INTERVIEWEE: Dr. H. Keith H. Brodie
INTERVIEWER: Jessica Roseberry
DATE: June 17, 2004
PLACE: Dr. Brodie's office, East Duke Building

BRODIE INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. H. Keith H. Brodie, President Emeritus of Duke University and James B. Duke Professor in the Department of Psychiatry. It's June 17, 2004, and we're here in his office in the East Duke Building. Dr. Brodie, thank you so much for agreeing to be interviewed today. I really appreciate it. If we could start maybe with just a little bit of background of yours, maybe just start with when you were born.

DR. H. KEITH H. BRODIE: I was born August 24, 1939, in New Canaan, Connecticut. I attended the New Canaan Country School until the ninth grade when I went off to boarding school at Milton Academy. Then I went to Princeton and majored in chemistry. Applied for med schools, chose Columbia University College of Physicians & Surgeons. Went there for four years. In that window I decided I wanted to become a psychiatrist. It seemed to me that the future of that field was going to be quite exciting, that there would be a lot of chemical and biological breakthroughs. And so my interest lay in the biochemistry of mental illness, and I chose a residency that would equip me in that field by returning to Columbia Presbyterian Medical Center after a year of medical internship in New Orleans. In those days you had to be a real doc with a year of internship before you could go into a psychiatry residency. I had a wonderful year in New Orleans. It was superb training. Then returned for a psychiatry residency at Columbia Presbyterian. And then the Vietnam War was raging. I applied for an officership with the Public

Health Service and was granted that and assigned to the National Institutes of Health in Bethesda and worked there for two years studying the biochemistry of affective disorders, principally bipolar disease—manic-depressive psychosis is what we called it in those days. My work there was with lithium and understanding the basic biology, the genetics, the pharmacology, the neurochemistry of that illness. And that attracted the attention of a couple of med schools, such that when I finished up my two years of service, I was recruited to join the faculty at Stanford and a few other places. But chose Stanford. So we moved out to California, and I taught there for four years. Then Bud [Dr. Ewald] Busse came calling and wanted to talk to me about the chairmanship at Duke. He also wanted to buy some skis, and I never had skied in my life. But I knew there was a ski store (*laughs*) in downtown Palo Alto. We went down there, he got just the skis he wanted and flew back to Durham. A month later I was invited to meet with the search committee, came to visit, liked it. Brought my wife back for the second visit with our at that point (*laughs*) two-week-old infant in tow. Liked it even more. And was offered the chairmanship of Psychiatry to succeed Dr. Bud Busse, who had been promoted to be the dean of the medical school. And so I arrived in—well, it was Halloween, October 31, of 1974, and began eight years of chairing the Psychiatry Department at Duke. And have not left.

ROSEBERRY: What was attractive to you about Duke?

BRODIE: Well, it was a department that was nationally recognized as one of the leaders in the psychosocial field. Dr. Busse had not only built a strong clinical department with clinical teaching programs and psychoanalysis and group therapy and psychopharmacology, but he'd also built an aging center and used the Department of Psychiatry to bring faculty in to work in the field of aging. So Duke was really ahead of its time in identifying geriatric psychiatry. It was the case that many of the faculty that I inherited had come principally to work in geriatrics and

the aging center. And as a result, the Department of Psychiatry was the third largest in the university, behind Medicine and Surgery. We had at that point sixty beds on the inpatient service. I felt that I could bring some value added to the equation by being able to recruit some additional biologically-oriented psychiatrists; expanding the psychopharmacology research base; developing a departmental interest in family therapy, family studies; and strengthening the child program to embrace psychopharmacology of children, which was not then represented in the faculty skill set.

It was also the case that my wife—we had married when she was a nurse and I a resident at Columbia—her family was from Jersey, mine from Connecticut; we were East Coast people. Living on the West Coast was fine. We began having children. We brought three with us to Durham and had a fourth here in Durham. And we wanted to expose our kids to their grandparents without the big fanfare of a transcontinental migration. *(laughs)* So it was helpful to move east. And the South was a very welcoming part of this country for us. We've really enjoyed being here. My wife comes from a fairly religious family; her brother's a minister. So we found a welcoming spiritual dimension here, which we had not totally experienced in California.

ROSEBERRY: Can you talk maybe about some of the issues related to the Department of Psychiatry as you worked there?

BRODIE: Well, the fascinating issues at that time were that there were not enough beds to accommodate all of the patients that were clamoring to get into the Psychiatry Department. We had sixty beds. We had a waiting list usually at any point in time of about fifty patients. And doctors were financially dependent on their ability to treat patients in the hospital; that's where

the money lay. And so there was tremendous pressure to expand. When I left the department eight years later, we had 120 beds. We added an adolescent unit, we added another adult inpatient unit, and we added a medical psychiatry unit which focused on providing mental health care to those who had distinct medical problems. So we were able to double the bed space and increase the faculty. The income stream was substantial. We were able to log a good deal of surplus each year. We built a second story onto the Civitan Building to house the increase in faculty. We put up some wet laboratory space to expand the biological dimension of the research in the department. And we maintained the psychoanalytic tradition by adding faculty who were great teachers in that field. My goal was to increase the number of psychiatrists in America and to recruit aggressively into the residency those who would become future teachers, future leaders. And it was rewarded, because now a number of departments are chaired by graduates who were in the department when I was the chair.

