KLOTMAN: Mary Klotman
INTERVIEWER: Jessica Roseberry
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KLOTMAN INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. Mary Klotman. She's the chair of the Duke Department of Medicine. It's October 21, 2010, and we're here in her office in Duke North. And I want to thank you very much, Dr. Klotman, for agreeing to be interviewed today.

MARY KLOTMAN: It's my pleasure.

ROSEBERRY: I appreciate it. I wanted to start kind of looking at the first time you were here at Duke and things that might stand out as a medical student or faculty member or fellow. I know you were here originally, so—.

KLOTMAN: Well, I first came to Duke actually as an undergrad, and that was 1972 to 1976, and so I really wasn't very aware of the medical center then. I started medical school in 1976, and at that time we were largely confined to the Davison Building, and my life really existed in that tower in Davison with the elevator, a very close-knit group of medical students that lived and breathed and ate together. And it was all very exciting. It was an exciting time for me personally. Duke at the time was a lot smaller and geographically localized entity, but it still seemed overwhelming.

ROSEBERRY: So as a medical student, what did the Department of Medicine look like then?

KLOTMAN: So we first—when you're a student you barely even understand what departments are, particularly as a first-year student. So we first started to kind of get introduced to the concept of clinical departments as second-year. When I was here it was the new curriculum, so it was what exists now, which is you do your clerkships your second year of medical school. And I can remember hearing that medicine and surgery were the tough ones. They—it was very intimidating because the Department of Medicine had the reputation as being a very, very demanding clinical department with a level of excellence that was intimidating as a student, so there was always a lot of sort of jockeying around when you do your medicine rotation because you knew that it was going to be—it was really going to be the thing that determined whether you could make it or not. When I did my medicine rotation, I just loved it. I was very fortunate to have two wonderful attendings: Andy Wallace, who I had the real pleasure of seeing again recently when I came back, and Bob Rosati; and both of them are still at least attached to Duke in some way. But at the time they were very thoughtful, engaging, approachable attendings, and it sort of set for me a career path right from then when you said, I want to be like them. The house staff were like that as well, very passionate and serious about medicine, intellectually engaging. So it was a wonderful first experience for me when I did my clerkship. I thought, Wow, I want to be like them.

ROSEBERRY: So did you find it varied from the reputation that it had?

KLOTMAN: Well, yes and no. It was tough, and you sort of stepped up and worked as hard as the residents worked, and the residents worked extremely hard. So in that sense the reputation was true. It was a very demanding, both physically as well as mentally rotation, as was surgery. I mean, both of those departments had that reputation. But I

think as a student you kind of got up for it, and you sort of took the challenge, and tremendous personal growth to be able to do that, to be able to tackle something that had such a reputation for demanding excellence. So for me personally in doing a rotation in medicine and surgery was a real personal transition from wondering whether I could do it to saying, Yeah, I can do this. It was kind of transformational.

ROSEBERRY: Do you remember anything about Dr. [Joseph] Greenfield?

KLOTMAN: So Dr. Greenfield at the time was not chair. I actually went through from student to house officer here a transition in leadership. So when I was a student it was Jim Wyngaarden, and then when I became an intern he had taken the job in Washington. So the second year of my residency David Durack was the interim chair. And so I don't think Dr. Greenfield was appointed until maybe 1984—I have to check that—which would be when I was a fellow.

ROSEBERRY: Okay.

KLOTMAN: Now, I knew him from his lab in the VA. So when I was a student and when I was starting my residency he was a cardiology faculty member, had a very interesting lab at the VA, and my research eventually when I became a fellow was at the VA, and I knew him as a physician-scientist.

ROSEBERRY: Okay.

KLOTMAN: And at that time he was a very engaging, colorful physician-scientist and again very demanding but very approachable. So I knew him more as a faculty member than a chair.

ROSEBERRY: Well, during the time that you were here as a medical student or a faculty member, do you have a sense of what the chair's role might have been and how it might be different from your—?

