work as an Advisory Dean. So you said a fifth of the incoming students?

RD 1:11:29
We've expanded to five Advisory Deans as the class expanded.

JM 1:11:34
Is that about 20 to 30?

RD 1:11:36
So we have a class now of around 120, so about 24 a year.

JM 1:11:39
24 a year, and then they stay with you the whole time. So maybe about 100 people at any one time, is that right?

RD 1:11:44
Well, it's larger than that, because we have students who do dual degrees, like MD/PhD students. So I have about 120 advisees right now.

JM 1:11:55
And how do you make sure that you can maintain connections with this many folks at one time?

RD 1:12:00
So the first year it's easy, because I'm meeting them weekly. For the second year students, I meet with them as a group once every eight weeks during the beginning of the third weekend, during clerkship. Then every year we have individual meetings with each student, twice a year. And then a lot of it is as questions come up they'll come by. During the pandemic, a lot of Zoom meetings.

JM 1:12:31
How do you make sure that you are able to create an environment where people feel comfortable talking to you? I assume many students are coming in feeling like they have to be high-achieving in every setting, and with someone who's advising them they need to maybe be a bit more vulnerable.

RD 1:12:47
They feel vulnerable in large part as well because at the end of their career, we're the ones who write their so-called, what was called, Dean's Letter, or the Medical Student Performance Evaluation. So we try to demystify that early on. Saying, "Here are the things that are in it, here are the things that are not in it." If you're coming to me because of mental health concerns, that doesn't go in the MSPE. And yes, I can help get you plugged into different resources. I think that's why that first year with the weekly meetings is so important. So they get to know me. It goes back to what I was saying before about using first names, I encourage them to call me Bob. Most of them don't feel comfortable with that. I say, "Well, I'll accept Dr. Bob or Dr. Drucker, but don't you dare call me Dean Drucker." That's way too hierarchical for me, and we just can't have the relationship. So I think that helps overcome it. But the other thing we offer them is they are more than welcome to go to any Advisory Dean with questions or concerns. If they have a concern about one particular thing, and they don't want me to know about it, that's fine. They can go to one of the other Advisory Deans, who won't tell me that they've been there. And that's totally fine. So the relationships really do work out very well.

JM 1:14:03

Well, thank you for sharing that. And I was asking you about your committee work too. But this is all fascinating. So I wanted to ask you about the Fourth Year Curriculum Committee, that sounded like something you'd been very involved in, and writing about as well.

RD 1:14:17
So we have a curriculum committee for each of the four years. As Advisory Deans we sit on each of them. So I sit on the first year committee. The second year, it's all clinicians really coming together monthly. Third year committee meets monthly, that one is more focused on the research. And I've been the Advisory Dean representative for that one. And then the fourth year committee, I was in a slightly different role, where I'd been Clerkship Director, and I was a fourth year Course Director. I sort of wore two hats in there, representing Student Affairs but also able to look at what was going on in the fourth year. Which has become a very interesting year. Different specialties see fourth year in different ways. For some of the surgical fields, they would love it if students did nothing but that specialty for all of fourth year. For the school it's saying the fourth year is the completion of your general medical knowledge. And so having a diversity of courses is important. So being involved in the fourth year committee as we try to work through those [perspectives] is interesting. It did lead to an opportunity to sit on a panel at one of the AAMC [Association of American Medical Colleges] meetings about what is the fourth year. I was representing pediatrics on that, where pediatrics is a field that still believes in the more generalized fourth year. In fact I discourage people going into ped[iatric]s from doing too many pediatric courses in fourth year. Take advantage of other things that they may never get again.

JM 1:15:53
What do you think that brings to medical education?

RD 1:15:57
The diversity of fourth year? It really is a chance to see what other people in medicine are doing. Someone going into pediatrics, I think a phenomenal course that they should all take is dermatology. Doesn't matter what aspect of pediatrics they end up practicing, kids get rashes, and having some familiarity with that will help them tremendously. I actually recommend dermatology to anyone going into any clinical field. So another course that's become popular is autopsy pathology. It used to be part of the first year curriculum that students would get to experience what is an autopsy and what do you learn from an autopsy. That isn't part of the first year curriculum now. So a number of fourth year students will do it. Not that they will ever do an autopsy again, or be involved with it. But they now get a sense of what can I learn about one of my patients who may die unexpectedly, and why might I really encourage the family to have an autopsy done.

JM 1:16:57
So you're also on a committee called the Pediatric Undergraduate Medical Education Committee.