ROSEBERRY: Can you talk maybe a little bit about Highland Hospital?

BRODIE: Highland Hospital had been a gift to Duke University and was an element of and division of the Department of Psychiatry. We found it difficult to manage an entity that was four hours away by car. The residency program there had come on hard times. We were able to send some of our own residents and some of our own med students up to Highland. But in the end it seemed somewhat remote. It also seemed that, although it was a surplus-generating entity, it might someday become a loss leader for us. Given that, we decided to sell it. And that created a huge ruckus. We got on *60 Minutes*. There was a lot of opposition, because the people who were most interested in buying this hospital were, of course, in the for-profit sector. And the mere concept of running a psychiatric hospital for profit created a great clamor amongst the faculty at Highland. They put a consortium together to buy the hospital. Unfortunately, they never seemed

to have enough wherewithal to meet or exceed the offer from the for-profit group. And in fact, their offer was far less. And so at the end of the day the university sold Highland Hospital to the Psychiatric Institutes of America. They ran it for a few years. They merged with another for-profit entity. And the long and the short of it is that ultimately Highland ceased to exist as a hospital and was shut down.

The fact of the matter is that as our 120 beds were going strong, now we have 20 beds in the Duke Hospital. And most of our residency training and service provision is done with the VA or at the state hospital. So there's been a real decline in psychiatric beds across the state, including Duke and the closing of the former Highland Hospital.

ROSEBERRY: Can you talk maybe about some of those relationships, to the VA hospital—?

BRODIE: Well, it was fun. When I got here in '74, there was talk of merging Lincoln Hospital with Watts Hospital. Lincoln had been the African-American hospital and Watts the white hospital which had become integrated under Medicare back in '65, but which was, for the most part, serving the white community. And a new hospital was going to be built that would merge the two inpatient facilities, Lincoln and Watts, and I was asked to help plan a psychiatry inpatient unit for that hospital, because neither Watts or Lincoln had such a unit. So we spent a couple of years designing it, putting it all together. And 6-2—which is what it was called, on the sixth floor of the new Durham County General Hospital—opened up. I was able to recruit one of my colleagues from Stanford, a man by the name of Fred Melges, to run the unit. And he hired the nurses and the therapists, and we rotated three of our residents over there and put in a chief resident. They staffed the emergency room and did the treatment programs for the private docs on call on the service there. And it was a real success. It turned out to be the best teaching

rotation. We also forged a relationship with [John] Umstead [Hospital] and began to rotate our residents out there. Because we were expanding our inpatient beds at Duke Hospital, we needed another facility to provide some outpatient and elective opportunities to increase the size of our overall pool of residents. So Umstead came in to help us with that. And we'd always had a very strong veterans' hospital program in psychiatry. We built on that, added two faculty positions and two residency slots during the eight years I was there. It's interesting now, that those are the two mainstays of the department. The 6-2 unit was closed. Duke went from 120 to 20. But Umstead and VA are still going strong. As you know, Umstead is now going to be merged with the Dorothea Dix Hospital, and a new hospital entity will be built in Butner, which is where John Umstead is today.

ROSEBERRY: Would you like to say more about the child psychiatry program?

BRODIE: Well, the child program was pretty much psychoanalytic. We had five child psychiatrists, and I think they were all certified in psychoanalysis. So one of them, Dr. Hal [Harold] Harris, showed great interest in drug treatments for kids and began training and learning about the newer drugs in the treatment of ADD, for instance, and depression in children. And we added and strengthened their residency. We brought people like Jean Spaulding, through—who ended up being the vice chancellor of the medical center here and now a distinguished member of the Duke Endowment's board. But it was nice to see a move from the old Freudian analytic approach to children to actually hospitalizing kids in the inpatient unit in the adolescent/child unit that we created and giving them the needed psychopharmacology treatments as well as psychotherapy. Shortened their length of stay, shortened their duration of illness, improved their mental problems dramatically. It was quite effective.

ROSEBERRY: What were some of the other foci, I guess, of the department as far as

methodology or—?

BRODIE: Well, as I say, we built on what Dr. Busse had set up in biological areas, such as electroencephalography and added to that dimensions of imaging. We recruited a number of people. Dan Sullivan was a radiologist who came through our program as a resident and ended up directing our imaging program. We were able to visualize receptors in the brain for dopamine and looking to see defects that might relate to illnesses like schizophrenia. We recruited a number of biology-oriented folks. Mark Linoila was particularly interested in the biology of addiction, addictive states. We began measuring blood levels of psychopharmacologic agents, adjusting dose to produce optimal blood levels for treatment. This improved response rate, and it also shortened the treatment time. So we were able to build on some of the newfound approaches to the treatment of mental illness. We, with the Department of Neurology, started up a sleep program and looked at sleep abnormalities. Perhaps one of our major focus programs was expanding what Redford Williams had done here in the area of behavioral medicine by looking at biofeedback as a treatment for muscular tension and migraine headache and hypertension, teaching people how to relax. He added Richard Surwit and a few others to look at behavioral aspects of such conditions as diabetes and the ability to somehow behaviorally engender an increased output of insulin. A fascinating arena, just recently published. We look at the interface between psychiatry and medicine on a number of fronts, not least of which was the work with what was then DUPAC, Duke University Program for Preventive Approaches to Cardiology, in which exercise motivation and stress reduction and diet all played a major role in the post-MI [myocardial infarction] patient. So we were able to provide support for that through the appointment of James Blumenthal, who is now a major figure here, thriving in his work with that center.

