INTERVIEWEE: Dr. Joanne A.P. Wilson
INTERVIEWER: Jessica Roseberry
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WILSON INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. Joanne A.P. Wilson. She is professor of gastroenterology in the Department of Medicine. It's May 24, 2007, and we're here in Duke Hospital South in the Orange Zone in the Division of Gastroenterology in a conference room. And I want to thank you so much, Dr. Wilson, for agreeing to be interviewed.

JOANNE WILSON: It's a pleasure, because I do think that a lot of times we don't have the history as it was lived by those who created the history. In the past I've tried to—with my own family—to get some oral history. Haven't really been as successful as I'd like in having the voices and thoughts of those who've passed on. So I think this is an excellent idea.

ROSEBERRY: Great. It's very kind of you to agree to put your thoughts down for history as well. I wonder if we might start with a little background of yours, and just ask you what year you were born, if that's okay.

WILSON: I was born in 1947. Actually, I was born in Raleigh, at St. Agnes Hospital, which is now a historic site. It's being refurbished, actually, by St. Augustine's University. And so the structure—the outside of the structure—still exists. I was raised in Raleigh. I'm the oldest of seven children, daughter of Conorah Watson Peebles and John Henry Peebles, Sr. We all went to parochial school in Raleigh at St. Monica's, a mission school. We converted Catholic as children, and I proceeded through the parochial school system in Raleigh, through Cardinal

Gibbons [High School]. I now sit on the board of trustees for that school. I went to college at the University of North Carolina at Chapel Hill. My class was the first year they admitted women as freshmen. So it was a unique class: 300 women and 2,000 men. I was a chemistry major there and matriculated here to Duke University Medical School in 1969 in a class that was, again, at a time when women were not well represented in medicine. There were only three of us in the first-year class out of a hundred students, and I was—one of two African-Americans. The other student, unfortunately, didn't continue through the entire first year.

ROSEBERRY: Do you remember the name of that student?

WILSON: Cooke. The pictures are all downstairs in the hall, so you can see them quite frequently. And I continued through the medical school. I was a very good student. I actually finished first in my class at Duke. I had been a chemistry major as an undergraduate, with an honors thesis in biochem[istry]. So the curriculum was not difficult for me wrap my arms around that first year. And I was Junior AOA [Alpha Omega Alpha] and was president of the Davison Society (medical student body). I generally liked to be involved in what was going on with the students—and it was a time of great activism. As a college student, I had not been terribly active in the political side of things. I had been active in community service and that type of enterprise, although for most summers I had to work in order to supplement part of my educational funds. And also had had some really excellent internships, which I suspect helped getting into medical school. I had chosen to come to Duke primarily because my husband and I got married just before medical school. I had gotten accepted to Carolina, Duke, Hopkins, and Harvard for medical school. My husband was a year behind me in college and felt that this would be the best balance of educational opportunities as well as family opportunities. Subsequently during my medical school years, I had some excellent mentors; they were not

women but people that were able to help me quite a bit. My third year, I worked in reproductive physiology and endocrinology, and I was in Dr. Hal Lebovitz's lab, who was a very positive influence. I finished medical school here in 1973 and went on to house staff training at Peter [Bent] Brigham [Hospital] in Boston. I think I was still curious about what Boston was really like. It was an excellent training program. Again, it was a different environment than most of the women and underrepresented minorities see these days. Typical of the times at the Brigham they had had before me no more than one woman per year. And as best I could tell, occasionally an African-American or an African, as the case may be. In my year, I was the only woman and the only African-American in the group. But there were three of us from Duke, although none of us knew one another prior to coming to the residency program, because we had been in different years. One was an MD/PhD from here at Duke—and he became a very good friend of mine—as well as the other Duke student who had a PhD prior to coming to Duke so had spent three years here. So we were all in really different classes. We've all continued to communicate to this day, and I had the pleasure of nominating both of them for Alumni AOA a year ago, and they were both selected. They're both prominent physicians in research medical school administration in other areas of the country. Both are quite accomplished. And just by flukes of the way things were done at that time were not nominated and obviously would have been selected, as they were, in fact, as alumni members. My husband and I continued through the years to try to make sure that we were able to coordinate our training. So my husband did his fourth-year medical school in Boston at the three different medical schools there, while I did my house staff training. His second year he did a residency in pathology for one year, and then came to Washington, DC for his house staff training at [The] George Washington [University]. I did a senior residency in Georgetown [University]. Though prior to even starting that, I had decided I wanted to do

gastroenterology. And I subsequently did gastroenterology at the Washington, DC VA/NIH [Department of Veterans Affairs/National Institutes of Health] program, which was a great program with some very prominent people in the program. And it was an excellent learning experience for me, because I was able to do some things at George Washington as well. After that we both went to University of Michigan, where I joined the faculty. At that time, one of our former faculty here at Duke, Dr. Bill Kelly, was chief of Medicine and had recruited me, partly knowing that I was available from one of my colleagues who had been house officer with me at the Brigham. My husband did his fellowship there, when I joined the faculty. Subsequently he was on the faculty as a basic researcher and clinician, having gotten an R01 [grant] after like one year to do research in infectious diseases and gut microecology. So for us, it's generally been a good match. All three of our children were born at Michigan, very close sequences: 1979, 1981, and 1984. And at the same time, because there was not much advocacy for women and so forth, there was very little time for maternity leave. Actually I was the first medical faculty person who had taken maternity leave. There had only been one other person who'd had a child as a faculty person at that point, and we were all very close friends. She was a research person. So she was not clinical, as I. The second important point at that time was there was no alteration of the tenure clock. So within seven years, I had to complete enough publications for tenure, regardless of whatever other events—namely three children—had occurred. And I was able to do that, certainly with some support from my husband, primarily, because we didn't have family up there. I was able to be the second person in the Department of Medicine to be tenured on what they called the clinical-academic track. It was an interesting experience at that time in transitions in medicine, at the same time that there were transitions in my own life in trying to match. Now at Duke—and many other places—there are opportunities to alter the tenure clock

for women and men for care of family members, both children and elderly parents or other situations that may meet those criteria. And also ability to—for instance, at Duke in the same kinds of track, there are many fewer publications that are generally expected. In my case, there were twenty-five publications expected, just the same as with clinical research track faculty. It was very interesting and challenging. And very stressful, for sure, because we had a dual career family. But we had the opportunity to come here in 1986. And since both my husband and I were both from North Carolina and all of our immediate family was here, it seemed like a very reasonable transition to make. We were fortunate to be able to get two faculty positions here at Duke. My husband came in Infectious Disease[s] and I in Gastroenterology. And Dr. Joe Greenfield was very helpful and supportive in endorsing the recruitment of two to his department. And my husband had a really nice laboratory opportunity at the VA [Veteran's Administration Hospital]. And he continued an active lab until just about now, when he's starting to wind down the lab and have some different interests in infectious diseases and general medicine. So it's been interesting. So is that pretty much what you want?

ROSEBERRY: That's lovely. Thank you. Well, I wonder if I can go back and ask a few questions about your being in medical school at Duke? And you said that there were very few women in your class.

WILSON: Right.

ROSEBERRY: I think you mentioned three?

WILSON: Three. Yes.

ROSEBERRY: And you were, I think, among kind of the first wave of African-Americans here.

WILSON: Yes. I was, I think, the fourth African-American.

ROSEBERRY: The fourth.

WILSON: Yes. Mm-hmm.

ROSEBERRY: And I read somewhere—and I don't know if this is accurate—but the first African-American woman to matriculate here—do you know who that is?

WILSON: That was Jean Spaulding.

ROSEBERRY: Okay.

WILSON: Jean was the year ahead of me. Jean was a year ahead of me, but she had a child and took a year off between her first and second years. So we did second year at the same time; we actually did a rotation together, our first rotation in medicine. She continued through with summers and so forth and graduated about with her class. So yes. So [Wilhelm Delano] Del Meriwether was first, and John Walker was the second. And then Jean and then myself. Then after that, the numbers did increase. I worked one summer with the student program for disadvantaged students. And one of those students from that program matriculated to the medical school and is a fantastic physician, Dr. Ed Treadwell, who practices down in Greenville and is on faculty at East Carolina [University]—in Rheumatology. And he went on to do a rheumatology fellowship and so forth. He was a fantastic student and physician. Yes. But that was a great summer program, where the students did academic programs. It's sort of similar to the summer program that we have here now, that's under the direction of Drs. Wigfall, Cullins, and Armstrong.

ROSEBERRY: And tell me a little bit more about what that program—

WILSON: Well, it was to bring students from historically black universities to Duke for a summer, to give them some idea of the curriculum and the sort of preparations necessary to orient them to medicine. So they would go on the wards. So we'd set up a schedule. It was a much smaller number of students than now. I think it was maybe six or eight. Whereas the

program now has—I think it's over a hundred students. And they stayed in the dorms and so forth. It was a program just—I'm blocking on the name of the person who's a professor of physiology, who's very, very dedicated. Dr. Lieberman, I believe. Very, very dedicated to this cause. And this was back in the 1970s. Yes. It was either 1970 or 1971. But very dedicated to the idea—and that was early on—that there were just not enough African-American students at Duke in the medical school. And as a matter of fact, the interesting thing at that time—which a lot of people don't realize—is there were very few North Carolinians in Duke. In my class, only ten people were from North Carolina. And that changed when the legislature set aside some funds for North Carolinians. I think it was 26 percent at Duke, and 40 percent at Wake Forest [University]. But neither school had a high representation of North Carolinians prior to that.

