INTERVIEWEE: Dr. Charles Hammond
INTERVIEWER: Jessica Roseberry
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PLACE: Dr. Hammond's Office in Baker House

HAMMOND INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. Charles Hammond. He's the E.C. Hamblen Professor and chair emeritus of the Department of Obstetrics and Gynecology at the Duke University Medical Center. It's June 2, 2004, and we're here in his office in Baker House. Thank you very much, Sir, for agreeing to be interviewed today. I appreciate that.

DR. CHARLES HAMMOND: Thank you. I'm delighted to do it. I may be the last living person that remembers all of the generations of faculty in this department and spans, really, the leadership groupings that have occurred in the department. The department was formed in 1930 when the medical school opened. And the original chair chosen was Dr. Bayard Carter, F. Bayard Carter, irreverently called "Nick" by many people who knew him, for a fictional detective in those days. He was an amazing guy. He was a Rhodes Scholar, a Golden Gloves boxer, and a wonderful obstetrician-gynecologist. He came to Duke from, as I remember it, the University of Virginia, where he had only been a short interval of time, and he actually sent Dr. Robert Ross down ahead of him, who actually really opened the department but wasn't the first chairman. Dr. Ross stayed until the early 1950s when the UNC school was made a four-year school. And he became its first chair. Other faculty that were here with Dr. Carter were Walter Thomas, who did gynecology and oncology; Ed Hamblen, who was one of the first reproductive endocrinologists in the United States; Leonard Palumbo, who was a surgeon and gyn oncologist before his time; Robert Creadick, who was a generalist; Violet

Turner, who was involved in infertility; and a PhD named Kenneth Cuyler, who was a cytologist and helped put the Pap smear on the map, because it was the very early days of Pap smears at that time. Finally there was a guy named C.P. Jones, who had a master's and who was going to medical school but got tuberculosis and so dropped out and was in a sanatorium for a while. Never went to med school but came here with his master's as a bacteriologist. And he and Dr. Carter did a lot of work on identifying the bacterial species that were involved in pelvic infections, which in that day and time were huge problems for women. Dr. Carter remained the chairman until 1964, so he spanned thirty-four years, which is an amazing (*laughing*) interval of time. And he was followed by Dr. Roy Parker, who was the chairman from 1964 until 1980. The faculty that he recruited—and there are some overlaps in each of these groupings between one chair and the next. Well, Dr. Charles Peete, who was an absolutely superb gyn surgeon but also did general obstetrics; Walter Cherny; Harry Johnson—and the four of them, Parker, Peete, Cherny, and Johnson were the general ob-gyn group for the medical center. Roy Parker also recruited Stan Gall, who was a reproductive immunologist; John Steege, who was interested in sexuality and ultimately went on to become interested in endoscopic surgery; Bob Brame, who was a gynecologist primarily; Don Christian, who was a reproductive endocrinologist; Bill Creasman, a gyn oncologist; George Wilbanks was a gyn oncologist; Carlyle Crenshaw, who was a maternal-fetal medicine specialist, as was Marcus Pupkin; David Nagey had started as a PhD in physiology. He also had Nels Anderson, who was a muscle physiologist PhD; Dave Schomberg, who was a biochemistry PhD; and Louise Kauffman, who worked with Dr. Cuyler in the Pap smear arena along the way. I'm also sure I'm going to leave some names off, but I've tried to double-check the list. I became chairman in 1980 and was chairman until spring of 2002. And individuals

that I recruited who worked with me included Roger Young, who was an MD/PhD basic science investigator; Stan Filip who headed our—the ultimate development of our three general ob-gyn groups; Herb Wiebe, who was a reproductive endocrine person as was Arthur Haney; Al [Allen] Killam, who was a maternal-fetal medicine specialist. Haney went on to become head of the Endocrine Division. And Killam for a while headed Maternal-Fetal [Medicine] Division, as does Phillip Heine now, who is the current chief of Maternal-Fetal Medicine here. Nick [Charles] Livengood joined as an individual with real strengths in pelvic infectious disease. Jim Holman, Steve London, and Kevin Bachus, who were young faculty in Reproductive Endocrine about the time of development of in vitro fertilization. Subsequent to them, David Walmer and Grace Couchman and Tom Price, who have worked in that area. Al [Allen] Addison sort of crosses between Roy Parker and myself and just retired last week. He had been head of the Gyn Division, was an absolutely special gynecological surgeon and one of the people that helped launch the whole specialty area of urogynecology and urologic problems in women. And more recently, Allison Weidner, who's head of that Urogynecology Division. Cindy Amundsen is also in that group. And Evan Myers, who is head of a new Division of Reproductive Research, which is really interested in outcomes research, clinical research. Elizabeth Livingston, Leo Brancazio, Andra James, Martha Decker, and Amy Murtha, who are faculty in the Maternal-Fetal Medicine, have added a huge amount. Joanne Piscitelli, who is a generalist; Dan Clarke-Pearson, who is the current chief of Gyn Oncology; and joined by John Soper and Andy Berchuck, Angela Secord, and Laura Havrilsky, all in that same division. Tracy Gaudet, who came to Duke to start the Integrative Medicine Program but is also appointed in our department. Dale Bearman, who is a gynecologist. Rick [Richard] Bump, who was here and was head of Urogynecology, the original head. Diana Dell, who was

an individual that was a generalist and then went back and took a residency in psychiatry. She now sits on the fence in psyche [*spirit*] and soma [*body*] in women's gynecology, particularly as it relates to the dysfunctional issues that cross both areas. Arnie [Arnold] Grandis, a reproduct—I'm sorry, a maternal-fetal medicine person; Bill Herbert, who was the head of Maternal-Fetal Medicine went on to become the chair at Charlottesville. Claude Hughes, an MD/PhD, who primarily is a basic scientist now in the research triangle at Quintiles; Gus Rodriguez in gyn oncology; Andrea Lukes in gynecology; Jeff Andrews, a generalist who went on to work in computer education for the institution; and Gerry [Gerard] Nahum, a generalist who was the director of student education for a number of years. So there was a diverse group. There also were two more PhDs, Lee Tyrey and Pat [Patricia] Saling, along with a cadre of individuals that were in our arm of our faculty in Fayetteville, which I might add, Roy Parker had started, but I supported. Warren Patow, Steve Gooding, and then David Richardson. David now is here, although he was at Fayetteville. Haywood Brown became the fourth chair in the spring of 2002 and continues in that role. And I'll let him speak for himself (*Roseberry laughs*) at some future date. There were a number of interesting transitions that occurred or developments during those years. As far as facilities are concerned, we started with a single delivery room and a couple of labor rooms in what is now Duke Clinic, which is on the fourth floor of what was then Duke Hospital. I might add, through the years I had two children born in that delivery room. One delivered by Charlie Peete and one by Harry Johnson. They must have dropped both of them on their heads at some time during their life. (*Roseberry laughs*) But it was a very close-knit, family feel to this department. The caring for each other was very, very striking and one of the things that attracted me to the department. And it continued from Carter's chairmanship through Roy Parker's. We didn't all get along all