ROSEBERRY: Did you find the NIH funding to be—to support those?

BRODIE: Yes, he got a lot of federal grants, mostly through the NIMH. And we were able to find a few grateful donors to give us an endowment and help us with our building needs.

ROSEBERY: Was there anything else that you'd like to mention about the Department of Psychiatry?

BRODIE: Well, I think Dr. Busse left an incredibly strong foundation, and it was an honor to build on that as best I could, and to leave a department that certainly was bigger and perhaps a bit better in moving onto the chancellorship. During those eight years I attempted to meet the goals of my mentor, the man who recruited me here, Bill Anlyan, by becoming president of our specialty association, the American Psychiatric Association, and by publishing a major textbook in the field with Lawrence Kolb; I was added as co-author of the tenth edition for his text. When Bill recruited me, and I tried to get a sense of how he measured his chairs and goals for them, it was, Well, publish a book in your field, become leader of your specialty society, and provide strong clinical service, research, and teaching to the various members of the academic community. So that was basically what I did. But as you have come to know, if you're successful in teaching and patient care and research, you get booted upstairs to administer. Thus I moved into the chairmanship. But what I didn't know was that if I did that well, then there was another rung to climb here, *(laughter)* which was the chancellorship. And thus it was that I came, I guess, to the attention of Terry Sanford as I was a member of the Long-Range Planning Committee for the university. And in that role, although I was at that time the chair of Psychiatry, I represented the medical center and provided some input to the overall formulation of the future of Duke.

ROSEBERRY: As you were the president of the American Psychiatric Association, I understand that there was also a Duke figure who was president of the American—

BRODIE: Psychological Association. We were literally twenty feet away in the Allen Building, Bill Bevan was the president of that much bigger APA—

ROSEBERRY: Okay.

BRODIE: —than the little APA that I was heading up. (*phone rings; pause in recording*)

ROSEBERRY: So the two APA—.

BRODIE: So we were cheek by jowl over there in the Allen Building, and I think that made for a more harmonious relationship between those two organizations, which had been somewhat at war over issues that related to the prescribing privileges for psychologists. Interesting.

ROSEBERRY: Tell me about the prescribing privileges.

BRODIE: Well, the psychologists have for many years felt that if they took a crash course in psychopharmacology, they should be allowed to write prescriptions for the increasing number of drugs used in the treatment of the mentally ill. So it was always the position of the American Psychiatric Association that they wouldn't be very good at that, that you couldn't teach what eight years of medical school plus residency provided to a psychologist in some sort of crash course in psychopharmacology. So the psychologists had been always nibbling at that foundation, and the psychiatrists had always been blocking it. And we agreed just not to discuss it. (*laughs*) We didn't want to get into that. But it's interesting, now here it is 2004. Two states have approved granting licensing privileges for the dispensing of psychopharmacology agents by psychologists if they take some sort of a course of study in psychopharmacology. New Mexico was followed by Louisiana. So those are the two states.

ROSEBERRY: That's interesting.

BRODIE: It is. It is interesting.

ROSEBERRY: So we had left you as chancellor. You had just become chancellor.

BRODIE: Chancellor. Just became chancellor. And moved over to the Allen Building. Was serving as president of the APA alongside of Bill Bevan who was then the provost and president of his APA. And I spent three years in tutelage really as the chief operating officer of the university responsible for budgets and internal management of the place for Terry Sanford. Terry Sanford had run for president twice from the Allen Building and had been very active in politics, former governor of the state of North Carolina, a brilliant politician, a great leader of Duke, and a wonderful mentor for me. Psychiatrists are taught to keep things private, (*Roseberry laughs*) and Terry knew the grand world of public relations and university relations and community relations. And worked hard to instill in me a broader vision of the place having to do with service, international, national, and local—the dimensions of which I had not really come to grips with in my past years. So that was a great three years. And two years into it he announced he was going to retire. Two and a half years into it, the search committee asked to meet with me, and we talked some. It then became clear that they were interested in me to succeed him. I think the board of trustees really liked the direction the university was going in. And in those sort of circumstances, they would naturally turn to the number-two person to continue the momentum that the number one person had been providing. So that's what happened, and I accepted the presidency. We started up in July. July first of 1985 after three years in the chancellorship. Well, that began eight years of presidential appointment. It was four years and then a renewal. It was certainly something that I had not planned on. You know, those sorts of things you might—if you knew you were going to suddenly end up there, I might have taken a little course in finance or speech-writing or public relations to get ready. As a chemist *(laughter)* I was not really equipped. But I learned. It worked out, but it was quite challenging.