ROSEBERRY: Do you know why that's true?

WILSON: Well, Duke had traditionally not been a school that necessarily attracted North Carolinians. So there were not a lot of North Carolinians, for instance, when I went off to college—black or white—in the undergraduate population. It's always been a national school. So it did not necessarily have a heavy representation of North Carolinians.

ROSEBERRY: You mentioned that you were able to be active—your activism during your medical school time.

WILSON: Yes.

ROSEBERRY: I wonder if there were other programs, or opportunities, or even just—?

WILSON: Well, the disadvantaged student program for the summers. When I was president of the Davison Society, I always tell people, You'll look, and then our year there is not a yearbook. They had a medical school yearbook on which no one in our class wanted to work. So we took the money and gave it to the Edgemont Clinic, which was a student free clinic. And so that

bought a lot of supplies and medications for the clinic. And I think it was a great thing. And to this day as then there were several people in my class that were very activist. Michael Nathan, who was killed with the Greensboro Seven [Five], was in my class. Paul Bermanzohn, who was seriously wounded in Greensboro—and there were several other people who were very active with the unionization of the workers. At the time, that was just getting started. And several of those people were really good friends of mine. Mike had been my lab partner when we were first-year students in the physical diagnosis section, so I knew him very well. So there were people that were much more activist than I. But they were really quite ready to get involved. And typically in the past, the Davison Society presidents had not been—I mean, it was a fair amount of work, you know, being on committees and so forth and so on. But they had not been particularly big in community activity, at least that's what I had ascertained. And obviously there had not been a woman, and there had not been an African-American. But it introduced me to the Student American Medical Association, and more importantly the Student National Medical Association, which still exists today and is very active here at Duke. Now the minority students are very active. And actually my daughter will be running for co-president next year—actually partly because of her own independent activism. But she and my younger daughter are much more active than I ever was. My oldest daughter's in West Africa (Niger) right now on a rotation, which she is the first person to do the rotation for second-year medical students. She created this rotation. But they've always been introduced to the concept of doing some volunteerism through their schools and so forth. And we've always supported that.

ROSEBERRY: Do you think there was that kind of spirit on campus during that time?

WILSON: Yes. In the sixties, there was a lot of a volunteer spirit. It's waxed and waned in the schools over the years. And I read surveys now about there being more or less activism. I know

the African-American students here and some of the under-represented minority students that are part of the Student National Medical Association have been incredibly active. They organized a two-year or more program for high school students who are interested in health careers, and they brought them to various sessions on campus and so forth. And they actually have raised money to give one or two of those students scholarships at the end of this year. Also I participated in a program on campus recently—which I had been aware of—but it was for young African-American and unrepresented minority grade-school girls—I think they're nine and ten, so early middle school, late lower school girls. And they were introducing them to various professional careers, not just medicine. And I was one of the people. It was a Saturday morning, but what better thing to do with a Saturday morning than to talk to children. The kids were just so enthusiastic; they had fantastic questions. There were women that were lawyers or law students and teachers and so forth. And they wanted to know about the various professional careers, how much training and so forth. And then we broke off into small sections to sort of talk to the girls on a small-group basis. But it was really fascinating. They meet a couple times a month all during the year, and these are Duke undergraduate students who organized the program. So there are a number of students now that, at least around here—and I'm more familiar with some of the African-American students and also the ones that have interacted with my daughter in a global health initiative that they've done. I think it's the Duke Alliance for International Women's Health or something of that nature. And they've raised money for help of women—primarily in Africa—funding clinics and so forth. So there is a lot of activism. My daughter's also been involved in a group primarily of women raising money for lung cancer as well. So it's alive and well. I don't know what percentage of students are involved. I certainly would like to see more, especially in medical school, to have people look beyond their own personal growth

and look for the growth of the community as a part of what they're giving back for what they're receiving.

ROSEBERRY: As you look back on some of the activism that you were involved in—or that was alive on campus during that time—would that be more activism, or was there also a spirit of unrest as well?

WILSON: I think I was not as active as many of the other people were. Because I was more involved in "the establishment" but tried facilitating things: Okay, we'll get the money, and we'll do this or that with it. But I think that by that time—by the late sixties, early seventies—it wasn't unrest. It was true activism. I think in the earlier sixties there was more unrest, especially I think on the campus. Brenda Armstrong can certainly speak better to the issues of what was going on in the mid-to early-sixties on campus here, because this was, for a Southern campus, was very active. And at UNC [the University of North Carolina] with the black student movement there, I was not integrally involved. I knew the people and supported their thoughts, but had been more of a nose-to-the-grindstone person. I had participated as an undergrad more in some international student activities and volunteer efforts but had not really participated much in the black student movement—although there were many very dedicated people involved.

ROSEBERRY: Did you receive any negative attention, being a woman or being an African-American during that time?

WILSON: Here in the medical school it was a very interesting time, I should say. I always remember once, when I first got here—and the same thing happened to me as an undergrad—some people assumed that if you're an African-American student, you were somehow academically disadvantaged. And so I remember one student in the medical school class coming up to me and saying, "Well, if you need any help, I'll be happy to help you." Or something like

that. He didn't know me, didn't know where I'd come from or anything. And then I think later on, I had finished one exam, and he said, "Well, that was really tough. How did you do?" And I actually had gotten a perfect score. So you know, I was a little bit miffed that, you know, that he'd come up and asked me, as opposed to asking a bunch of other people. I'm sure that he meant well. And then I think at that point, some of those students understood that. At that time, rarely were the African-American—I mean, any of the African-American students that we've had, save for a couple, were top students. I mean, you know, they were taking few chances, put it that way. And so they were just really not taking a lot of chances with students. And so it was not a difficult transition. Because I had been educated at probably one of the best schools in the state at the time, because the nuns were from the North and had very high academic standards. And they had a tendency to, if they saw the students were capable, to set new standards for them and not necessarily have the same standards, knowing what kind of world you were going to compete in, I suspect. And I think most of them have no idea that some of their students did so, so well. But it was a credit that if they start you off in second grade saying, Okay, you know, this is what *you're* going to do, as opposed to saying, Well, this is all I expect; their expectations were high. And knowing that many of the students could reach those expectations was invaluable, and I think it's one of the things that's missing frequently in schools now. As I talk to parents of academic people who are minorities, that they frequently find that the teachers—be it in college or high school or grade school—do not have high expectations for some of their minority students. And a lot of times the educators aren't even aware that they have given this impression. I had this happen once when my one of my daughters was in seventh grade at an independent school here. And she had gotten a not-so-great grade in math on her first quarter. I went to the teacher, and I said, "What is going on?" He said, "Well, that's a very good grade." I

said, “Well, not for her. She was an A student last year.” And so he goes, “Oh!” I said, “Didn’t you talk to the other teachers?” And he, of course, had not. So he had just had this low expectation of her I think, primarily, because she was African-American, not knowing that she is a brilliant person. And you might guess the next grading period, you know, all the homework was done, everything was on track, and she was an A student again. Just like an overnight transition—that she had with the expectations and encouragement. I had said to her, “I want to see all the tests. I want to see the homework.” You know, this was something I’d never had to do for her. And never did again! But it was only for about four weeks that, You can do this. I know you can, you’ve done it before, and so you just do what you know you can do. And that’s the end of that. And I think that that’s in our education system now many, many times, these expectations—low expectations—of the children start at an early age. They fall behind, and then it’s all fulfilled. So it really is. So I think that it was here. I mean, I did have situations where—as a bunch of us were talking recently—where people decide that you’re the janitor, you’re the cleaning lady, or you’re the nurse’s aide or whatever. And that happens to both women and minorities, but more to minorities than anybody else. That people just assume that there’s no way that you could be the doctor. And that would get sort of tiresome. But a lot of times you just put it in the back of your mind, and you move on. But because at Duke at the time there was one African-American faculty—and that was Dr. [Charles] Johnson, who came, I think, my second year, second or third year—and there were no other African-American physicians. So there was no one—patients hadn’t seen any African-American physicians. Most of them had never seen African-American medical students. There were nurses, and that was like the extent of it. And pretty much one hundred percent—of the support staff, cleaning, cafeteria, and so forth were that. But one of my colleagues was telling me—he’s chief of a division in medical