RD 1:17:06
Yes. So that one I started when I was the Pediatric Clerkship Director, recognizing that it's crazy for one person to think that they alone should handle the whole curriculum for all the medical

students in pediatrics. So I started this and it was other people in the department of pediatrics. It's grown, since I'm no longer clerkship director they still let me come to those committee meetings to throw in my two cents worth. If nothing else, I can provide history. If they say "Oh, we have this great idea, let's try this." I can say, "Well, we tried that 10 years ago, it didn't work for these reasons, [but] those reasons no longer exist. So why not try it again?"

JM 1:17:47
That's great. Instead of being the voice of, "That didn't work, so we're not doing it."

RD 1:17:51
I've been around long enough to recognize you've got to constantly change and reassess, and I mentioned that earlier. But you've got to do that all the time. Because what is working beautifully this year, may be the exact wrong thing in two years. So you've got to constantly look and be willing to adapt.

JM 1:18:09
So that's an interesting segue. So I was curious how COVID has affected your responsibilities in the last few years. Are you still on the Admissions Committee?

RD 1:18:17
I'm still on the Admissions Committee.

JM 1:18:20
So you went through that. And advising students during this, what has that been like?

RD 1:18:26
Oh, it's been a problem. For Admissions Committee, to start there, we were able to switch to virtual interviews well. In fact very well, to the point that even after the pandemic, it's very likely we will continue with virtual interviews. We're able to actually get a wider range geographically of students now "visiting" Duke, because they don't have to pay the money to come to Durham, North Carolina. So that has helped tremendously. The cost savings for students, for the school, is astronomical. And we found that we are able to get a pretty good feel for students. Before we felt we had to see them in person, and maybe not. There are other ways to get that same information. So we do have the interviews. We also just have social gatherings, where it's our current students meeting with applicants. So that's worked out very nicely. So I think that will continue.

For advising students, oh, when we went to virtual -- and so my weekly lunches were all on Zoom -- it was completely different. You don't get to know them as well. And yes, cameras are great and wonderful. But when I finally saw them in person it was, "I didn't realize you were that tall." Or just different characteristics, and not recognizing them. Not really knowing them. Now an advantage for me, early on, is that on Zoom they all have their names displayed. So you can learn names more easily. But being in the virtual world -- much, much harder. And so, as we've been able to get back in person, it's been better. I say better, because even when we got back together this year, it was more using the conference rooms rather than our small group rooms. And 12 students rather than eight students. And everyone in masks. And it's not the same. You

don't get to know each other as well. It's been much more difficult to get conversations going, and get people engaged. It's been wonderful the past few weeks, as masks have become less required and the weather's been nicer. I've had two weeks in a row, I was able to meet with my group outside on our patio. Some of the best conversations we've had. Just everyone energized. And whether it was the weather, or the fact we're all seeing everyone's full faces for the first time, or whatever. It was great. Now, this week, the weather was bad, and we couldn't go outdoors. And I tried using our small group room, which is designed for about 10 people. We had 18 people, not ideal. We closed the door, everyone did wear masks. We closed the doors so no one could see how overcrowded. Not really following all the code rules. But again, it was just the fact that -- a circular room and a group room, rather than a lecture room or conference room -- great discussion. And I'm thinking, "Boy, here it is. It's April. If we'd had these back in August and September, where would we be today?" So it's been a challenge.

JM 1:21:50
And the students have had major changes to how they were doing their medical education.

RD 1:21:56
Very much so. Going back when I was talking about my experience, the bonding of the first year class is so critically important. And that has been much harder. Especially [for] our current second year students. So they walked in and everything was virtual from day one. I say everything [but] there were a few things, and great kudos to our faculty. Anatomy is not something you can really do online and virtually. And Duke very much believes in dissecting cadavers. And I support that completely. They were able to continue that. They had to modify the way it was done. But it was one of the rare times students were together in person. But other than that, it was virtual lectures and small group meetings where they didn't have that same connection. And we've seen that, where they don't have that same bond. We're seeing that in our second year residents. I mentioned my daughter is a second year resident, and she has commented on that within her group. They don't know each other as well.

JM 1:23:01
Well, I'm glad you're able to see some of that life coming back to campus in recent months.

RD 1:23:07
Yes, so important.

JM 1:23:10
Yeah. So I just had a couple of more open-ended questions for the end. You've talked a lot about some of your important collaborators and mentors. But is there anyone that you wanted to to mention that maybe we hadn't talked about in more detail?