ROSEBERRY: I'm sure your background in psychiatry maybe provided you some insight into

dealing with—

BRODIE: Yes, it was helpful in dealing with people and in dealing with myself and in sort of observing me in the course of those eight years. But it is the case that I was pleased at the end that I was a psychiatrist, because I could go back to that. If I had been a surgeon, there would have been no way. In other words, eight plus three years, or eleven years out of my field, from chancellor to president, would really—I would never have been able to go back and operate. But you're right, I was sort of practicing psychiatry. I also made it a point to teach. I taught two courses during the chancellorship and presidency first term. In the second term the trustees wanted me to raise more money, so I cut back and gave only one course. But by teaching I kept my hand in and kept current with the literature. And was able then when I left the presidency after a sabbatical to really come back full time into a teaching mode. I've taught in this very room, Psychobiology, for these past eleven years.

ROSEBERRY: Well, what was the relationship between the medical center and the university as you became president?

BRODIE: Well, in the old days, when I chaired Psychiatry, the university was sort of a distant cloud. We took care of the faculty and students from a mental health standpoint. But I didn't really know much about the issues of higher education and some of the challenges it faced. At Stanford we had a much closer relationship to undergraduate teaching, and I had taught in the Human Biology Program, that allowed faculty in the professional schools to teach undergraduates. And so I pushed a little bit for a similar arrangement here. But it wasn't until the Commonwealth Fund began to show interest in catalyzing medical faculty teaching undergraduates that we developed a bit of a program. And I started a course called the Biological Psychology of Human Development that I offered through the Department of Psychology,

funded by the Commonwealth Fund, to undergraduates at Duke. And I taught that with Bob Thompson, who's now dean of Trinity, and Dan Blazer, who was the dean of the medical school and is now the Gibbons Professor in the Psychiatry Department. And the three of us, aided by Cathy Smith, whom you've met here, developed this course and offered it as a seminar to thirty students, and it was very popular; it was well received. So that opened the door a little bit to my view on the world of the Arts and Sciences Departments. But it really wasn't until I got into the chancellorship that I began to see the overall relationship between the medical center—. I think the medical center, much like China, had tried to diminish any relationship between itself and the (*laughs*) rest of the university. (*woman's voice in background*) There was really very little dialogue, and it was a great desire to be left alone basically that permeated the center. And I think it was felt that the medical school was quick and nimble and had aggressive leaders that stayed in positions for very long times and built up national and international recognition for their departments. Whereas in arts and sciences, the chairmanships turned over every three to five years. You never got more than five—you usually got three, and then it was someone else's turn. So that everyone was sort of rotated through the—there was no individual commitment or the ability to promise that when you hired an assistant professor, you would be able to support that person and carry them on through the years.

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BRODIE: When I got to the chancellorship, it was very interesting to perceive the medical school from the other side of what Bill Anlyan loved to call "the gauze curtain" and to see that basically there were some great and strong elements to the medical school philosophy of longevity but that there were also some real problems. And that involved the need to review chairmen and officers leading the Medical Center administration. The Academic Council pressed

for that. So we ended up approving that arrangement and created a situation where at least every five years a chairman was reviewed or a dean was reviewed, and then a decision was made as to whether they would be reappointed. And it was felt that two reappointments would probably be enough. We wouldn't have anyone on more than fifteen years. It was also the case that I perceived the external world as willing to fund and provide a lot of support to integrate the place, to bring medical and nonmedical together. We had a couple of really good programs. Our biomedical engineering program was one of the top three in the country, and that created a dialogue, obviously, between Engineering and the medical school. But there was so much more in areas like toxicology and health policy and health law. We set up a center for health policy. Bill Bevan was particularly interested in that. So was Bill Anlyan. That was building when I was in the medical school. But when I became chancellor, we expanded that a bit, gave it some good space. I think, you know, there are not too many universities where the medical school, the hospital, and the university were all on the same campus. Stanford is that way. Duke is that way. But Harvard certainly is not that way. And it's the case that we, I felt, had a tremendous advantage by having everyone on the campus and in sort of the same community to forge dialogue and joint research and teaching and service programs. So I pushed very aggressively in the chancellorship for that. One of the things that the med center did was to fund the lion's share of a lot of the support services that were at a level of excellence that the university, had it been alone and apart, could not have afforded: a great phone system, a really good OIT and Internet infrastructure that I spent time (*laughter*) laying fiber optic cable all through the campus to get Internet up and running. And we really have state-of-the-art stuff that the medical center pays the lion's share of the cost for. We also have personnel policies, personnel systems and payroll and newspaper—I mean, just a host of benefits that the lion's share, again, of the costs were borne by

the medical center. And so the rest of the university benefited from those things. On the other hand, the university, I think, was somewhat vulnerable always to the health of the hospital. I mean, every malpractice suit, every legal problem, and ultimately every financial issue that affected the medical center affected the rest of the university. Nan [Keohane] was a little worried about that. And, as you know, set them up with a separate board for a while. But now with [Victor] Dzau coming in, that is being changed, and he reports to the president much as Dr. Anlyan reported to me when I was in the presidency.