the time, but we all cared about each other, and everybody seemed to care a lot about patients and about education and about research. And it was a fun, good place to be. We then moved in 19—it must have been '67—to the new main entrance building where a new obstetrical suite had been developed, and it was the Carter Suite. And Dr. Carter actually did the first delivery in that suite, and it was the last set of children he delivered, because it was a set of twins. I was a resident then. We were quite concerned he might drop one on its head, because he hadn't delivered a baby in some years at that point. They're really pretty slippery. But he didn't. That was a really wonderful unit and served us very well until 1987, at which time we moved to the north hospital into what has turned out to be an absolutely special facility that we had a chance to build. It was an add-on to Duke North Hospital, as we did not move when everybody else moved. We and Psychiatry were left in the south hospital, because we had the newest facilities. And I always laughed; I said, after I became chairman, "We were only a mile away from a major teaching hospital." So it was different, because we didn't have a blood bank, and we didn't have labs; we didn't have a lot of things that the north hospital had. We could get them, but it was always slow and painful. But it was a good facility. And particularly good while everybody was still in Duke South before the majority of people moved to North.

ROSEBERRY: Did that present a problem?

HAMMOND: It was a problem. And getting consultants over. There were a myriad of things that made it problematic to be in South. And candidly I finally had a seizure one day and said, "Either move me to the north hospital or fire me." And that's the only time I ever threatened to quit as the chairman; but I was sincere, because we really felt we were in a second-rate situation at that point. And fortunately they moved us, so I didn't have to go look for work

elsewhere. But that's turned out, as I said, to be a wonderful facility. It now has all labor, delivery, postpartum in one room. It's really a very fine unit with a very good intensive nursery unit that's there. Things have sort of come along through the years. Dr. Parker developed an outreach program that was called "Outrider." And the neonatal or childhood mortality in the counties north of us between Durham and the North Carolina-Virginia line was really unacceptable. The area was generally poor. It was usually minority. And by minority I mean African American, because there were not many Hispanic people here at that time.

ROSEBERRY: When was this? I'm sorry.

HAMMOND: I'm sorry?

ROSEBERRY: When was this?

HAMMOND: This was in the '60s, '50s. I guess it was probably about the start of—it started about 1960. And it goes on today, though diminished in volume. And patients had poor transportation. And it was very hard for them to get here, though the general trend around this state through the '40s, '30s—'40s, and '50s was there were relatively few physicians in rural areas. And so to get care, they had to come to the few places that existed that could provide it. Duke Hospital was one of those, including its clinics. But at any rate, these county clinics were set up with state funding. And residents began to go out and see patients in those clinics, large numbers of patients, and they were spread like a chain—a bead of—chain across that section of North Carolina. And you would perhaps work in two towns in a day—a morning, and an afternoon in a different one—and see dozens and dozens of patients. If they needed hospitalization or surgery or delivery, they came here. And we had transport systems in place to help move them. The neonatal mortality, which is a convenient figure to document for

health care delivery, improved fairly dramatically over those years in those areas. So quality of care was clearly going up. It's been interesting as more and more of these patients are funded by Medicaid or something else and as there are more physicians practicing in those communities—a number of whom we trained, doing obstetrics and gynecology, a lot of those patients are now staying home. We still run clinics in some of the towns, but we are not seeing the volume we were seeing at that time. And there are choices for patients among local physicians in those communities. Somewhere around 1960 we had been sending a resident down to Concord, North Carolina who worked there as an out-rotation taking care of underfunded patients under the supervision of three or four obstetricians who practiced in Concord and trained here: Vince Arey and John Ashe and so forth. But because of volumes and issues about the educational opportunities for residents, they were moved to Fayetteville, North Carolina as they shut down the Concord program. And from the early ’70s until now, we have had a fairly strong arm of our department in Fayetteville. It's been headed by three or four individuals. Warren Patow was probably the longest serving head, followed by Steve [Stephen] Gooding; David Richardson, who was a faculty member there and subsequently moved here and was on the faculty here. And we now have three residents down there, a second-, third- and fourth-year. And that has been a wonderful adjunct for a volume of really sick patients, both inpatient and outpatient. So the Fayetteville program has been an important part of our education and outreach. There's been a real concern about trying to provide care for underserved populations. And doing for the right reasons, but also they provide a wonderful source of patients for residents to be involved in in the care of and under the supervision of faculty, clearly not practicing independently at that point. We had a similar arrangement in Durham in the ’60s practicing out of the County Health Department downtown

but also at Lincoln Hospital. Lincoln Hospital was a black hospital. At that time, Durham, North Carolina had two hospitals. Lincoln, which was for the black members of the community and Watts, which was for the white members of the community. Never the twain would cross. Both blacks and whites came to Duke, but at Duke were segregated into all black male wards, all black female wards, all white male and female wards. And then to even make it worse, there was private and then staff. It was an amazing time, and the facilities were large wards that were separated by curtains rather than individual or even semiprivate rooms. And there was no air conditioning. So it was a long summer. (*Roseberry laughs*) And I was a medical student at Duke, graduated in 1961 and a resident at Duke from '61 through 1969, though I was away for two years at the National Institutes of Health and came back in '66 and finished and then stayed on the faculty since. So I really did live through all of that time. It was interesting, because there was never any real doubt in the ’60s that it was appropriate to integrate our services and our house staff and our students. And the only real question was how to do it in a way that was effective and sensitive to both patients and learners. And it was not all smooth, but it was smoother than you might expect. And I thought the faculty were very careful and thoughtful in recruiting very strong minority members as trainees and students. And then they defended them fully, completely and supported them totally. And there was never any looking back over our shoulder about, Was that a right decision? It was, How did we do it in a way that was effective? We sent more than a few patients away who would not be seen by a black physician or a black trainee. We made arrangements for them in other facilities, but we did not cut off our trainees from our supervision and our patients without there being other reasons than their ethic derivation.