school, chief of gastroenterology—that he walked into a room with his white coat and medical students and everybody trailing behind him—and the patient asked him to take the tray away, because she thought he was from the cafeteria. And so this is 2007 that this happened, so—. And he said he was so used to it that he said, "No, no, no. I'm not here to take the tray." And he said the medical students, they were like, "Oh, my God!" Because they quickly adapt to the hierarchy. Just the idea that the man taking the tray would come in a long white coat with five people with him would be, was— (*laughs*) it was funny. But you know, as a physician, he said his thing was—the lady was of course very embarrassed. And then he was trying to comfort her and say, you know, "Okay, don't worry about it. We're going to get to our part now." But it was really interesting. But just that, that kind of thing going on all the time. And sometimes from staff, too. Because I've had it happen from staff, from nurses or other doctors—where they'll just kind of look at you, quickly look, and say, "Oh, can you get me this?" Or something like that. And you're going like, "No, can't do that right now. I've got something else I'm doing." But when I was in medical school, it was a bit more. But the thing that was gratifying was that many of the nurses and the African-American support staff were so proud, and they were so helpful. It was really—it was such a positive experience. And when I came back on faculty, I realized that some of the people who were Caucasian, who had been, you know—. This one patient of mine, who had been in engineering and so forth, and he said, "Yep, I remember you when you were a medical student." And he described how I looked then, which was a bit different from now. So he did remember, because there were so few. But I think that that idea that everybody would know who you were because there was only one or two can be very stressful. Because, you know, you need to be always on your p's and q's or whatever. There's no time for relaxation, so to speak. And I only say that in retrospect, because I don't

think I thought it at the time. But I'm pretty sure I've lived it. And a lot of people talk about that kind of stress. But it was, by and large, a wonderful experience. And obviously a top-of-the-line educational experience. I had rotations with—Drs. Wendell Rosse and John Laszlo on my first medicine rotation, which was really fantastic. I mean, when I came back on faculty, a lot of the people who had been my teachers were still here. And so to become their colleague was really, really impressive. Drs. Vic Behar and Jess Peter are people I remember. Dr. Harvey Cohen was junior faculty at the time, he's now chief of our department. Lois Pounds Oliver—who was in charge of the students and residency program in Pediatrics—came back. And we have become fairly good acquaintances, because we have a lot of similar interests. But it's just really impressive to sort of see people over a thirty-year period. It's really amazing. I guess almost forty. (*laughs*) Yes.

ROSEBERRY: So were there women in the department as you returned, or when you—?

WILSON: When I returned in '86, the number had increased significantly.

ROSEBERRY: Mm-hmm.

WILSON: Because the curve had gone up. I mean, not to the fifty percent it is now. But still, obviously, the higher echelons of the department—the professors and so forth—still are limited in number, simply because that reflects what was going on, you know, twenty years ago. And so that's why now, still, within academic faculty the number of women and minorities is limited.

ROSEBERRY: So it's twenty years behind?

WILSON: Well, yes, because once you bump up the number, then they've got to do training then they've got to be on the faculty. If they're going to be on the faculty, they've got to be on the faculty for *x* numbers of years. So whatever you see now is a reflection of *x* years previously. So the assistant professors would be, say—they started medical school maybe,

what's it—three, six—so over ten years; they would've started medical school over ten years ago. So it's that kind of thing, because medical training is so long, with four years of medical school, residencies, and fellowship combined being anywhere from six to nine years. And then, subsequently, coming on the faculty, and so forth. So it's a long period of time to see the changes.

ROSEBERRY: Did you ever interact with Dr. Grace Kerby?

WILSON: A bit. She was here, but I didn't really have any rotations with her. She was a rheumatologist, and I didn't have any rotations with her. The interesting—the connection I have with Dr. Kerby is that Dr. Kerby was Professor of Medicine, and the next Professor of Medicine was me. (*laughs*) So it was thirty-two years before another woman became a professor of medicine. It was ridiculous, in a way, when you thought about it.

ROSEBERRY: Were you the second woman?

WILSON: Yes, yes. I mean, which is, as I've said, I'm not that old. But, yes. It was amazing. In the Department of Medicine. There were professors of medicine—women professors—in other departments. But in the Department of Medicine, I was the second woman to become a Professor of Medicine, Department of Medicine.

ROSEBERRY: So that's full professors.

WILSON: Um-hm. Um-hm. Yes.

ROSEBERRY: Okay.

WILSON: So it was assistant professor, associate professor, then professor and drop the modifiers. Yes. When I became Professor of Medicine, she was still living. She'd retired, I think, to Florida. But when I came back on faculty, I came back here as an associate professor,

because I had been promoted at Michigan. And so I didn't meet her since—didn't see her again, after leaving medical school.

ROSEBERRY: I wonder if I could ask also about Dr. Johnson, if you interacted with him?

WILSON: Oh, yes. In medical school I didn't. But subsequently I've interacted quite a bit with him. He is just an incredible person, both from his medical accomplishments as well as his personal accomplishments in, you know, from the military and so forth. And he has such an incredible sense of humor and such an incredibly great sense of Duke, really, because he's been here a long time. He knew Dr. [Eugene] Stead very well, and obviously interacted with him very closely. And he has referred me a lot of patients once I got here for GI [gastrointestinal] consultation, procedures and the like. And I still see a number of those patients, who have now been cared for by other physicians since he retired. But he's unchanged from like the last twenty years, it appears—he's ageless. And also continues to be just a really sharp mind. Fantastic person.

ROSEBERRY: Well, tell me about gastroenterology.

WILSON: Well, gastroenterology is a relatively new specialty, really. It is an excellent specialty for me, because it's both cognitive and procedural. I like doing procedures. I had originally toyed with—ob-gyn was my original specialty that I wanted to do. And then, you know, just transiently surgery. I did surgery here at Duke—private general surgery—so I'd gotten to scrub with Drs. [David] Sabistan and [William] Anlyan and a number of others, and I found it very fascinating. But in the final analysis, I did not do it more from the standpoint of kind of the organization of the system—of the residencies and so forth—and the fact that there were absolutely no women or minorities in the specialty here when I was here. And the same for ob-gyn.

ROSEBERRY: In the eighties?

WILSON: No, this is—now we're going back to the sixties, seventies—early seventies. Obviously, those things have changed. For ob-gyn especially; not so much for surgery, but definitely for ob-gyn. But when I found gastroenterology—actually, when I was a second-year resident at the Brigham, I thought it was fantastic. I originally saw procedures done by Dr. Greg Eastwood, who's actually now president of University of New York—Syracuse I believe. But he was doing something relatively new. It to me was just fascinating, that you could treat people, and then you could do endoscopic procedures. Now, obviously, gastroenterologists are doing surgery as well. So the specialty has developed immensely over the last, you know, almost thirty years that I've been involved. I have been really active in the organization—two of the professional organizations—majorly the American Gastroenterological Association, where I served as secretary for five years on the governing board and a lot of committee work. I just got back from the national meeting. Also I have served some with the American [Society for] Gastrointestinal Endoscopy. It has been—it's amazing. The first meetings I went to were very, very small. No women. Now the number of women still lags behind the number of women who go into internal medicine, and so only about 23 percent as opposed to 50 of gastroenterologists are women—23 percent of the trainees are women. The number overall is smaller than that, because, again, you're looking at the transition over the years. Internationally, there are many more women involved in several countries. We just got back from a meeting that had almost 20,000 people. It was in DC, and it was incredible. I mean, there were women chairing sessions, and African-Americans, and it was just like a UN [United Nations] meeting. And that's been—to see that happen has been incredible, because I have been working with women's issues since the eighties—early eighties—and underrepresented minorities. Initially the numbers of

minorities were so small; it's hard to effect a change when you're dealing with such small numbers. And the number of women, I felt, could be bigger, especially within the organization and within the governance of the organization. And in the modern era, I'm like one of the first officers. I was the first woman, first African-American officer in the modern era for this organization. In two years, we'll have a woman president. We had a woman president back in the 1940s, during the war. But in the modern era we have not. All of the other major professional organizations in GI have, but we have not. And you know, it's really gratifying, again, to see the changes and to—. Because I worked for years compiling a database of women in gastroenterology, sending names to the presidents to be considered for their committees and so forth and so on. And sometimes you just got so tired of it, because you'd do it one year, and then the next year, you know, it wouldn't have carried through. They wouldn't come up with any new people, and so forth. So it's been a super experience.

ROSEBERRY: What are some of the common conditions that you deal with?

WILSON: Well, we deal with functional bowel disorders, like irritable bowel, functional dyspepsia. Also inflammatory bowel disease is one of the big ones that I deal with, and there have been major strides in the management of that, with biologic therapy that gets infused. Colon polyps, colon cancer. So screening for colon cancer has become—a major activity for gastroenterologists is doing colonoscopies. Then I also am involved in peptic ulcer disease, and patients with ulcers with gastroesophageal reflux or esophagitis, and that type of thing. My colleagues are involved in pancreatic biliary disease. I have done that in the past, but I haven't done it in the last fifteen or so years. Also with diagnosis and staging of cancers with endoscopic ultrasound. And we're developing new techniques now, because there's new approaches to perhaps doing the surgery through the gastrointestinal tract, so that people don't have incisions

on the outside. One of the areas that I've been particularly interested in has been, you know, screening for colon cancer—prevention. And in the past, I've done a series of community lectures on screening for colon cancer, because we have technology that's available and ways to pay for it. And still many people do not get their screening tests done. So that's been one of our goals. One of the areas that likely we will be involved in in the future will be obesity, because it impacts so strongly on a lot of our disorders, like gastroesophageal reflux, pelvic floor dysfunction, fecal incontinence, and that type of thing. And I have also in the past been involved in women's health issues and served on national commissions. One of the interesting things I'm doing now is serving as one of the sixteen commissioners on the National Commission on Digestive Diseases. And I'm really the only clinician that's on there, really. I mean, other people are clinical-academic but have a research bent. And it's been a real interesting exercise in looking at the disorders, and the match of research to the various disorders that we have, and recommendations for future funding of research over, say, the next ten years. Every ten years or so, we seem to convene one of these commissions. But I had to select a panel for my work group and was able to pull from some of the people I've known. The other interesting thing that I've done in the last few years—four years or so—has been the American Board of Internal Medicine, and I'm on the GI subspecialty board that actually writes the questions for the board of certification exam. And for me it's been a learning experience but also, you know, a feeling of the ability to impact our discipline going forward. And you know, I've met some really interesting people who are very knowledgeable—but eclectic. (*laughs*) A great group.