ROSEBERRY: Can you talk about the building of the Levine Science Research Center?

BRODIE: Well, there was an example of the tremendous need on campus for lab space, and everyone wanted their own lab space. Engineering wanted its lab space, the medical center wanted its lab space. Forestry wanted its lab space. Arts and sciences wanted—. And so we decided to bundle into one building with some shared research some very, very expensive equipment that no individual school could afford, but which, as a collective group, they could all chip in and use. And pulling those people together, getting them to share first in the design concept of the building and then in the allocation of space within the building, was not the easiest thing in the world. And there were a lot of Engineering faculty who didn't want the thing built in their backyard, saying the sun would never shine on the engineers. Well, it turned out to be a fine addition. So fine that now there's another science (*laughs*) building that is needed, the French [Sciences] Building, as you know. That Melinda [French] Gates has funded, that will be going up. It also is the case that what was the school of forestry morphed into and ultimately became the Nicholas School of the Environment. And that was the legacy that Philip Griffiths and I really left to the university is its newest school, housed in the Levine Building at one end of the long sausage that snaked across the campus.

ROSEBERRY: So does that building serve to maybe bring together those two entities?

BRODIE: Well, it's served to bring together four of the entities, yes: medical, environment, arts and sciences, and engineering. And it housed them in one structure. It, in my mind it was very, very important to have a central eating facility so these people could mingle and talk over meals. And so we tripled the size of the cafeteria the initial architect's drawings had shown us. We put in a great kitchen, a great amphitheater—the Love Amphitheater. And now I'm told that that facility does serve its purpose in bringing scientists from these four schools together with dialogue over good food at lunch.

ROSEBERRY: Great. When did the idea for that center first began circulating?

BRODIE: Well, it started percolating in the late eighties.

ROSEBERRY: Okay.

BRODIE: And it was built in the early nineties, and opened in the fall of '93. But it took about five years to—and the Academic Council was initially opposed, and we had to hold luncheons. The trustees were a little leery of it. It was a very, very costly building, $80 million. So we had on the one hand to convince the faculty that there was a need, which there obviously was or we wouldn't be now building a second one; and then we had to go out and to the external environment to raise the money.

ROSEBERRY: You may have already touched on this and, if so, please forgive me. But you mentioned that you had to watch closely the medical center, or they had to kind of be more accountable to you than otherwise, than before. I wonder if there were—

BRODIE: Well, I think Terry Sanford really left the medical school alone. And under Bill Anlyan's leadership, he just let them build and build and get bigger and bigger and stronger, and it worked out. But when I went into the presidency, I began to see a plateau occurring, and then I

began to see some detriments: we lost major funding for our cancer center, and we were losing some really good scientists. So I spent a lot of time interviewing people and trying to get a handle on the cause of that. And it turned out at the end of the day that it was the person who'd brought me to Duke in the first place that perhaps, after twenty-five years, he needed new challenges. And so I had the chairman of the board of trustees meet separately with a number of the department chairmen in the medical center. He became convinced of that as well. So together we put together an offer for Bill to come over as chancellor of the university, freeing up what was then the chancellor for health affairs position, allowing me to recruit a new leader for the medical center that would carry us through the turn of the century. And that search brought us a number of very good candidates, some of whom had been at Duke and left. And at the end of the day, we all agreed that Ralph Snyderman was the person to lead. He'd been a division head in Medicine. He'd left to go to Genentech. He knew the real world. And now he was willing to come back and lead the medical center forward. So we made the offer, he accepted, and he started in—I guess it was '89 that he began. And that has worked out. I think he was a very good leader in the nineties and at the turn of the century for Duke. Got us through major, major changes in the medical environment: reimbursement, Medicare, formula funding that went down, managed care that was, you know, very, very demanding on accountability, and diminished funding also for healthcare services. He extended our reach: bought up private practices, bought up other hospitals. Today we are in a very good position to attract another good leader in Victor Dzau to follow him. It's interesting. There's a book out describing the leadership of the medical center at Penn and at Hopkins, and what a disaster the issue was at Penn under Bill Kelly. How initially it was great, and then it just came crashing down. They were losing a fortune over there. Then he had to be let go. But it is not the case that Duke has ever had a serious financial

embarrassment in its medical school. Let us hope that it never does.

ROSEBERRY: Can you talk about the relationship between medicine and business perhaps?

BRODIE: Well, you know, it's interesting. When I was in Psychiatry, one of our stronger departments, or stronger programs, was the MD/JD degree. People saw that as equipping them to handle malpractice problems, working for insurance companies, and basically just understanding the language of commerce in the provision of medical services. That program has essentially gone by the boards; I mean, we may have one or two people in it. But in its place has come this tremendous interest in the MBA/MD program, which is a five-year program, which we offer. And physicians these days really have to be very aggressive business entrepreneurs if they're going to go out there and practice in areas where there is stiff competition. Now, you don't need the MBA to go to work in Liberia or in some of the backwater reaches of Africa or South America. But if you're going to open up a practice in New York City, you'd better know the rules in your area. *(laughter)* Manage your account-receivables. And it's a good thing to have a little business background. So we're seeing more emphasis on that with each year that passes, which is interesting. As you know also, it's less and less likely that an individual now when he or she finishes up medical school that they will go out and hang a shingle as a solo practitioner. It's much more the case that they join corporations providing services or large group practices that are incorporated as a partnership in providing services. And in those contexts they need to know the rules and the business of that enterprise. So good MBA training is very useful in this day and age.