ROSEBERRY: Now, is this common to the medical center in general?

HAMMOND: Yes. Yes, it was. And the statements that I made were medical center-wide, because I went from the Department of Surgery to the Department of Ob-Gyn, and I did a lot of consulting for other services. So I am very comfortable that was pretty accurate for everybody. I was very proud of Duke at the time, and I had grown up in the Deep South in an era of segregation. And I was very proud of how effectively it was brought in here to integrate the groups. And it was clearly time that that be done.

ROSEBERRY: What was the change in the medical center as they began to think about integrating—from—was it because of outside stirrings?

HAMMOND: I think outside pressures were clearly very important. I also would like to think that a lot of us had decided it was wrong. I remember thinking, The first time I might be told that my child couldn't drink from the water fountain in a gasoline station or somewhere, I'd probably be back in the dark of night with a stick of dynamite, and I'd probably be dead now, because somebody would have probably shot me. It was simply wrong. It was not separate but equal. It was separate and unequal. And I think a lot of people, notably caring southern people, felt it was wrong. It didn't happen overnight. It didn't happen without some bumps in the road, but it was a steady and purposeful change, as I've said, that I was very proud of to be involved in. And it was the right thing to do, clearly. We had other transitions occurring in the department. The resident education has always been a very, very strong part of our departmental heritage. And it is amazing the number of graduates who have gone on to faculty positions; that's not to say faculty positions are better than going into practice. It's been about fifty-fifty over the course of the years. Half had gone into academic careers, about half had gone into practice. About fifty or more have ultimately gone on and become department chairs in other institutions or here, which is, again, not necessarily the center point on

achievement, but it's one benchmark of that. And a number of the people that I had named as we were talking are included in that group who ultimately also wound up as chairs elsewhere. But that's a large number for the number who trained as house staff, which must be about 300 now, something like that through the years. We've gone from when I trained, four at a level to—currently there's seven residents at a level. And we've gone from programs that were as long as six and seven years down to programs that are four years long. And that's the current requirement for the residents here. This sense of family has carried on to the formation in 1952, I think it was, of a group called the Carter Club. And the Carter Club was named for the first chair and was former residents or faculty who had trained at Duke or had been at Duke who met yearly for education and social rejuvenation. And through the years went on to endow three chairs in the department. They continue to meet annually. And usually it's two to three years they meet away in somebody's community and the next year they meet here. But that support for the department has been amazing. I sat down and calculated monetarily; it is close to $3 million that they've funded over the years out of their own pocket to sustain, help the department have opportunities to do things. That has happened in very few other medical universities around the country. So that that family sense persisted, and their continuing desire to be related to the department and its faculty has been a very strong one. Another area that developed, starting in about the 1970s, and Roy Parker had a fair hand in it, was the development of subspecialty fellowships within obstetrics and gynecology. Originally there were three: maternal-fetal medicine or high-risk obstetrics; gynecologic oncology dealing with cancer; and reproductive endocrinology and infertility. Over the last decade a fourth has begun to develop but is not yet fully approved by the American Board of Obstetrics and Gynecology, and that's Urogynecology. And I predict it will be approved in the near future

and will be the fourth subspecialty. Nationally about seven to eight percent of our graduates wind up as subspecialists. That's national figures. Here I think it's probably been a little higher than that. These programs which initially started at one and two years now all are three-year programs after a four-year residency. And they are designed to help train individuals to be faculty members in that discipline, to do research, to teach and to practice but at an elevated level of complexity compared to the generalist who is the person who has finished four years of a standard residency. We felt that three additional years of training would be a bit of a waste on somebody who was going to just practice the clinical subspecialty, because a fair bit of those three years are aimed at teaching research skills and educational skills and a lot of those things. We're probably one of only seven or eight departments in the United States that have divisions in all four subspecialty areas and have approved fellowships in all four areas. And the American Board approves fellowships after site visits and applications and things. It has added huge strength to the department, because these are very bright, capable people. It also is a wonderful breeding ground for young faculty. And I think each of the—Roy did and I have certainly done a fair bit of recruiting out of the fellowship pool as we needed young faculty in different areas. It was about the 1960s that the department began to structure itself in divisions. And those divisions lined up just as the subspecialists I just finished naming with urogynecology being the last and occurring only about five or six or seven years ago. But it allows you to bring in a division chief, which gives you a senior strength in the department. Division staff, so there will be three, four, five, six or more faculty members within the division; and they eat, breathe and sleep that discipline. There also have been three general ob-gyn groups in the department. It started with one back in the ’60s, but I was able to take it to three when we were trying to purchase Durham

Regional Hospital as an institution. And so we actually have three groups, each with six generalist obstetrician-gynecologists and two practicing at Durham Regional and one here. These include the Harris-Smith practice and Durham ob-gyn. That has added again the large volume of patient material that our learners and clinical teachers have access to and our faculty have had opportunities to be involved in, in appropriately sanctioned and approved research protocols. And the department has gone on to become of the larger departments in the United States by virtue of having those individuals as extra faculty, if you will, in addition to just the subspecialists who are sort of the hard-core academic people in the department. It's been an interesting involvement of basic scientists in the department since it was formed when Ken Cuyler started—Ken and Louise and C.P. Jones were involved in that first generation with Dr. Carter; Nels Anderson, the muscle physiologist; and Dave Schomberg, the biochemist. And then I added Lee Tyrey, who was a neuroendocrine person; and Pat Saling, who was interested in gamete physiology. But all of these people have worked in the department usually hand in glove with people from the clinical side and basic science— (*tape ends abruptly*)

(*tape 1, side 1 ends; tape 1, side 2 begins*)