ROSEBERRY: Well, are there any cases that stand out in your mind of patients that you—obviously without coming out and giving information about them—but are there cases—?

WILSON: Right, right. Yes, there have been a number. I was talking—a few times—one of the—probably, for me, is one of the most dramatic cases I had—was not my patient. It's a friend of mine that I was talking to with a series of symptoms. And I was listening very closely to her, and sort of said, "Well, you know, has your doctor considered *x*?" And she said, "Well, I've never heard that." And I said, "Well, you know, you really should go back to your family doctor, ask for this test, this test and this test. And if he wants to call me, I'll be happy to talk to him." I mean, I hadn't examined her or anything. And she did. And he did the tests. And lo and behold, they were positive. And she had just one of the most florid cases ever. And it was a celiac disease, celiac sprue—or they call it sprue. She's about my age, and it had gone undiagnosed for years. And I had, you know, I'd never sat down and talked to her about the medical—kind of—condition. I found it fascinating, because, I mean, I found it, you know, incredible, that if you just listen to somebody tell their story and you have the knowledge, that you can make a diagnosis, because that's what I do all day. I mean, I, by and large, I mean, usually I like to examine people before. But I felt that—but it was just amazing to find that you can use your skills, that if you listen to people—I think the thing that had happened to her was that her doctor was not listening to her and putting it all together in a big picture. Rather than five different little diagnoses, let's pull these things all together and come up with a unifying diagnosis. And the second thing has been some of the older patients—and one just recent simple case of an older woman who came in and was having some problems with fecal incontinence, and she admitted to me that this had totally wrecked her life. I mean, she was eighty-four, and she said she felt like she could do things, but she stopped going to church, she wasn't having her kids over for dinners, she wasn't traveling—which she wanted to do—she wasn't even doing her cardiac rehab. And all of it was because of this bowel problem, which was not something that

was an earth-shaking life-threatening problem. She wasn't going to die from it or anything. But it was just so—it was causing her so much distress and depression. And I just made some fairly—I felt—fairly simple recommendations. One of the things I discovered was she was lactose intolerant. Well, eighty-five percent of the population, unless you're Caucasian, is lactose intolerant. And she was not aware of her—even though she was eighty-something. She could take anti-diarrheals. And she was drinking a whole bunch of coffee. So it was like I had to sit down and get through this whole story. And I did, you know, the usual colon exams and so forth. But she'd already had most of that done. I did a simple exam to make sure nothing in the interim had occurred. And the thing was—when she came back to see me, she said, it was the beam on her face, "My life has completely changed." She said, "I go to church now. I had everybody over for dinner," she said, "and I'm doing the cardiac rehab, and I've got *x* more weeks of that. And I'm going on a trip." (*laughs*) You know, it was like—and she was like—she just kind of bounded out of—she was eighty-four, but she really did bound out of the office. I mean she was so, so happy. And it was like—there weren't a lot of expensive things done. But it simply involved talking to her and figuring these things out. And to have someone have such a good response to that was really so gratifying to me. It was like great! I wish everybody could have this kind of response. But those kinds of simple cases for me have been more sort of illustrative of the kind of impact that a lot of times we make in gastroenterology, because it's an outpatient discipline. Now, the other things have been, you know, doing a colonoscopy or finally getting the person who had avoided coming for colonoscopy in and finding a lesion that's correctable early. Because a lot of what I do is not the things that happen at Duke, you know, the very complicated surgery, the incredible chemotherapy and so forth. But it's—the idea is prevention of disease, because we have one of the few specialties where we can do something

that will prevent a cancer from ever happening, and that doesn't happen very often that you totally prevent it. And that's what we can do. And frequently very simply, too, if we can get people in at the right time. But also we can intervene in things like the person with the celiac disease. And once you can recognize it, then you can take wheat out of the diet which they don't need to eat, treat them, and so forth, and get them back to a better lifestyle. So it is really—it is gratifying. It's an interesting specialty. The only thing I don't like that's happening with our specialty is so many people are tending toward procedure-only practices, where they like to just do the procedures all the time, and you don't see any patients at all. And we have the opportunity to have a good mix. We do E&M [evaluation and management] similar to urology. There are several specialties that are a mix of procedures and clinical management. But clinical management in medicine is undervalued.

ROSEBERRY: What is clinical management?

WILSON: When you see patients and evaluation and management. They call it E&M. Where you see somebody, make a diagnosis, give medical treatment or other management. And you don't do a procedure and draw blood and so forth. But that's undervalued in medicine, by and large, because of, they call it relative value and some things like that. And they're much higher when you do procedures, even if it takes less time. The assumption is that the skill level—and risk level—is higher. So therefore it's valued higher.

ROSEBERRY: So the risk level—

WILSON: In the course of doing a procedure, the expertise—the training expertise—and risk level are higher—and the assumption being the stress level is higher. And therefore it's valued higher. So if you're spending an hour seeing people and talking to them, that's valued lower than an hour of doing some sort of procedure.

ROSEBERRY: Um-hm.

WILSON: But we have a nice mix. So we can mix it, which is great. I mean, some of the specialties, obviously, there's no procedure that they do. So their work is one hundred percent evaluation and management, E&M.

ROSEBERRY: Do you see patients over a long period of time, or is it kind of—?

WILSON: Oh, yes, yes. I've had people that I've seen since I first came, yes. So I have people—. And a lot of times they pop in and pop out. (*laughs*) Excuse me. In other words, they have a problem, and that gets resolved. Because I saw one lady just recently—she said, "Do you remember me?" And I said, "Yes." And she said, "I saw you in 1992." And I said, "I didn't remember the exact date, but I could look it up on the screen." But yes. And that happens quite frequently. When you have a community like—if you stay around. Duke has a large number of their faculty who've been here for a long period of time. And when I'm going to the national meetings, I'm always struck by some of the people who've changed locations so many times. I mean, I don't know how they can keep track of themselves. But in academic medicine, there is a tendency toward that because of, you know, promotions—especially if you have an interest in leadership or promotions. And I think frequently if you're a single-career family, it's easier to do that than if you're a dual-career family, because it's hard finding two jobs at the same time.

ROSEBERRY: Um-hm. So, has your husband been able to stay in the same—?

WILSON: Yes. Um-hm. He's at the VA. He's stayed on. He was promoted to full professor, and had research funding. The funding has just about run out. And so he's not renewing his research funding. He's closing his lab to pursue clinical interests. Yes.

ROSEBERRY: If I might ask, how—with two physician researchers in the family, how is that, balancing a family life?

WILSON: Well, we—it took effort. We, as I said, we have three children. We've been married since 1969, actually. So we were married ten years before we had children. Our daughter was born a month after our tenth anniversary. I was thirty-two, my husband was thirty-one. And he was a second-year fellow, and I had finished my first year on faculty. And then two years later—twenty-five months later—our son was born. And then about two and a half years later—thirty-three months, to be exact—our other daughter was born, in 1984. Then we moved down here at the end of '86. But what we did was to try to, again, to get the best childcare we could for them. And then to—initially, we tended to stagger our schedules. As a research person, you have more control over your schedule. In other words, if you're going to go in the lab or review the data, you can do that without other people being there. Whereas a clinical person, I mean, the patient's got to be there, certainly, and the other—your ancillary staff has to be there to do whatever you do. So that was one of the things we did early on with the children. The second thing was that we did decide that childcare was a top priority, and that we would find the best possible, and it didn't have to be in a certain location. In other words, we've used family daycare homes, a daycare center which was associated with our hospital when we were in Michigan. And then we've had in-house people. When we had three, it was easier to have in-house people. I mean, because we needed to take somebody to school, pick them up, and so forth and so on. And we've been very fortunate in having very good people. But we have had very rigorous interviews of people. And each of us has absolute veto. That means that if either one person doesn't like the candidate, then no go. And then the other concept is that if you could not find someone, and you had to take a leave, you'd do it. And we haven't had to do that. But