ROSEBERRY: I wonder if you could maybe talk about relationships with corporations like GlaxoSmithKline as well, Ernest Mario.

BRODIE: Well, it's interesting. You remember, now, that I left medicine really in '82. So I'm

twenty-two years out of the field. But when I left medicine, it was very unlikely that an individual physician would serve as a consultant to a drug company. Now most of my colleagues in psychiatry and many in medicine are on panels advising drug companies. Their trips are paid for to attend professional meetings. They're salaried as members of these panels. So there's a much closer relationship between the individual practitioner and the drug house for starters; that's interesting. And you see that whenever you read a paper that's published in the literature. The author has to list their affiliations (*laughs*) or their potential conflicts of interest or—any entity that has paid them money to serve as a consultant. And you see this long list, and you wonder, How in the world can that single psychiatrist work for, you know, advise five different pharmaceutical companies? It's interesting. Secondly, you see a tremendous industry now in drug testing, allowing Duke to set up our Clinical Research Institute with millions of dollars, over a hundred million dollars, passing through to basically enroll our patients in clinical trials. Whether or not our patients realize this is another thing. But they do know that by coming to a place like Duke, they may be experimented upon and they may have, you know, student learners learning on them. But they're exposed to doctors at the cutting edge and drugs that may be in development and not available through FDA approval for the general public but available through a FDA-approved protocol that allows the doctors to experiment. The result of that is that hospitals and medical schools have suddenly discovered this as a profit center, and a lot of money is being made in carrying out those protocols. Furthermore, it's the case that a number of the testing arenas in the sixties and seventies have been shut down. Prisoners used to be the principal source of Phase I, Phase II types of trials and studies. No more. It's viewed that the prisoner is incapable of giving informed consent, because they don't have much choice (*laughter*) in the matter, and they're buying time on a sentence reduction or clemency. So it's

also the case that it's viewed as unethical to be experimenting on people who don't understand the risks. So in developing countries you can't go in there and vaccinate a bunch of people with the understanding that they will clearly understand that they're at risk for a number of different problems. So you basically end up testing drugs on our populace here, with informed consent being given and hopefully a minimum amount of cover up *(laughs)* in the sense of lack of full disclosure.

ROSEBERRY: Can you talk about your continued dedication to psychiatry?

BRODIE: Well, it's been fun. You know, I've always felt that if we could interest undergraduates in what psychiatry is all about and what mental illness was and the potential for treatment and the huge burden of illness that these problems like schizophrenia and bipolar disease cause, it would be very helpful in encouraging some of our brighter minds to go into psychiatry. So I've been teaching at the undergraduate level freshman and senior seminars in psychobiology. About half the students I've taught are premed, and some of them have gone on into psychiatry, which gives me great pleasure. Others, even though they may have gone on into corporate life, business work, investment banking, carry with them an understanding of the human mind and an awareness of the stigma of mental illness and hopefully an altruism, an acceptance and tolerance that would preclude any prejudice that would be applied to the mentally ill. And I consider that a strong plus as well. It's been fun. Because I've taught seminars, I've remained fairly close to my students and been invited to attend their weddings. Obviously you write letters of recommendation for them at each stage of their life's passage. I don't think a day's gone by we don't get some piece of mail from a student whom I've taught at some point in the last twenty, thirty years. And they end up doing very interesting things. Today's mail brought a letter from a young woman who graduated here three years ago who's in the Peace Corps in

Senegal. And is now wanting to go to med school. So I'm going to have to write a response. Also, as you know, the wonders of the Internet allow you to stay in touch with people, (*laughs*) and the e-mail traffic is equally fun. It's been very rewarding. I've enjoyed it immensely. I've also found that after the first year of sabbatical where I did have to spend a lot of time refreshing my memory of some of the older drugs and then learning all these new drugs that have come out during the time of my chancellorship and presidency. All of the SSRI drugs—the selective serotonin reuptake inhibitors; Prozac, for example—were developed and brought into the market in those years. So I had a lot to learn. But now I have somewhat of a consultative practice. I go away in the summers, so I don't commit myself to treating patients over the long haul. But I will spend some time with a patient and try to understand the diagnostic entity that best describes their condition. And then I have a good sense of some of the therapists in town and on our faculty, so I can refer them for treatment elsewhere. And that seems to have worked. I've enjoyed that. To me there's a lot of intellectual challenge in trying to discern, just what is the illness that these people are wrestling with? What are the problems that can best explain all the myriad of symptoms that they come to you with? And as you know, today, goodness! You have so many people taking so many different drugs. Who would have thought that a drug that was designed to lower your cholesterol would produce depression? And yet I've seen now three patients on Zocor who have depression related to the administration of that drug. Never depressed before. Go on that drug. Months later they begin serious symptoms of depression. And of course, the treatment's easy: get them off the drug, (*Roseberry laughs*) and they blossom. Then it's up to the internist to try to find another drug that will lower their cholesterol. But more and more people are on more and more drugs for all sorts of reasons. And many of these drugs do have psychiatric side effects. So one has to learn those as well as the drugs used to treat these

mental illnesses.