HAMMOND: —steering the process. (*laughter*) Another project that really got started somewhere around the time Roy Parker and I overlapped. There was a series of subspecialty clinics that were being run about fifty miles from Durham. And they were in places like Concord and Pinehurst, Dunn, Greensboro, Raleigh. The goal was to send subspecialists out to seek consultations for practitioners in those communities with subspecialty problems. And so we would go out and see patients and in turn send them back to the referring physician. But often if there was enough complexity, they wound up here. And so we used them as intermediate points that were easier in access for patients—and we're now talking private

patients—but also were opportunities to continue to feed subspecialty-level patients back into the mother ship, if you will. That has grown. We now have subspecialty clinics in oncology, maternal fetal, endocrine, and urogynecology in Raleigh and in Greensboro. They have onc[ology] clinics in Southern Pines, and we have all four in Concord. We have all four in Fayetteville. And this is in addition to the resident outrider service that runs in the northeastern area. When I say resident, that's an underfunded patient. Again, it's always residents supervised by the faculty. But those clinics have been very valuable. We opened the maternal-fetal medicine consultation and diagnostic unit in Raleigh about four years ago that is doing by far the lion's share of that very complex work in Raleigh, which is the biggest growing area in the Triangle. I think the institution's been a little bit like the dog who chased the fire truck. What's he going to do when he caught it? We caught Raleigh Community Hospital as part of the expansion to health system. And yet Raleigh, while it's only twenty-five miles away with I-40 and US 70, that's a hard twenty-five miles. And so we have been trying as an institution to develop appropriate programs and clinics and other things there, but it has not been easy because of that distance and because your faculty does not particularly want to live in Raleigh. They joined the Duke faculty because they wanted to be over here. But it is now getting off the ground in a better way, and I'm encouraged that we will begin to really tap into the Raleigh population. Though again, not many of us have great interest in doing absolutely routine, general things beyond the three groups that we have, which are very helpful in our education processes. But I think outreach has been an important part of this department since way back, way back yonder. I mentioned research, and the department's faculty have done research since the department was opened. Dr. Carter and his group certainly laid the groundwork for the management of pelvic infections, which were rampant at

that time. Usually started by sexually transmitted diseases like gonorrhea but then usually being superinfected with mixed flora, anaerobic and aerobic. And antibiotics were really very poor at that point, and surgery was a mainstay in the management for those patients. Sounds a little crude now in light of having very good antibiotics, but it was life saving in those times. Dr. Carter and his group were also interested in gyn cancer and developed a fair number of the early surgical techniques to advance the survival of those patients, particularly patients with cancer of the cervix. Roy Parker was a gyn oncologist before there were gyn oncologists. And gyn cancer was certainly one of his major interests. Again remember, this was the pre-subspecialty era. Ed Hamblen then was one of Dr. Carter's early recruits, was a generalist and a surgeon, but he was so difficult in the operating room, they made him quit operating. And that's a true story.

ROSEBERRY: Mean to the patients?

HAMMOND: No, he was mean to everybody around him. Intolerable. So he decided to become a reproductive endocrinologist and was one of the first in the United States and came within an inch of being recognized as the father of the birth control pill. He did a lot of the early work but never quite put it all together as [Gregory] Pincus and [John] Rock did. But certainly Ed Hamblen contributed a huge amount to our understanding of reproductive endocrinology. Once again, before it was a subspecialty or generally recognized as such. There certainly were other people in Roy's tenure who contributed. Stan Gall, as I say, was an early reproductive immunologist, which was a rare bird, and was a maternal-fetal medicine subtrainied person. Bob Brame, the peripatetic professor came to us having already been at four medical schools in Virginia and North Carolina. He subsequently left us. He was a gynecologist. He suddenly left us and became the chair at East Carolina [University] and then

went on to four more medical schools in North and South Carolina before he ultimately retired. He was a wonderful pelvic surgeon and academic gynecologist who was actually the residency program director for a number of years before he left to become the department chair at East Carolina. John Steege and Anna Stout were early workers in human sexuality. And from that they got interested in PMS and pelvic pain. And from that they got involved in laparoscopy or keyhole surgery, endoscopic surgery. Both have built very strong careers in those several areas. As I've mentioned, John subsequently left us to go to UNC where he became chief of the Gyn Division there. And Anna Stout is still here. George Wilbanks was a gyn oncologist and did a lot of the early work on early cervix—well, preinvasive cervix cancer. There's a phase of cervix cancer that is heralded by changes that are not yet malignant but if untreated may progress to malignancy. That's where the Pap smear really is very helpful, because it will detect those changes before you have frank invasive disease. But George spent a lot of time in ways to make that diagnosis beyond, you know, after you had the abnormal Pap smear, now what do you do? sort of steps. Bill Creasman was a gyn oncologist for a good while. And went on to go chair at the University of Charleston. Wilbanks went on to become the chair at Rush. And Carlyle Crenshaw was the head of Maternal-Fetal Medicine for Roy Parker and went on to become the chair of Ob-Gyn at Maryland. He died early in a car wreck. And was an amazingly capable academician. He had lots of interest in pre-term labor and in a variety of things in maternal-fetal medicine. And had a whole cadre of people he trained. And most of the division chiefs—I mentioned that all three divisions, now four, had fellows. So in addition to the department having residents, each division chief has fellows. And they generally are one fellow at each year level, so there would be three in each division. We now have a trail of fellows out until 1970 or '72 when the divisions were formed

and the fellowships were started. And as I've said, those have been amazingly capable people who have gone onto do great and wonderful things. And many have stayed on our faculty through the years. So research has always been important. It's probably been more clinical than it's been basic science, but it has been predominantly done by the PhD's in the department. And candidly in both Roy and my chairmanships, I think both of us were somewhat frustrated there that our NIH support was not stronger than it was. It was present and it was good, but it wasn't earth shaking.

ROSEBERRY: Due to the NIH?

HAMMOND: I'm sorry?

ROSEBERRY: Because of the NIH?