you know, as—and then as the children got older, we had to figure out how to, you know, do things at the schools and so forth. But generally that means that—if both parents work—is that you have to have year-round childcare, and we did. We always did. We've never had live-ins, because neither one of us wanted additional people living in the house. It just was complicated enough with the five. And so that sort of restricts some of your options, it means that you may have to interview other people for a summer or whatever. But usually—I used to have my master book with three different colors, and trying to figure out, say, summer camps, and stuff like that so that it all meshed. And I might be dictating at the swimming pool. Because one time the secretary goes, "What's all that yelling and splashing and so forth?" And that was because we didn't want them unsupervised wherever they happened to be, even though there were lifeguards and everything. So you might take off from clinic with the dictations in hand and end up sitting in a corner doing some dictations and trying to get the work done while you're there, and being splashed every so often. But by and large, with the two of us working together—. And that's been, I think, one of the major advantages that I have had is that my husband's been a full partner in doing what needed to be done for the children. And that's been great. The second thing that we did was we did not do a lot of traveling or presentations—other than national, one or two national meetings—a year. I went to one a year for almost my entire career until recently. Actually, I had never gone to more than one. Which means you have to make some sacrifices, and that may be sacrifices in career advancement, because part of the, sort of, story with medicine—it's not written, and it's not a part of the contract—but a lot of people go around giving serving as visiting professor here, visiting professor there, to become known not just from their publications and so forth. So that is one aspect, for both my husband and I, that we had given up. I became an officer partly because a lot of the people that had gone through this

program and the Michigan program knew me, and were in positions, you know, of authority. So that was helpful. And I had not shied away from doing a lot of committee work, and making presentations at the national meeting. So that's an alternative way of becoming known. And I'm a clinician. So you're not in as much demand to go around to major institutions giving talks and the like, so. But anyway, it's worked out well for our kids. We made a choice, for instance, that they go to independent school, rather than public school, because the schedules were more controllable as were interactions with the teachers. My husband and I were co-secretaries of the parents' council. When they asked me to do it, I said (it had always been women doing it by and large) I said, "I can't be sure that I'll be there. But between the two of us." And they said, "Well, I guess we can do that." We were the first ones to do it—subsequently, there have been co-treasurers, there have even been co-presidents. And it was no longer just women. And at the school, over fifty percent of the women—of the mothers—work. And so it's perfectly logical that that would be the case. And they started having an auction be all co-chairs, many times the husband and wife doing it. And so I think that it was great. And then for—like reading, when they were in lower school—I frequently had difficulty getting there at noontime. So my husband started reading at noon. And then, the next thing you know, other kids had their dads read, because they didn't want—you know how competitive little guys are. So why can't my dad read? And of course they could. So I think you can have—I mean, people probably don't even know the impact that somebody else had on the way things are done. But you know, it was really interesting. And I've done lunches and so forth, like that. I mean, one of the things—as you organize the lunch, you can sometimes get the people to deliver it. When you do the organization, you can get them to deliver it, rather than you actually taking it over there. And I've done that, and it's worked out. And we've gone on field trips. If you can plan things in

advance—. And the one thing that I did for the school was to say, "You have to let parents know far in advance. You just can't pull things on them at the last minute." Because you put it on the calendar, and one of the things that we always did was I would make out a calendar. And so I might take a day off if I know far enough in advance if the kids were going to be out of school, whereas if somebody was sick and a short notice, my husband was typically more likely to be able to do that than I. And the second thing was that when we coordinated our schedules, we would not have patient-care responsibilities on the same day. Because, you know, you can't do short-notice things if you've got patients coming. You can't just say, I'm not coming—unless, of course, you're sick or something. So we would do that. So for years, because my husband's clinic is on Wednesdays at the VA, I never had Wednesday clinic. And I never had clinical things on Wednesdays, unless I was on the inpatient consult service. But I didn't have procedures, I didn't have clinic. Wednesday was the day I didn't have things, and it was for that reason—because you can't just up and leave. Once our son ran into the side of a swimming pool and knocked his teeth out. And they paged me, and then they were having trouble getting through to my husband. I'm like in the middle of clinic, and I said, "I'm going as fast as I can, putting off dictations and so forth." And I was continuing to call my husband and the dentist, and so he was able to get over there, because somebody had to get over there to get him to the dentist. But there are just all these things that happened in the best-laid plans, and you've just got to be able to go with the flow and be flexible. Flexibility is key. And being here—we thought that, also, being closer, that my in-laws are in Chapel Hill. But there have only been like two or three times that they've had to step in and my mother-in-law come pick somebody up and take them someplace. But it had not happened that often. So flexibility and plan as much as you can, and especially—and our three children, they have all done very well academically. All three

went to the [North Carolina] School of Science and Math. They went to Durham Academy through tenth grade, and they were admitted—competitive admission—to the School of Science and Math. Our oldest daughter was the first one to go had to convince us that it was a good thing, because we were not convinced that we wanted her to stay on campus. But it's in Durham. So she sort of said, "I can walk to your office." Which, actually, she did a couple of times, for something or other, and—by walking to East Campus and taking the bus. And it's not even you have to walk the whole distance. She was an excellent student and athlete, as well, and therefore got a Morehead scholarship. She got accepted to all kinds of schools—undergrads: Harvard, Stanford, Brown, and Duke. But she decided to take the Morehead—over our objections, actually. And it was a fantastic experience for her. She's the one who—she took four years off and is now in medical school. But she's the one that's sort of an international traveler and interested in global health, women's health, and that type of thing. Our son has a very different personality. He's a very reserved fellow, who was actually a really tiny guy in middle school. He was five one when he graduated eighth grade. He's now six one. But he had very different interests. An excellent science and math student as well. But he also applied to Science and Math and was accepted. And he was very active in things like the investment club and chess club and stuff like that. His team—they got the MSNBC [MicroSoft National Broadcasting Company] award for his investment club making the most money in a day on their investments. (*laughs*) So he's always been interested in the stocks and bonds and so forth. And he went to Duke undergrad. He actually was accepted to Wake Forest and got a name scholarship there but wanted a slightly bigger school and came to Duke. He only applied to ACC [Atlantic Coast Conference] schools—UVA [the University of Virginia], [the University of North] Carolina. Out of those four, he selected Duke and graduated from Duke in 2004. Had a

reasonable time there. Was a chemistry major with a minor in physics. Our younger daughter also went to Science and Math. Excellent math and science person, particularly math person. And she hesitated to go to the School of Science and Math, because her major interest was drama, but then decided to go. And actually just did incredibly there academically. And continued her math through Cal-3 [third-year calculus], and was the only girl on the Math Modeling Team that got a national honorable mention. But also continued her drama there through the Drama Board and directed a couple of plays and was in a couple of their annual plays. And also was a peer counselor, which is some of her other interests, and got the Martin Luther King Award for the work she did during 9/11 in helping other students, and her Amnesty International work. She was nominated for the Morehead and was a finalist but didn't get the final award, partly because she does not do sports, I'm convinced of it. But she ended up going—she really wanted to go to Stanford, and she ended up getting into Stanford and was a President's Scholar there. And she loved it. She was there four years and graduated a year ago. And she just loved it. She did a semester abroad in London, doing drama at the London Academy of Music and Dramatic Arts. And before that she did her President's Scholar project in Southern India, so she spent two months in Southern India. Her older sister did her semester abroad in Australia and spent her senior Morehead project in Nepal for two months. So they've both been our international travelers. As I said, she's in West Africa now. And so she continues to cause us to bite our nails and wonder what's going on, you know. You can't ask her, How safe is it really? kind of thing. But she's doing good work there, and she's done volunteer work in Thailand, as well, and Dominican Republic. So sort of all with a similar theme, sort of environment/health kind of theme for all of them, they've been that. And it's been really great. Our son spent one summer in DC doing a nanotechnology fellowship, and that actually for me

was, in a sense, one of the most scary—because we live such a protected life here. And being a black man in a major city where there's so much crime and so much negative interaction with the authorities was an adjustment for him—and for us. Because—actually, I looked up the crime statistics, and actually he was in the most dangerous place. You know, even tallying Dominican Republic, Nepal, Thailand, Southern India—the personal crime rates were much lower in those places. I mean, petty theft is probably higher. But I don't even know that for a fact. It was really kind of interesting. But he got a lot out of that summer, because he had personally elected—he had gotten into the program, and personally elected to do it at Howard [University] over Cornell [University] and UC [the University of California]-Santa Barbara and Penn State, because he wanted to experience that area and to be at a predominantly black university, which he'd never been at before. So it was fun for him. From an experience standpoint, it was sometimes stressful. But I think all of them, you know, they've sort of sometimes pushed themselves to the stress level of interacting with people that you haven't interacted with before. I guess it's the only way to ever know the world is to experience the world, and so often we don't around here. Or some of the students will go on an exchange program with all of their people, you know. So it's like you've gone to this other place, but you've taken all of your people with you. And that's the way some of the physician trips have been, because I know people will say, you know, you'll say, Where have you been? And you know, they went to a meeting in Thailand, they went to a meeting in China, and so forth. But it was kind of like you took your crew with you, and it's not really the same as having experienced that culture and having somehow gotten a chance to know the people. But even in London—for our younger daughter there were only two other Americans in the program that she was in, in the drama—

they were from Europe, from all over. Which was really a different experience than the typical kind of program a lot of the students do.

ROSEBERRY: We had talked about them pushing themselves to the stress level, and I wonder if that's something that you experienced as well.

WILSON: Well, when they're doing those things, I do definitely.

ROSEBERRY: Well, in your own work or—?