RD 1:23:25
Oh, there's so many. Again, Cathy Wilfert and Sam Katz lead the list. And they know they are why I am at Duke, and why I've stayed at Duke. I came back here because of them. So, absolutely incredible people. Others I mentioned -- Tom Kinney. Phenomenal mentor, just really, really supportive. He was the person I could go to and say, "Okay, Tom, I have the option to

become an Advisory Dean, or should I work more with residents?" And just talk things through with him. So great. I mentioned Debby Kredich. She was one who was Program Director and an Advisory Dean, who when I was debating becoming an Advisory Dean was the first one who made me sit down and asked me the question, "What are you going to give up?" I was sort of used to just adding on more and more. So, really making me think it through. So just incredible. Support from the different chairs I've had, so Sam, then Mike Frank. Joe [Joseph] St. Geme, I haven't mentioned, but just again, very, very supportive of the role of education. He really helped build up the education group in the Department of Pediatrics. He hired our first Vice Chair for Education in the Department of Pediatrics, someone I had known because she was a Pediatric Clerkship Director out of Wash[ington] U[niversity] in St. Louis. The small world phenomenon. And then Ann Reed has been very supportive, as our current Chair.

JM 1:24:55
Many people.

RD 1:24:57
Many, many, many people.

JM 1:24:57
And I wondered if you could talk a little bit about some things that you're especially proud of during your time as Associate Dean.

RD 1:25:06
Associate, Dean, so much of what we do is a group effort, it's all of us. I think our advising has gotten better, more consistent, and more recognizing what's going on around the world and really staying in touch with other places. But it's great having the other colleagues, because we each have our own areas of interest. And that has helped tremendously. I think looking over the years, what I'm most proud of really is what I was able to do with medical students as Clerkship Director, and then continuing on with Advisory Dean. And really help formalizing things, some of it because requirements changed, and you had to. But just being willing to try new things, implement new things. There's a short time where I was actually sending some of the medical students out to private practices in pediatrics. And there were just some tremendous opportunities. There was one practice out in Laurinburg, North Carolina, the Purcell Pediatric Clinic. Students loved going there. And they'd go for a month and really get immersed into that world. But they'd spend the day working in the clinic, and then in the evening they'd go with Dr. Purcell to city council meetings because he was the Mayor of Laurinburg.

JM 1:26:24
Oh, wow.

RD 1:26:27
He's since gone on to state legislature, and is just a phenomenal representative of what a physician can do in the political world, to really be an advocate for children. Or another pediatrician down in Pembroke [North Carolina], Dr. Joey Bell. Most of his patients are Native American, and Joey is Native American. And students would spend time with him and he would

take them to pow wows and just immerse them in that culture. I think those are great opportunities. They ended because of educational needs to have the students local. But it was great being able to try those, and helping give students those opportunities for a while.

JM 1:27:02
Would students live there?

RD 1:27:04
They would live there. Housing is provided for them. Wow. There's a statewide organization that helped with the housing. So just great opportunities. And so I'm proud of being able to provide that opportunity for some.

JM 1:27:19
Is there anything that we haven't touched on during this interview, that's really important to note, or anything we missed while going through the chronology?

RD 1:27:29
You've hit the high points, and nothing in particular. I would say, and I alluded to it, just to collegiality, the cooperation between different groups. Nobody does anything by themselves. They may think they do, but they don't. Having the colleagues, people I can just talk to saying, you know, "I've got this issue, this thing going on." Other thoughts are so valuable, so helpful, both locally, and Duke's doors are open, you can talk to anybody. I've been here a long time. The connections I've formed, a lot of them are because I've been here so long. But as an example, our Dean, Mary Klotman. Mary was a year behind me in medical school. I don't know if she remembers that. But this is back when we had post office boxes. And students had to share those, and Mary and I shared a post office box. And then I worked with her husband when I was a second year medical student, he was my intern on the medicine clerkship. And then Mary and my wife were infectious disease fellows together. So that's an easy relationship. And there are many others like that, which helps tremendously.

JM 1:28:38
And finally, I wanted to ask you about what you're excited about for retirement.

RD 1:28:45
[Laughs] It's very mixed feelings. I am going to miss tremendously what I'm doing, though. I've already talked to the Admissions Committee, and I think I'll be able to still work with them. Excited. It's really been emphasized with COVID. I do have three grandkids, one's local so I do get to see her a lot. But I have a seven year old grandson, almost five year old granddaughter in Atlanta, and it's been much less often that I've been able to get down there. So I'm very much looking forward to that. Some other ideas, things that I'm working with with COMSEP, some ideas there that I may explore further. So just opportunities, and not quite as much under deadline, and, "This has to be done now."

JM 1:29:34

Well, thank you so much for taking a couple of hours to talk with me. I really appreciate it. And congratulations.

RD 1:29:41
Thank you very much. This has been fun. I've thoroughly enjoyed talking with you.

JM 1:29:47
Oh, good, great.