HAMMOND: To compete for those grants, you really have to have people who want to stay in the laboratory all day. Not part time. And I could recruit a lot of really good people that wanted to do part time but not many who want to do it full time. You could recruit PhD's but you couldn't recruit MDs, and candidly there was a real risk with recruiting PhD's, because if they became unfunded, then nobody'd make a living. So it meant you have to carry them out of some other source of revenue if you had it. While we had enough money, we never had a lot of extra money lying around. But again, I think research has been a strong part, but it has not been basic science, NIH funded as much as I would have liked it to have been. One of the things that we were doing to try to remedy that, we hired Evan Myers just before I stepped down as chairman to head of a brand new sixth division of biomedical research within the department. And Evan is an MD with a MPH [Master of Public Health] in outcomes research and is absolutely the hottest property in the United States on clinical research and probably the best-funded person in the United States from the NIH. So that part of the department is

booming right now. And we have actively recruited others to work with him to build and strengthen that division. As I've mentioned the fourth chairman is in place now, and that's Haywood Brown who came in the fall of 2002. So he's only been here actually a year and a half at this point. He's already recruited three or four new faculty members, and one is the new head of the Gynecology Division, Craig Sobolewski. He's got another coming, Fidel Valea, who is nationally recognized as a teacher, and he's a gyn oncologist who's going to become the new head of the residency program. Dr. Brown is now; I was in my tenure. But the demands of our job have gotten so complex, it's hard to put the time to being a residency program director in addition to doing that. He's included several other faculty members in areas where he wanted to strengthen and got money to help launch it. I had laughed and told the dean if he'd given me that much money, I would have stayed. (*laughs*) But I think Haywood has done a really good job so far in his tenure of picking up reigns and taking over things and refurbishing them and rebuilding things that needed further attention. I think he has been and will be a very good chair for this institution. I'm about to run down. (*Roseberry laughs*) Maybe you've got other things you want to ask about.

ROSEBERRY: Sure. Well, how—or has the feminist movement affected Ob-Gyn?

HAMMOND: Yeah, there's been a real change in one sense. A sea change. We've gone from a specialty that was essentially all-male practitioner to one now that is rapidly approaching fifty-fifty female to male. And 75 to 80 percent of our trainees are now women. And they used to be a very small minority. Us boys hope they'll be gentle with us (*laughter*) as they take over the reigns, because very clearly by 2008 or -9, they will well be in the majority. And I have been totally supportive of this. I've been involved nationally. And I think it's a wonderful trend as more women got accepted to medical school, in turn as they chose

disciplines to practice, we were attractive to them. Now, we are also a physically demanding discipline. And women are still the people who have children. And to a fair extent rear children, even though I think the men of this generation are more attuned to being involved in that than perhaps my generation was. And what that means is you have another whole set of stresses on practitioners, which is how to balance all of those pieces, of practicing, a family, and so forth. And it's hard. There also has been in this generational change, a change in attitude with a dis—and this is not gender-based, this is men and women, and I think it's been seen by a lot of people, not just me, that this generation is a lot more interested in their time than work time. They're willing to work hard for the time they commit, but they're not willing to do it twenty-four hours a day, seven days a week. I think we were too dumb; we just thought that's what you had to do. We also had wives at home, because most of us were men at that time, and the wives took care of a lot of the stuff that now couples split. But you see a real difference in willingness to go to educational meetings. And it's true in men and women. Time off is much more treasured for personal things than perhaps it was in my generation and certainly the generation before mine. Women have been attractive to patients as providers but they have not thrown us boys out. And I think that what patients in general have enjoyed, a choice of mixture between men and women. How the new generation coming up will play that, I don't know. I think that's true for women in their twenties and on up, a balance as far as it doesn't make a huge bit of difference. I would hope that women would judge us on our competence and not necessarily just our gender. I'm sure women have felt that way for a long time. (*Roseberry chuckles*) But I think, you know, we're no different than the rest of the population, and times change and a lot of priorities change, and values change. And the feminist movement, which again I've been pretty supportive of, has impacted on this

discipline. There's no doubt about that.

ROSEBERRY: What about the patients?

HAMMOND: Well, that's really what I'm saying when I say it that way, because I think patients drive this—you know, if they would never see a woman, there would be no women in the discipline. And I think the men's concern is they may never want to see a man. They may want to see competent women, and we may be drummed out of business. But I'd like to believe that there is enough openness to say, Let's go on the basis of skill and ability to communicate regardless of gender. Because if you don't do that, you wind up taking your trainees from 50 percent of the medical school class. You take a hundred percent of your trainees. That means you're going to miss half of the class as far as candidates for your training. And would like to believe at least that half of that class is going to be as smart as the other half of that class. So if you really want the strongest discipline you can have in addition to, quote, being "fair" to both sides, you would want the highest quality people you could get, and that would suggest you need men and women. Not that one is superior to the other, but that you need both. It'll be interesting to watch.

ROSEBERRY: What about your own interests as far as—well, what about teaching? What would you hope that someone who had learned from you, what would you hope that they—?

HAMMOND: Well, I hope they'd care about people. I think teaching humanism is very hard to do, and I believe people are born with it to a fair extent. How it is transmitted to patients and integrated into one's practice is a learned set of skills. The basic caring about people, I think you're born with that or not. I would hope people that I've taught believe that I cared and you should care about patients in the full breadth of it and not just as a uterus or an operation or a baby, but as a person, a human, a mother, a wife, all the pieces that go into describing us.

So a humanistic person. I believe you need to have a base of knowledge, but I believe you also need to have a continuing ongoing education. It doesn't stop at medical school or residency. And if it does, your patients are going to get very poor care, because you will be out of date very quickly. The discipline changed. When I trained, there was no ultrasound. As I've mentioned earlier, antibiotics were really pretty primitive. There was no laparoscopy, there was no MRI, there was no CT. And so I've seen the ability to do things change dramatically. And if I had not worked hard to try to stay abreast of how we practice and what we can offer, my patients would have received less than good care. I would hope people have trained here would also believe that we have an obligation to the next generation. I.e., that they should want to teach, themselves, whether it's a in community practice to nurses, nursing students, whether it's in a medical school faculty, the medical students or residents, whether it's a subspecialist teaching fellows and residents. It doesn't really matter. I think you've got to give back. And the best way to give back is to get involved in educating efforts. Research is not for everybody. And I'm pretty comfortable with that. I think every learner needs to be exposed to research so they at least know how to evaluate articles and things that are published as to their validity or not, but I don't think you can drive everybody to work at the bench and tip test tubes all day. Many of them went into medicine because they didn't want anything to do with that. And there ought to be room for both. But I think there is a lot of joy in research. And I have had the pleasure of doing a fair bit of research in my career, and I've treasured it. But once I discovered that they probably weren't going to invite me to Stockholm to give me the Nobel Prize, I then thought if I was going to make a difference, it'd people. People that you've trained and were involved with. And that is certainly the joy of my career has been helping educate bright, capable, caring people. But it's the blend of all of it that's been so