WILSON: Yes. Well, the only thing that happens, I think, with me, has been just sometimes overworking. You know, you commit to more than you can comfortably do. And you go through the years trying not to do that. But, you know, somehow it just—my husband and I, we're always saying like—three months from now seems like far, far away—and it's not that far. And then by the time you get there—and you've got like five different things you've said you're going to do three months from now. But I don't know. I mean I think it's—in some situations, it's not good. But in others a lot of times—I think a lot of especially philanthropic activities would not be done if everybody said, Well, you know, I have to fit it into my normal workday. Because by definition they're going to be extra, and volunteerism sort of counts on people taking their spare time to do these kinds of things. And so if we didn't have those people, I think a lot of things wouldn't be done. So I think it's good as long as you don't stretch yourself so far that you can't function—and you have to back off sometimes and just take a break if you have to. But each person knows their own limits, or they try to know them. So that's—like our youngest daughter is moving here in psychology. And one of the things she decided to volunteer for was to be a rape crisis counselor for Spanish speakers, because right now they have so few people that can do that. And they were looking for more age matches. So she's twenty-two, and there are not a lot of twenty-two-year-old Spanish-speakers who were available. So she's training to

do that. And I think that's naturally helpful. Our son has done tutoring for kids. And again, there are not a lot of people who can tutor in chemistry and math. It's like really the numbers are limited. And so I think doing that type of thing is really great. One of the things I've done—like with the undergraduate students, with the young women, with girls—to say, "Well, you know, I was born in Raleigh, and, you know, and I—." They don't see a lot of people that were born like right around here that actually went to school around here and ultimately have gotten through medical school and can be on the faculty and so forth. But that they, too, might. So I tell them, you know, "When I was nine, ten, I did that." And I was selling papers—newspapers—on the corner and so forth and so on. And you know, we didn't have a lot of money, but as the time goes on, you look for all the opportunities that you can get. And those opportunities can turn into the ability to get to the next step, as long as you make sure that you have done your homework and that you're doing well in school so that you can keep going. And some of the girls there were incredibly—had incredibly stressful lives. I mean, they had parents that weren't able to take care of them, and they were living with grandparents, and living with aunts. And, you know, some of the kids had been teased in school. Things came out as we were talking about it, when they were asking, Well, what can I do about it? And you're going like—. And actually, one of the students was incredible, because one of the people who was talking about her career was actually a counselor. And so she immediately arranged for this one child to get some really additional help. So just out of the session—it was like this career-type session suddenly becomes an opportunity to help. Just like me talking to a friend about your health situation, where you have a knowledge base that can put them in touch with the right person. It's really fantastic. It really is. But through volunteerism—and my daughter—oldest daughter—sort of, I think, found the limits of how much you can do on occasions, because she was a Big Sister for a

young woman—a high school student—in Asheville who just had a disastrous life. I mean, a single-parent family, mother disabled because of some mental disability. Mother with poor organizational skills for the home and just like moving constantly. And she tried to help her with activities of daily life, as well as trying to—she was very bright—in advanced classes, even in spite of this all. So she was obviously brilliant, really. But she in the end was not able to get her to the right support system. Because I told her, I said, "This is beyond a simple volunteer type thing." I mean, the social workers have got to be more involved. And she actually went to the girl's school, once, to get her into the right classes, because her mother had moved, not understanding that this meant that she'd get pulled out of some of the honors-type stuff. And they'd go to this new school, and then they'd just throw her into God only knows where. And I told her, I said, "Get the mother to sign a release saying that the school can talk to you." Because the mother just wouldn't have been able to carry on the kind of back-and-forth to explain. And she was able to do that. But again, that wasn't enough. So there are some times that you can find that, in spite of your best efforts, it's just not going to be successful, because the problem is bigger than one person can handle. She called the social workers and so forth. But it was just—and it was unfortunate, because it didn't have to be if our systems were better. And that's when you find that you need to—in order to make it better, you have to go to the head of the system and make them change it, which you can't do as you try to if you have a complicated enough life of your own.

ROSEBERRY: Well, let me ask if—changing topics just a little bit.

WILSON: Yes. Um-hm.

ROSEBERRY: Have you done any research?

WILSON: I have in the past. In medical school, I did my third year in the Endocrine Lab research with Dr. Lebovitz and Dr. Jerry Feldman, who just retired. Jerome Feldman just retired from here a couple, three years ago. And actually, it was really wonderful, and I was able to publish it in the *American Journal of Physiology* and present it at the American Federation for Clinical Research, Southern Section, and got the Student Research Award for bench research. Because I had a strong background in basic research with my honors—at UNC, I did an honors thesis in biochem for graduation with highest honors. And so you had to actually publish your thesis, print it all up and bind it, and it goes in the library, in the Chemistry Library. I'm sure nobody ever read it. And then when I was a GI fellow, I did research as well. When I joined the faculty at Michigan, I had intended to go on to the NIH, and I had gotten a clinical research fellowship there. But my husband didn't have a similar position in DC. So we had to, again, go where there were opportunities for both of us. And my position at Michigan was more clinical; I did try to do bench research, you know, sort of in my spare time. And I did publish one paper, some of the data—my data—in a paper with Dr. Jorge Gumucio, who was hepatology researcher there. But after that, I did not do any more bench research, because it just was not possible timewise. So I've done clinical studies—both prospective studies, primarily industry-funded studies—and then I've also done retrospective chart reviews. So that's been most of the research types of things that I've done, either associated with industry-funded drug studies or retrospective chart reviews, that type of thing. And that's what a lot of the clinical people do if you're not a clinical research person. Some of those studies can be very good starting points for further investigation, and that's kind of the idea, that you have a hypothesis and you test that in a retrospective manner. But it's not, obviously, controlled. So that may be the jumping-off point for people to then pursue the prospective controlled trial. I think one of the advantages that I've

had when I—even now, for new drugs and so forth, was that I did have a strong science background. Sometimes in medicine you question why on earth do you need that. But for me, reading about drugs and reading about studies—it's not difficult. And I tend to be able to get to that point that you have, to understand that particular sequence of events in order to understand why this step, this step, and this step occurs. And I think that's helpful. If it all looks like gibberish to you, then it's hard to learn that. And that's why I don't know foreign languages, cause, I mean a lot of verbal things don't come to me that way. But reading papers and so forth, then I can understand what they're doing, because of the science background. And so many things have changed over the last thirty years, that to try to keep up with medicine is a constant learning—. Because a lot of the genetic work, the sequencing, all those things are very new. They were doing sequencing—and actually I worked at Eli Lilly one summer on a summer internship when I was an undergrad—they were doing sequencing, but it was so tedious. It was nothing compared to what is being done now, and the rapidity with which you can do the studies. A lot of times the importance of being able to understand it is—sometimes people do things, and they report it, and it really is not. It doesn't add anything to our understanding. But it looks pretty glitzy. And I think being able to understand that—and what we also do for our fellows in trying to understand the significance of various things—I mean, I had one of the posters, and it sometimes is sort of deflating, because they said, Oh, this is statistically significant. But I said, "But it's not clinically significant." And that's always one of the caveats that you have when you're dealing with patients. If there's a two percent difference and you have a huge population, then it may be statistically significant. But unless it's a very major endpoint, like death or harm or whatever, then it's not going to be clinically significant. One of the trainees was talking about some prep. That we scored this a three, and we scored this—we had a scale of *x*, and we scored

this much at three and this much at four. And then when the final data emerged, it was like, well, this prep is better than that prep. But it was just this tiny difference and in part subjective. Where if you asked people five times whether this was different or the same, they probably couldn't tell you. So then it's statistically significant, but not clinically significant. You want to know other things about the dimensions of the analysis, and so. But it's kind of interesting, because we always deal with very different parameters when you're talking about medicine—in some areas. I'm sure that's not very interesting. (*laughs*)

ROSEBERRY: Well, have you enjoyed the education pieces, or the teaching?

WILSON: Oh, yes, yes. I really love the teaching. The only thing that I—the only regret I've had at Duke has been that I've done less teaching than I had previously. And part of that is due to the structure of the institution, the way things are set up. That really, for me, they have almost no mechanism—there's very little mechanism for teaching medical students, for instance, except in the clinical arena. When I was at Michigan, I, for instance, gave lectures to the first-year students, along with an eminent GI physiologist, Dr. Horace Davenport. It was a great treat. And then second-year students—I actually was the one to design their clinical GI lecture series. And it was, again, a really fun lecture. That I decided on the topics, I found the speakers I picked the questions from the questions that the lecturers submitted—and so forth, and I had an opportunity to change the course to make it more reasonable. Because some people had a tendency, when they were doing the clinical GI course, to talk about the things that they liked, as opposed to the information that was most important for the students. For instance, I remember them spending a great deal of time on Crohn's disease and ulcerative colitis and no time on acute diarrhea, which is much more common than these inflammatory bowel diseases. And so if you're a medical student, you needed to know about acute and chronic diarrhea and then chronic

disorders that might cause, you know, inflammatory bowel as one of the causes of those, as opposed to spending a huge amount of time on knowing all the nuances of inflammatory bowel disease. But as a gastroenterologist, you're more interested in that, especially if that's your major interest. So I had them sort of revamp their various lectures to come in more generally, to bring the students to common acute causes, common chronic causes. And then to give more information about less common topics, but not to spend an entire hour on a subset and no time on what is—the major causes of this particular disorder. So it was really kind of interesting doing that. Now, the time that I do some of that is with the American Board of Internal Medicine, the GI subspecialty exam. But that's very different than teaching medical students. When I first got here, I did do more medical school, medical student teaching, and it was really fascinating. I remember doing the CPCs [clinical pathologic conference]. But now they've tended to sort of have people who are GI research people do it, and they do a very good job. But it's not necessarily from its clinical standpoint, as it might be for the Duke students, because they're doing—I did the same curriculum that they did. And so it's really nice, in your first year, to have some clinical things done by a clinician—to sort of have you see where you're going, because they do a very intense academic program the first year. Very intense.