ROSEBERRY: How else has psychiatry changed since your first—?

BRODIE: Well, I think managed care has had a major impact on the field. It's shortened the treatment times. You see someone ten or fifteen minutes instead of the usual fifty-minute hour. You're only allowed a certain number of sessions with a patient, and then their insurance won't cover it. They can't afford it. You basically are speeded up in your therapy. It used to be you'd bring a patient in the hospital, treat him in the hospital for depression maybe two weeks, three weeks, four weeks. Now it's two, three, four days. You start them on a drug and get a little bit of a response, and then bring them out into partial care and then outpatient care. So time seems to be of the essence. And it's hard for our psychiatrists here to make a living doing outpatient work. And it's harder for them to do inpatient work because there are only twenty beds, and there're not that many patients even to go in those beds. So I don't know where the patients are going. A lot of them, I fear, are ending up in our community mental health apparatus, which, as you know, is undergoing a huge change in this state. And so I fear greater and greater neglect is in the offing. But it is the case that we will take in our emergency room all patients regardless of their ability to pay for at least that initial assessment. Then we send them off to the state hospital at Umstead or the VA.

ROSEBERRY: How else has the Department of Psychiatry changed?

BRODIE: Well, there have been a succession of chairmen. In Jeff Houpt, who picked up as an acting chair when I left, we had a consummate clinician who ran the Consultation/Liaison service. And he was terrific. But for whatever reason, Dr. Anlyan didn't want to appoint him to the chair, and he left us and went to Emory. Became chairman there, then became dean there. And is now just finishing up the deanship at Chapel Hill and going off into health policy. Then

came Barney Carroll, who was a consummate researcher. He really strengthened the research element of the department, broad based, broad gauge. Brought in a number of distinguished investigators. And built on what Busse and I had laid down as a research foundation, such that we moved up in the ranks for federal funding, NIH funding; we are in the top ten now, doing well. Barney may have had some difficulties in the teaching and service provision areas. So he was let go after a five-year term, and Dan Blazer served as acting chair. Did a great job. But didn't want the permanent chairmanship. And so Allen Frances was brought in. Allen Frances was fresh off the development of what we call *DSM-IV* for the APA, which is the *Diagnostic and Statistical Manual [of Mental Disorders]* number four. And as chair of that committee he was viewed by the *New York Times* as the most powerful psychiatrist in America. It was sort of amusing. So he came for five years. That was a period of some unrest and strife. I think it was also a period of managed care and carve outs and a diminishment of census, and the shutting of wards. He only lasted one term and left after five years. At that point Ranga Krishnan was appointed chair. Ranga had been in the department as a psychopharmacology investigator. A very calming presence. His Indian background is perfect for calming the troubled waters of this department (*Roseberry chuckles*) that had been through some rocky times with these two chairmen who had come in well heralded, but then had not been renewed for appointment. So Ranga now is, I think, having calmed the waters, beginning to think about the future. One option for him is to leave to go back to my alma mater, Columbia, which has offered him a chairmanship; I think he will turn it down; but he's wrestling with that. He had some opportunities he didn't want to pursue because he didn't feel the department was totally together enough. One was the Menninger Foundation Hospital, an $80 million endowment that could have come to Duke and created a large inpatient facility—they had their own money to build.

But they ended up going to Texas. In deference to Ranga, I think he just didn't have the support to go after it. But we could have had it if we'd wanted it, I believe. Then we were going after—sought out—the old 6-2 unit in Duke Hospital South and allow community physicians to hospitalize. But, for whatever reason, that didn't get off the ground. And then in Ralph Snyderman's purchase of the Raleigh Community Hospital we acquired a wonderful psychiatric inpatient unit—I think it was twenty beds up there. It was doing well, but Ranga never really staffed that too aggressively, to the point that it ultimately closed. And so there have been some missed opportunities for expanding the inpatient sector, which I thought would have been income producing. But I certainly trust Ranga's judgment in these things, and it's obvious that he didn't value them at the time. He did ask me to review our child division, which I did, and provided a report. And to his credit, he's acted on that and has made some new appointments and provided a bit of support to strengthen that entity.

ROSEBERRY: Let me put in another tape.

BRODIE: Sure.