much fun. Our discipline also lends itself very well to doing different things at different parts of your life. When I finished residency—well, first of all, during my residency—fellowships weren't at the end in those days—so I interrupted my residency halfway through to take, in essence, a fellowship at National Institutes of Health. And there I learned how to treat a previously incurable malignancy with chemotherapy. I came back to Duke and opened up a center for that, which was only one of two in the United States. And while a resident, I treated patients from all over the country with that disease who came here for that treatment. I had also been cross-trained in reproductive endocrine. Candidly, I didn't do well with patients from cancer if I couldn't cure it. I took them home in my head, and I couldn't sleep, and I thought about them and worried about them, and I came back, and I still couldn't cure them, but for that one disease that I was talking about earlier, which was curable. And I decided my psyche wasn't going to handle it very well, the others. So I was forced to make a choice between endocrine and oncology as the two specialties were developing, and I chose endocrine. I still did the choriocarcinoma business, the malignancy for that disease, but that's the only oncology I did. And I picked well, because we cured about 95 percent of a thousand patients that we treated. And it was a "we" effort, it was not a "me" effort. And it's been—like I said, you can do different things. I was a general obstetrician-gynecologist for a while. I was a reproductive endocrinologist. I did high-tech infertility things for a while. I did cancer for a while. And I now do general gynecology, some infertility, but not the high-tech stuff. And sort of the primary—gynecology was my primary practice. I've always loved patient care. And people have laughed and said, Why do you keep running clinics when you, you know, you're a department chair? And during some of the years I was head of the private clinic, or whatever. And I said, Well, you know, that's really why I went to medical school

was the pleasure of practicing medicine. I would strongly recommend to anybody regardless of what they do academically or administratively that they somehow keep in touch with medicine. It's pretty hard to teach it if you're not practicing it. And it's pretty hard to administer if you're not practicing it. The hard part is to practice a little, you know, not a lot. It can become very consuming very quickly. But OB has offered—ob-gyn has offered the opportunity to do different things at different points in one's life. And that is an attraction for a lot of people to choose ob-gyn as that they are not forced into a standard mold of only one type of practice throughout a career. And many people choose it because the long-term relationship with patients. I mean, I've had the pleasure of delivering patients, of working with them with infertility and helping them get pregnant or delivering the baby and providing the gyn care. Now their menopausal care. You know, we've been members of a family for a long time together, and I've really treasured that. In a lot of disciplines you don't have that. You're a gall bladder going through or you're an X-ray picture going through, but there's no long-term relationship. We've had that. We've also had surgical and medical techniques involved in the care of that system or that part of them. But that's nice to be able to do everything that's needed in that area if you will, not having to refer every patient for every thing. So a little of it depends on what your psyche—how your psyche is, what things you really enjoy; long-term relationships or snapshots, et cetera.

ROSEBERRY: May I ask how you first became interested in ob-gyn?

HAMMOND: The faculty. I mean, I knew I wanted to be a physician from high school or junior high school, and don't ask me why. (*Roseberry laughs*) I had a grandfather I never knew who was a family practitioner and a neighbor who was a GP [general practitioner], but I really didn't have much exposure to either of them. It just always sort of seemed like the thing

to do. And I came from an army family and was the black sheep because my brother went to West Point and my father was and army colonel and so forth. But I did go astray and wound up—I went to the Citadel and then went to med school after that. OB was my first rotation on the clinical side as a medical student. And I had a very, very good experience. It was because of the caring and the enthusiasm and so forth of the faculty and house staff. I had good experiences elsewhere. And that was here at Duke. I had good experiences elsewhere, but they were never quite as good as they were in Ob-Gyn. And again, my personality was one that wanted the sort of things I just finished defining, about long-term relationships and the ability to do surgery as well as medical things, and the complexities of reproductive endocrine that was so fun. And it was a wonderful time in Ob-Gyn. The specialty was blooming with new technology and new things you could do that were helpful. So it all boils down, once again to people. A really good faculty, really good house staff. I had a little debate along the way about general surgery, urology, but I just didn't particularly like standing in the operating room all day, every day. So it was nice to have some other options within the same discipline than just spending time in the OR.

ROSEBERRY: As chair of department, what were some of your goals that you set for the department?

HAMMOND: Yeah, Jessica, I probably talked about all of them.

ROSEBERRY: Okay.

HAMMOND: It was—I don't mind clarifying them.

ROSEBERRY: Sure.

HAMMOND: Clearly, I wanted to see us expand and further develop the subspecialties. And toward that I worked hard to build and expand divisions with very high-quality faculty. I took

a lot of pride in the house staff and who we recruited. And we recruited the best in the country and opened doors for them so they could do whatever they wanted to do within the discipline. That rippled back to the medical students in much the same way. Those house officers have been just special parts of my life. As I said, I was the resident program director for twenty-two years. And I miss it now that it's gone, but I don't—it was time to let somebody else take that challenge as well as the joy. I think I was worried and wanted to expand research.