ROSEBERRY: So can I ask just, kind of, what, maybe your impact has been on Duke in your—?

WILSON: You know, you never know until it's all over. (*laughs*) And I mean, what I would hope that I have done would be in several arenas. I've never thought about that really. I guess one of the most gratifying recent recognitions that I had was that I was awarded the Trailblazers Award from the Student National Medical Association. It was really—for me, it was just incredibly moving. And my daughter presented it to me, which was even more moving. (*laughs*)

And it was a recognition that some of us had been involved in the institution when times were not as easy. That there were trials that we had to endure. And I think that also the fact that some of us were excellent students and excellent physicians—and therefore let it be known that these kinds of accomplishments can occur from both genders and all races. And I think that that would be one of the hallmarks. The other would be that women and minorities can and have made significant contributions to the university and the medical center, both from their clinical expertise—from their academic pursuits—and from their volunteerism. And the Student National Medical Association, I think, really exemplifies that, because the students have been very, very active. I mean, I talked to the superintendent of schools, and he actually was not aware of their program, and I made sure that he was aware of it. But it's a level of activism and volunteerism that we don't see a lot within the professional schools, or that's not recognized within the professional schools. I'm sure it's going on in other professional schools as well. The law students and business students helping the community and reaching out to all people to really—but it's really—. So that's one we know that we have been here, that we've contributed. The other thing that I'd like to leave is the feeling that the university and the medical school can do more, because I don't think that they have reached as deep and as far as they can—to make sure that in the future, that everyone has equal access to the education. That it can't just be because there are African-Americans and other minorities pushing. That it has to be a part of the integral structure of the university and the medical school. I have said before in the American Gastroenterological Association, it is my goal was that we *not* have to have a committee for underrepresented minorities, that we not have to have a committee for women; that people would recognize—that the administration and persons in authority and power would recognize the need for diversity. And that they would not look to the gender or the race or other characteristics of

people when they were choosing whom they admit. And I know—and I'm not naïve to not realize that there's always a subjective character, a subjective component to any kind of selection. And that's one of the things that I've told—I've always impressed on students is that there always is a subjective component. People try not to, and they make all kinds of scales with numbers and so forth. But if it's based on subjectiveness, then it's subjective. And to try to recognize that, and to try to determine, you know, where that's going to fit in, so that you can counter it in any way that you can. And that you—but the bottom line is that I think the institution has an obligation to people to make sure that they are fair and nondiscriminatory. And if it does occur—to correct it and to just not allow it to be. And it's a difficult situation. Here at Duke I have applauded Dr. Sandy Williams, the past dean, for his efforts, because—and I think he did a fantastic job in trying to correct the past omissions in getting more women and minorities in levels—higher levels—in the university. Because if you wait for the time, if you don't take an active, proactive stance, then things tend to act in a slower fashion. Because we can just continue as we've always, and nothing much will change. So I'm really—I'm hopeful for the future. I'm somewhat disappointed, because I think that our accomplishments and our strides should have been greater. That's just my way of looking at things, because I was telling one of my kids, when my husband and I first got married—we got married in 1969—our marriage was actually illegal in North Carolina, and a lot of people did not realize that. But it was illegal in North Carolina, the law was on the books that you cannot have biracial marriages. So it was illegal. It had been challenged in the federal—in the courts—in 1967. But the law was not removed from the book of North Carolina until 1970, '73, something like that, because North Carolina was slow in changing the law. Because even though it had been challenged in federal court, it had been overthrown in Virginia—*Love v. the United States* or the State of Virginia,

whatever. But I had felt that things would have changed more in this country. And we've been married thirty-eight years. But they haven't changed as much. But they're changing faster now. It's like women in medical school—it was a slow number up, and then it kind of bounced around, and then it just took off. For underrepresented minorities, the numbers have not gone up at that rate. And we know part of the problem. And Duke, to its credit, has been addressing that through some of its people, to reach down to middle school and high school, and actually middle school, and it's probably even lower. My contention—and, actually, I had one educator support my contention—it's algebra. Algebra is the first time that students are asked to do something totally abstract. And a lot of schools—Durham Academy was one of them—some kids can get to do algebra even earlier, because they understand abstract sorts of things—but a lot of students, it takes a maturity and previous education to do it. And sometimes it takes some effort to try to teach kids to do things that are abstract. You know, $2x + y$, that's not something you can line up on the table. So it's actually way back in middle school. Because if you don't do algebra when you get to high school, then you can't do a lot of other courses. So if you don't get the math and the science early, then you can't go on to do other things. And though they hardly ever—they test algebra on the SATs and so forth, they don't test calculus, really. So it's really important that now—and that's why the program that the undergraduates were doing with the young girls—and there's a companion program for young boys—that they try to keep those kids engaged in education, so that they can get those points across. You've got to have tutors. Because a lot of kids don't have parents who can help them. I've actually found a problem that had the wrong answer in the algebra textbook, just because I have a background in math from college. Because one of my children—I can't remember which one—was so frustrated, they couldn't get the answer. Then I said, you know, I went through it, and I thought, Oh, crap! Then

I said, “Give me the book,” and I read it. And I said, “Well, they didn’t give you enough information. You can’t get the answer.” (*laughs*) It’s, like, impossible. But you know, most kids don’t know that books can be wrong and would think, I’m too dumb to get this, or something, and then just get frustrated. In this case, my child back to the teacher and found that. there had been an addendum to the book that said that that question was a misprint. And so reaching down to these children in the middle school—and Duke’s planning that kind of program is important. So there’s supposed to be a school attached to Duke who will send Duke undergrads to tutor kids. So we have all these young people here who are brilliant, sitting right next door to young people who need help. And the students have a lot of extra time that they can spend (so they don’t they themselves get into trouble). The programs that they’ve set up have been fantastic. But it’s also to make sure that there are people that look like the kids going out there, too, and not just middle-class Caucasian students.

ROSEBERRY: Well, Dr. Wilson, I know that our time is reaching an end.

WILSON: Oh, it’s up! That was fun.

ROSEBERRY: But can I ask one quick question?

WILSON: Sure.

ROSEBERRY: Just to give you a chance to name some other women who might be people that I should look at, or people who—

WILSON: Yes. Well, as I said, Brenda Armstrong, because I think she brings an incredible amount of experience and knowledge. She’s a native North Carolinian, from Rocky Mount. Her dad was a doctor, which is different from me, because my dad was a plasterer. I come from a family where of the seven kids, I’m actually the only person that graduated college. My mother did graduate college, going back. My dad has an eighth-grade education but was probably one of

the most brilliant people I ever knew. He would read law books, newspapers, all kinds of things, and have debates with lawyers. And if he'd gone to college, he would have been a force to contend with. And you said you'd talked to Jean [Spaulding]. Jean is associated with one of the most affluent families and influential families in the area. Has certainly a different take. So you've got women from all kinds of backgrounds. Maureen Cullins is in charge of the summer program—she's a PhD, originally from the university side. She hasn't been at Duke a very long time, but I think has crossed several areas within Duke, and I think would be a fantastic person to talk to about, you know, the Duke experience. Of course, Lois Pounds. Have you spoken with her?

ROSEBERRY: I have not.

WILSON: Lois was here in Pediatrics and then came back later. But she has experience from other universities as well as Duke, in the past, and with medical students. She's really fantastic, as well. I don't know how many—there are some younger women that have more—Michelle Winn—have you spoken? Michelle Winn is—she may get a Nobel Prize, I think. Michelle is also a native North Carolinian, from Jacksonville area, I believe. She went to the School of Science and Math in the early years, went to undergrad at UNC, medical school at East Carolina, and house staff training here, in nephrology. And she just became one of the—the new award for Duke research pioneers. She just discovered a gene associated with a renal disorder. She would be a person I would definitely interview. She has a perspective, I think, that would be very different from mine, another person growing up in the South here and so forth. And is really a fantastic person. And she's pretty young. I think she's less than forty, so. But has just had a dynamic research career. Originally coming here as a Med/Psych resident. And when we saw her in medicine, people just said, Oh, you've come to medicine! Which, not to say—I'm

sure she would have been a fantastic psychiatrist, as well. But has just made such contributions in bench research. And she's in the Department of Medicine, Nephrology. But definitely because there have been so few women that have been—African-American or otherwise—that have been involved in research here at Duke. So she's a major contributor to science. Her article was published in *Science*. Let me just think—Oh, Dr. Harrell, Liz Harrell, PhD in microbiology and clinical microbiology. Now she's been here a long time. Her husband is a family physician in Durham. She did a sabbatical in my husband's lab. And she is really another fantastic person. And she has been, in the micro—in the clinical micro lab—and has done major research, as well. So she's, again, an excellent person to talk to. And she's very articulate, excellent. Would give you a perspective—I'm not sure how many years she's been here, but she was here when we came back in '86, so it's got to be, you know, over twenty years. Hmm, let me just think a minute. A lot of women here have come very recently. And so I don't know if are you looking for more long-term?