(tape 1, side two ends; tape 2, side one begins)

ROSEBERRY: So how has Duke itself changed since your arrival here? I know that's a large question, but— *(laughs)*

BRODIE: Well, goodness, thirty years. It certainly has gotten more prestigious. It's certainly one of the top ten universities in America. It probably has always been in the top ten since the early eighties. But it has achieved an international prominence now through some of our efforts in Singapore and in Germany. The Fuqua School has set up a branch in—I believe it's in Frankfurt. The medical center has set up a branch in Singapore. We continue to do cutting-edge research in all our fields, and I think that there is now a greater equality across the board such

that our English Department and our Surgery Department were ranked in the top three nationally. In other words, medical and nonmedical I think are more equal and therefore more able to view each other as peers and colleagues, and the collaborative potential exists and is heightened though this parity. The Nicholas School has been a wonderful godsend to the university, at a time when students and the general public are very interested in ecology and conservancy, aquaculture, silviculture, remote sensing. These things are now the grist of their research interests enterprise. We're seeing a growing number of applicants to the environmental policy and environmental science and toxicology programs. Whereas before, we saw the gradual diminishment of applicants in our masters of forestry program, which we offered through our school of forestry. Certainly the business school has taken off. And that has expanded from a simple two-year MBA program to all of these executive education offerings tailor-made to different corporations for their executives to come. And our weekend program that will give them an MBA after three or four years and our evening program. Some of the students in that from Duke itself going over for after-hours training for the MBA over the course of three or four years. And now the added dimension of this German expansion of the Internet program, if you will. Our divinity school, I think, has always been strong, but again, growing stronger. It's fascinating that it now has a strong link with the Nicholas School of the Environment. Theology and environment. It's an area that I would not have thought would be as popular as it is today, but it really is quite strong. I delight in the divinity school's continuing emphasis on ecumenicism and its breadth of curriculum. It could have sort of folded in on itself and become just a totally focused Methodist institution. But in fact, it welcomes all creeds and is building a very strong teaching program in the Muslim tradition, religion, background; Buddhist philosophy and theology; Hindu theology. At a time when our students from an international standpoint are

demanding courses in those fields and want to know more. Certainly those of us in this country want to know a good deal more about Muslims and Islam. It's the case that the nursing school was practically shut down and now has been resurrected first with the strengthening of its master's program, which was kept in place. But now a return-to-practice program where you as a religion major, English major, whatever, can now go and take a two-year course in nursing and come out with an RN. And then go on to a master's in a particular specialty field and become a certified nurse. And now they're pushing for a doctorate, which is great. I think that would be a wonderful addition. Our new engineering programs in nanoscience, for example, I think are vastly improved. Our new dean is—she is just terrific. And as you can see those buildings she's constructing are rising out of the parking lot of the divinity school. *(laughter)* Looking very, very good. And Ethics, Genomics, and Cognitive Neuroscience.

ROSEBERRY: Well, we're going to have a new president and a new chancellor.

BRODIE: Chancellor for health affairs, yes.

ROSEBERRY: And a new dean of the nursing school.

BRODIE: Yes. And a new dean of arts and sciences. It's a time of major transition. A new head of the library, new head of the museum. A lot of our support functions. And these will be interesting transition times, the next several years.

ROSEBERRY: Is there anything more you'd like to say about the transition between Dr. Anlyan and Dr. Snyderman?

BRODIE: Well, I think I've covered it. I think it went relatively smoothly. Dr. Anlyan left the medical center and came over to work in the Allen Building for a couple of years as chancellor. And then the Duke Endowment invited him to join its board of trustees, and so he, in moving

into that position, had to relinquish his officership of the university, and now is a professor emeritus of Surgery and serves on the board of the Duke Endowment. His has been a lasting involvement with the university, ever since he arrived as a resident from Yale where he graduated med school. And he certainly has contributed substantially to the growth of the medical center, building on the shoulders of Davison and Deryl Hart, he did an outstanding job.

ROSEBERRY: Well, is there anything else that you'd like to say as far as the future with new leadership and what that might entail or could entail?

BRODIE: Well, I think it is interesting that we've turned to Harvard, Yale, and Princeton to fill our key positions of president, chancellor for health affairs, and dean of arts and sciences. How those three people will get on and influence what they discover here is going to be fascinating. It puts the provost in a very difficult position because he's going to be the voice of history, and he never served as a dean or as a chairman; but was catapulted from the ranks of faculty right into the provostship and has served one term and now a second term in that role. But he will be the only academic leader with any history of the place as the four of them sit around the table. So it's going to be fascinating to see how this plays out. I think it will play out for the best. Institutions like Duke benefit from a succession of strengths in their leaders, and you don't want a series of leaders that all look alike. So whereas Nan certainly emphasized student affairs and fundraising and development, I think [Richard] Brodhead's going to emphasize more the intellectual side of the university, its scholarship side, the academic side. And that will be for the good.

ROSEBERRY: Well, is there anything I have not mentioned today that should be covered?

BRODIE: Golly, I don't think so. *(Roseberry laughs)* I think we've covered the universe, so to speak. I think we've done a good job of—you've done your homework, and I think you've

covered the territory.

ROSEBERRY: Okay.

BRODIE: I tend to speak quickly. *(Roseberry laughs*) So I don't think the quality of what you've taped is to be measured by time, but rather by content. So when it's typed out, I suspect you'll feel good about it.

ROSEBERRY: Great.

(end of interview)