(*tape 1, side 2 ends; tape 2 begins*)

HAMMOND: Money has gone from being relatively easy—when I became a chairman, I wanted enough money to do the things I needed to do to recruit faculty and start a research program, so forth. And clinical practice generated enough money to do that, without anybody getting too tense about it. That has changed. And during my career it changed from relatively no problem to a big problem. Payment for clinical services went down; it's still going down. Expenses go up such as liability insurance, and for our discipline, they're massive. And out of all of that you've got to figure out enough money to hire and pay and keep a faculty, to do all the things that you want to do. So money has become such a critical part of the department chair, and it's not just only Ob-Gyn, it's everything—that you sort of need an MBA in and a real affinity to be a chairman to dealing with money issues. And it has become in my opinion a curse, because it distracts so much energy and enthusiasm from the primary mission of education and patient care and research. That was another reason I was not unhappy to quit being a chairman, because the job had changed so dramatically in my twenty-two years from no problem to big problem. How to find enough money to do everything you wanted to do. And finding that money took time and energy and consumed a lot of initiative and gusto. You still—and I'm sure Dr. Brown has exactly the same goals of education, research. We maybe

differ in how to get there, and we may differ in where the end points of achievement are and so forth, but we don't differ in what's important. But he has a very heavy load to worry about, balancing the books every month, making sure there's enough money to pay everyone and do all the things that need to be done with money. But I'd probably didn't, certainly in 1980, worry about that much. I've said I practiced in the halcyon days of medicine, and they indeed were that, but maybe they were also unrealistic, because they were so wide open. But it was a fun time to be an academic physician. I mean, I used to keep patients in the hospital a hundred days or a year to treat that malignancy I was talking about. I'd have them from California, wherever, and nobody would ever get tense about it. We had the money to keep them in the hospital, so we kept them in the hospital. I wouldn't try that now. (*laughter*) I wouldn't try that now. That's probably been—well, that's not fair. The technology changed and our understanding of disease and treatment have been impressive changes in my career. But the social setting in which we practice medicine has been a very dramatic change as well. And it's gone from clearly a physician in charge and money's not an issue—and I'm talking money for patient care or research or whatever—to money is a big problem, and we've got to figure out ways to reduce costs. And I agree with that philosophy, it's just not a lot of fun having to do. Whereas practicing without worrying about money was really fun, really fun. But like I say, it was a different time. My decision—I came to Duke as a medical student. It was a small, private, southern school, good university. New medical school—you got to remember the medical school was only twenty-five years old at that point, because I came here in 1957. Let's say it started in the '30s. And I have witnessed this institution go from that to a big-time national, upper-tier ranked institution. It's gone from one or two small buildings to a whole campus. It's been from a very small faculty, of whom even I knew everybody that was here.

The faculty, the house staff, cats, dogs, you name it. To now I know very few people because it's so big. But I think it has continued to strive to be a really good place in the areas that count, the same ones we've been talking about, patient care, teaching, research. And I don't think it has done it just to be, quote, "ranked." I think it has done it to be the best it could be. And it's now pretty much the best in the country. And I don't care how you want to rank them or what criteria you want to use, this is a really good university, a really good medical university. I've been, over the years, over and over proud of family members, of other people, the care they've gotten, the humanism they've gotten. It isn't always perfect, don't misunderstand me, but it's been pretty good. And that stems, all of it, from faculty, rippling down through house staff, as to involve the nurses, and all the other people that are involved with patient care. Like I said, it isn't perfect by any stretch, but it's about as good as there is. To see that occur in the expansion mode that I have witnessed has been very special. Not a lot of people have been a part of that. So I feel it's been a privilege to have been a part of it, been able to see it, witness it. Other things?

ROSEBERRY: Is there anything else you'd like to say about technological changes in your field?

HAMMOND: Oh, they've been huge for us. Like I said, when I first came, we didn't have ultrasound, as an example. Everybody gets an ultrasound now. And probably a lot more than one. Plus the quality of ultrasound has gone so dramatically upward from—it used to look like a cloud cover over Florida on the weather map. To now we can look at the thickness of the skin and on the neck of a fetus of twelve weeks duration and make a diagnosis of Down Syndrome from that, or other things. So all I'm trying to say is the technology has been radically—we often in those days before—we weren't even sure there was a twin in the uterus. Much less the position, the structure, a whole variety of things about it. Pictures now are the

3-D ultrasound. Just absolutely magnificent. It's like a photograph. And that's just sort of, to me, the prime example of what's changed technologically. We've also seen changes—when I trained, the cesarean section rate was under 3 percent, three out of a hundred were delivered by caesarean. It's now 25 percent. In parts of this country it's as high as 50. Whether that has improved obstetrical outcome or not, I have some reservations, but it sure changed how practice is done. And a lot of that's been driven by medical legal issues, so. It sounds pretty bizarre, and it is, in my opinion, pretty bizarre. I've been head of our national organization in the last several years, and I spent most of that time working on the front of legal reform for the Congress about how to get medical liability in hand. It's totally out of control at this point. And it's going to destroy our specialty, because we're the number-one target; there are two patients in every encounter, mom and baby. Our premiums now are well over $100,000 a year before you deliver your first baby. And you can't raise your fees to pay. So it simply erodes the profit line, and people have to drop out, move, go over to areas that have better laws. I'm just genuinely concerned that we're going to see a total disruption of, Who's going to deliver your baby? or, Who's going to deliver my grandchildren? We're going to lose a generation of obstetricians if we're not really careful. And neurosurgeons and orthopedic surgeons and others who are—none are probably worse than we are. Only a few as bad, but a lot of them have to pay more. And that's a major issue for our discipline and for the other high-risk disciplines, I think. This department has enjoyed a fair amount of activity on the national scene by its faculty. Dr. Carter, Roy Parker, and I have all been president of the American College. And so we have had an opportunity to work with some of the best of the specialty organizations in the practice of medicine. When I say "best," I'm talking about in their organization, and 95 percent of the obstetricians in the United States belong to that College.

So you really represent the broad sweep of the discipline. That doesn't hurt you when you're trying to recruit and do things, because you have sort of a national reach, which is fun. And I think probably all of three of us enjoyed—we stayed home and did a lot of home stuff in the first half of our careers. And we tended to spread a little bit more nationally in the latter part of it. And a lot of our faculty has done that as well in various areas of national medical politic. But that's been a fun part, I think, for our faculty over the years. And we still, today, have a lot of faculty who belong to the national groups. This is a department that's been a very good department. It's been recognized as very good department; it's gratifying to have recognition. Like I said, I've about run down. I'm not sure what else I can add.