ROSEBERRY: At the moment. But I plan to kind—

WILSON: Right, right.

ROSEBERRY: —try to expand and interview some women—

WILSON: Because I think that starting with some of the ones that have been here longer, like Brenda and Liz Harrell. Michelle Winn, because she's been in North Carolina longer, and the School of Science and Math put them close to—I don't know if she did her mentorship when she was in high school here or not. But we have that point of reference for some people, because they actually when they were high school students at Science and Math, they did research here at Duke, and then ultimately end up here. But I think Michelle, because she trained here and so forth, her—the number of years she's been here has been longer. Let me just think. I can't—I

mean, there must be others. You said Dr. [Shirley] Osterhout, so she's a great one. I'm just thinking, Department of Medicine. Oh, Nancy Allen, because Nancy has been chair of Academic Council, and she's from Virginia originally. But she's been here a while, because she did her training here. And she's done a lot of things over to the university, interactions between the medical center and the university. Then also the other thing Nancy does that's interesting is that she does outreach clinics in Roxboro and places like that. So that's that whole interaction of Duke with the community and outlying communities. So just thinking of people that bring different perspectives to you regarding an oral history. I think that—yes. And I think that all of those women would have very different perspectives. Because somebody like Michelle, for the research, and, you know, the North Carolinian. Brenda, again North Carolinian, but the university. The community with [Durham] Striders. The university as a faculty person living in the dorm, and there are not many of those. And then medical school admissions. And then Brenda is a pediatric cardiologist. So she's one that you absolutely—if you only had to do one more interview, I think an interview with her would be a critical interview. She's gotten all kinds of awards—Distinguished Faculty, Distinguished Alum, and so forth and so on—because she's a very articulate person who's contributed a lot to the university. I mean, I think she tends to have a rather giving life. She's a wonderful person. But it's been interesting here. I probably won't go anywhere else. I've had opportunities to go to other institutions since I've been here, but I haven't, and I probably won't. But they shouldn't hear that. *(laughter)* But it's been really fascinating. Anything else?

ROSEBERRY: No.

WILSON: Okay.

ROSEBERRY: Thank you very much, Dr. Wilson.

WILSON: Okay. Actually, I have a—I think I have a brief bio that's somewhere online for the medical school which is like a—I can E-mail you. Did I E-mail you a CV?

ROSEBERRY: No.

WILSON: Okay. Well, let me E-mail you a CV. And I did, like, a bio sketch thing for them, which is more chatty. And I'll E-mail you a recent CV.

ROSEBERRY: Great. Is there anything that I should have asked you that I didn't ask you, or—I don't want to take up too much of your time. I'm sure that you—

WILSON: No, I don't think so.

ROSEBERRY: Okay.

WILSON: Well, I think, for me, a lot of inspiration to continue in medicine—as people talk about mentors and so forth, and one of the points I've always made—is that if you can't find mentors like you, you have to take a little bit from a lot of different people. And for me, a lot of the mentorship—the inspiration—came from women. My mother, who has seven kids—and ultimately graduated from college when I was thirteen—and worked with seven kids. My grandmother, who worked outside the home, with ten kids, who was a sharecropper's wife. And she was a really hardworking lady and very, very to the point. My Grandma Maggie, who spent fifty-five years working for a family in Raleigh, and the kids all felt that she was like their mother—and had one son, whom her mother took care of so she could take care of somebody else's kids. And then the nuns, who were incredibly giving and hardworking. Again, a lot of women who were very organized. When I was a candy striper over at Wake Med, they sort of couldn't find a place for me, for whatever reason, except in sterile processing. (*laughs*) But those ladies were awesome. They knew that equipment like—the surgeons probably didn't know, and they knew everything. They would tell me all the things and what it was used for, the

Kelleys, the this, the that. And, you know, what surgeries were being done. And I learned a huge amount from them, not even going up on the floors or anyplace else. It was almost like—it was less of a candy striper than a kind of introduction-to-medicine-type-thing, which was really kind of interesting. And as I always said, I always debated whether it was harder being the only woman intern or resident, or being the only woman paperboy. (*laughs*) Girl paperboy. Because I remember when I went to the party—I always wore jeans when I was selling papers, I was like ten, eleven—and I went to the party, and I wore a dress. "She's a girl!" Because I was very tall, and I just always wore jeans and a hat. So they didn't know that the girl selling at that market—the paperboy at that market was really a girl. But you made a whole lot more money selling papers than babysitting back then. And so that's why I did it, to save it. But it's been interesting. Yeah. But for our kids, we basically have told them that they could you can try a whole lot of different things in order to get to the success. That you don't have to follow the path that everybody else has taken. But Drs. Wendell Rosse and Laszlo were just fantastic when I was a medical student. Dr. Lebovitz, for his research and support. And then when I was a house officer, there was a guy named Marshall Wolf at the Brigham who was just really fantastic. His wife was a doctor. And he was very supportive of the women in the program. Of course, he only had three, (he was program director) women in the program. And Eugene Braunwald, is the one who selected our group, and selected three Dukies. But it was really great. When I came here, Nancy Stead was my big sister—Stead's daughter—she and one of the other ones, they were so funny. When I was doing physical diagnosis, they gave me extra. Like they said, Okay, we're going to take you around to see—listen to this murmur, listen to that murmur. (*laughs*) It was really amazing, because it was kind of like you can come and we've found this patient, that patient. It was really great. Because other people whom they had paired us with

(different upper-level students) weren't doing that kind of thing. And so I'm thinking, Oh, this is great. I ran into her just before her dad died, when he got an award. It was fantastic, back when you're a medical student, when you're just trying to get started. It was really great. Great to have people take an interest. So there were some really good times. But I mean, the hospital was definitely coming out of a segregation period, and it was still truly segregated, because on the wards were mostly African-American patients, and none of the private patients were black at that time. I mean, unlike now. When they built the new hospital, I think the best things they did was make all the rooms private rooms, pretty much. And in that sense, there was an equality there—that you didn't have wards—or whatever—then. But it's been interesting, changing. Where are you from?

ROSEBERRY: I'm originally from Nashville.

WILSON: Nashville—

ROSEBERRY: Tennessee.

WILSON: There's a Nashville in North Carolina, too. It's really tiny.

ROSEBERRY: Right. Sometimes I have to clarify that.

WILSON: Yes. Oh, great. Did you go to Vanderbilt?

ROSEBERRY: No, actually I went to Wheaton, in Illinois.

WILSON: Oh, Wheaton, yes, yes.

ROSEBERRY: And then Baylor for my graduate work.

WILSON: Oh, great!

ROSEBERRY: In Waco, Texas.

WILSON: Oh, at Baylor. And what was your graduate work in, history?

ROSEBERRY: It was American Studies, so it was history and literature. And then they have an Institute for Oral History there.

WILSON: Oh, okay. Fantastic.

ROSEBERRY: Yes.

WILSON: Nora, our oldest, was a double major—in environmental studies and anthropology—and went onto medical school. Which means she went back and did all the medical school science stuff. And our son was a science major. But our youngest daughter, Sarah, was a double major in drama and psychology at Stanford, and she actually did her honors thesis in drama, which she researched in the archives of UNC.

ROSEBERRY: Oh, how nice!

WILSON: Yes. She had looked at blackface in amateur productions in the fifties and sixties. Because in drama, they talk about blackface being done in the twenties, and that's the popular belief. But she was going through a lot of the fraternity productions and so forth. I think—what did she entitle it? "Not Just a Boy?" Or something like that. Because it was—it starts off with this picture of some—some guy in blackface—pretending to be a boy, you know.

ROSEBERRY: Interesting.

WILSON: Anyway. So she's delved into archives, but not oral history. That's more recent, isn't it?

ROSEBERRY: It is.

WILSON: Yes.

ROSEBERRY: It's become a very popular field in the last several decades.

WILSON: Um-hm. Will we be able to preserve it better than we did for the past?

ROSEBERRY: I think so. And definitely, you know—I mean, for—the sound quality is better. And so that helps, too, to preserve. And we know more about how to—how long things will last—and how to—.

WILSON: Well, I guess now with the digital you can like disperse it to the world.

ROSEBERRY: You can do whatever you want. That's right.

WILSON: Well, yes, I mean, it can be stored in multiple places.

ROSEBERRY: Right.

WILSON: So that will be part of it, because you won't just have one recording in the National Archives or something.

ROSEBERRY: Right.

WILSON: Because looking—listening to some of those records and some of the music, it's such a—you just get the feeling, oh, my God, this was just so great. I wish I could like have heard that without all the squeaky scratchiness. I guess some of the people are trying to fix those.

ROSEBERRY: I think so.

WILSON: Yes.

ROSEBERRY: Um-hm.

WILSON: Yes. Because I listen to NPR [National Public Radio] a lot, and they'll have some of the old recordings of this, that, or the other person— That's incredible. Well, good luck to you.

ROSEBERRY: Well, thank you so much, Dr. Wilson.

(*end of interview*)