ROSEBERRY: Well, do you mind, we had talked some before about maybe talking about Dr. Snyderman's tenure. Should we go ahead and do that now? Maybe make a note on the tape that this part may be restricted, so—

[the following portion was restricted until November 2016]

HAMMOND: Ralph Synderman had a fairly tumultuous time here. I was here when he was first recruited, and I was the department chair. I had the opportunity of being involved in the search for his successor this past year. He came in with very strong chairs in place in medicine and surgery. And this institution had been an institution that had been led by very strong chairs of medicine and surgery. The departments were massive by comparison to the little departments, and they had major sway over how the institution did business. That probably didn't go over real well with those very strong chairs. Who really did not want to give up control and power to the chancellor. We had had a chancellor who had been in place, Bill Anlyan, for I'm sure twenty years. I don't know exactly how long he was in place. And who was very strong but quite subtle, and you'd been had before you really realized you'd been had. And I say that in a good

way, by Bill Anlyan, who could talk you into just about anything he wanted you to do. He was the guy that appointed me by the way so I had a warmth for him. Ralph was probably not as politic. Not as adroit at doing that as Bill Anlyan was. There's no doubt that Ralph Snyderman clearly was a scientist and had exquisitely good scientific credentials. He had trained here in medicine and he was a known entity, if you will, but he was at Gentech on the west coast, an industrial medically related research entity. Candidly I don't think he had had the clinical exposure that might have been good. But that's what one does is set one's priorities by our background and our own personal interests. And medicine at Duke and any active medical center is very clearly an amazing balancing act between high quality patient care, really good research, and really good education, and I don't think that Ralph Snyderman was as strong in the arena of clinical care as he was in the arena of research. The research enterprise at Duke flourished under his leadership. The clinical enterprise grew and was capable but it was never as dominated by the chancellor as the other areas of work. And therein the tension did build, the clinical chairs having the much stronger maybe interest and sway in clinical care. Not all of them but a lot of them and to a fair extent medicine and surgery. The chairs at that time in medicine and surgery were amazingly strong people. And the clinical enterprise was the engine that was running the train up this mountainside in almost every way. Financially, prestige, you name it. So with that tension present, there was a fair amount of fighting, which was detrimental. And I unfortunately was not infrequently in the middle of it. Toward the later part of that epoch I was at that juncture then beginning to get involved in leadership activities in the medical center broader than the department. But we had just about a war going between the chairman of medicine and Ralph. And chairs were choosing sides and pretty soon there was gonna be an eruption that occurred. Fortunately, the majority of the chairs finally decided this

was ridiculous and it was time to start ringing in some people, and that did occur. And one reined in was the chairman of medicine that was the most difficult. He also was probably one of the brightest people I've ever known. And that's a terrible combination. But his philosophy in general was what was mine was mine and what's yours is negotiable. And candidly what this institution needed at that time was a much more movement to not what's mine but what's ours and how do we make it flourish, and that has happened in the last few years as those chairs turned over, other chairs came in to those roles who were more amenable to working together, and at the time the pressures on the institution were so great financially particularly to try to do that as only a department rather than an institution would be very, very hard to do.

So it's been an interesting transition for Dr. Synyderman from the boy wonder to the man under the fire to a difficult relationship with two of his most important chairs to he too then began to move out on the national scene which he's brought a lot of credit to the institution with his prospective health care and a lot of other things he has pushed on the national scene. But it's time that the clinical base resolidified and become under that person's leadership a major, major part of the day's work. And it is very hard to keep all of those balls in the air equally all the time. Teaching, research, and education. But we have some really good people in some of those roles and the right leader needs now in my opinion to come in and emphasize the clinical aspects, not to the exclusion of the other two. They need to be emphasized also but not as much. And attention needs to be turned in a greater extent to supervision of the clinical enterprise. We have a very strong good dean in place, a very good director of the hospital. I think a good cadre of chairs. And I think the institution's just simply waiting for some renewed leadership at that level. And we've now finished the recruitment of Dr. Snyderman's successor, and I am

optimistic this leader will rejuvenate that and hopefully sustain the impetus that Dr. Snyderman has achieved in the other areas.

Again this is certainly not all critical of his tenure. I've been very supportive of his tenure. But none of us are perfect all the time. And I think the institution needs a little emphasis change and probably a little leadership change focusing a little more on the direction of clinical care and how we practice it, how we teach it, how we research it, and so forth. But also maintain the progress that's underway in the basic science and education. Easy to be critical when you're not on the griddle. And I think Ralph suffered from some of that. Being shot at, if you will. Unfairly. On the other hand, he got his nose bloody several times in trying to take over various things in the clinical enterprise that physicians they won't give up, and the structure of the institution is such that they have to voluntarily hand over the reins and they ain't been willing to do that. So you have to lead by consensus rather than by fiat or directive and that's in this time of fiscal pressures and small margins is scary.

All in all I think that Ralph will be remembered as a very good leader of this institution and one who clearly moved it a very long way in his 15 years. In that direction that I was talking about from a small private southern school to a big time national force. All you got to do is look at buildings to see the change that's occurred. It's been huge.

I'll be interested some day if I'm still alive to hear how other perceive it. This is all the professional aspect I'm talking about. Personally I liked Ralph very much. I think he's been a good person and the demands on a person in that role are so massive about representing the institution and always being the leader who is pushing, pulling, energizing new ideas. It's a big time job, big time job. It's one I wouldn't have.

I never had a real enthusiasm to be either a dean or a chancellor and the primary reason was I couldn't practice medicine at that level. But also I didn't like the headaches. What's really fun in life I think is to be able to do what you really like to do, which in my case was practice OBGYN**,** but then do all this other stuff around that matrix. Teach, do research, and so forth. Which are simply add-ons to clinical practice, so you don't do as much clinical practice clearly but you can add the pieces.

ROSEBERRY: Well sir is there anything else that you'd like to add

HAMMOND: No. I hope the next 20 years are as much fun here as these have been, but I would predict that the next 20 years are gonna be tough years because of the fiscal issues. The ratcheting back of available monies to do things, but also the almost geometric changes occurring day in and day out in how we can practice medicine. Both technologically but also our very fundamental understanding. I think Duke is positioned about as well as any institution in the country to enter this next 20 years, but I suspect it will be a volatile 20 years in the process. I hope they take good care of me in my old age.

ROSEBERRY: Well that you very much.

HAMMOND: Well, thank you, Jessica.

ROSEBERRY: I appreciate it.

HAMMOND: I enjoyed it.

(*end of interview*)