KLOTMAN: I think about that a lot. As I said, when you start medical school you have no idea what departments are, you have no idea of the hierarchy. And I don't think you really start getting a sense of that until you become a resident, because the chairs are the head of the training programs, and you have the program director under them. But I didn't really have a sense of what a chair did because when you're in the trenches what matters is, Who is your resident, who is your chief resident? Those are the people that you really interact with on a day-to-day basis that get you through. When I was a resident they were doing a search. At the end of my residency they were starting their search for the chair and then I got a sense that this was pretty important because there was a lot of discussion around that it became a very frequent topic of conversation. But I don't think I really became aware of a role of a chair until I was transitioning from training as a fellow to faculty. Then all of a sudden the chair became extremely important, and I realized, well, the chair is who actually ends up approving hires. And I can remember—when I was making that transition Dr. Greenfield was chair, and I remember a very, very serious conversation with him in his office that had to do with the topic that I must say I hadn't thought about, which was my career path I was pursuing the career as a physician-scientist. And I got a sense then what a chair does, and the chair is really responsible for mentoring at the highest level and for making sure that when they bring on faculty, that faculty person knows what their career path is, the chair has a vested interest in making sure it's a good match. I remember that conversation as if it

were yesterday. It's a bit intimidating when you just think, Gosh, I made it, I finished my training; and then you've got to think about the next thirty years of your life.

ROSEBERRY: Do you remember any elements of that conversation that you'd like to share?

KLOTMAN: Well, yes; it was serious. It was reality—he was also very supportive because I was trying to pursue a career path that was very visible at Duke. The reason I was pursuing it is I looked around and I saw faculty members that I had tremendous respect for and I said, Well, how'd they get there? And many of them were physician-scientists. And so I said, I think I want that career path, and Dr. Greenfield supported that career path.

ROSEBERRY: Well, let me ask you a two-part question: Why leave Duke and why come back to Duke?

KLOTMAN: When I was a junior faculty as a physician-scientist-in-making I then really started to ask how do you get there, and realized that I needed a huge detour. If I really wanted to be a physician-scientist I needed to sort of step away from clinical medicine, put on some blinders, and learn how to be a scientist. That was a hard decision because at Duke you want to do it all and you want to do everything well, and so I had really started to be comfortable with clinical medicine and really felt that I was at the top of my game. I had just finished my fellowship, I felt I knew the subspecialty of infectious diseases, and now I was going to step back and start all over again. I started to think, Well, how can I do that best? And the NIH was for me the answer because it allowed me to go in a lab, not to be really constantly pulled to the clinical part of medicine, which I loved, and I knew if I didn't surround myself with some protection from myself I'd be

constantly drawn and wouldn't really be able to achieve what I wanted to achieve, which was really to become a physician-scientist. So I took a detour, found a great lab at NIH through the help of several faculty here at Duke, and went up there and spent more years than I had anticipated really training as a physician-scientist. After my husband and I were—we had done that then the real question came, Well, why not Duke at that point? And at that point it was really where both my husband and I felt we could go the next level. We had accumulated scientific skills, we had great clinical training from Duke, we were ready to be leaders, and the opportunity was at Mount Sinai. So we stayed there for a number of years. And what I smiled about every day is how my husband and I—my husband was my chief resident here, and we both were really trained in the Duke model of excellence—were making Mount Sinai the Duke of the North. We used many of the principles that we'd learned at Duke and applied them: in my case to developing an academic infectious disease program, in my husband's case to really developing the Department of Medicine at Mount Sinai to the model of Duke as a three-mission academic department of excellence.

ROSEBERRY: What are some of those principles?

KLOTMAN: Well, the principles of having a balance of all three missions—having excellent educators, excellent scientists, and excellent clinicians—developing a culture where that three-part mission is respected, celebrated, and supported. Trying to really have a broad understanding among the faculty and trainees as to what that mission is, which you take very much for granted here, that everybody buys onto the notion that that we're excellent in everything and we respect the faculty members that have chosen different career paths. My husband applied very much the operations part of it, too—

very rigorous morning report that he alone did with the residents. He didn't delegate it to anybody else. That was very much after the Duke model. A culture where, rather than just say you do things because that's the way it's done, a culture of: You do things because scientific literature and evidence supports what we do, evidence-based culture of decision making. And it was fun to do that at a different institution, and we used to smile about it—because it was successful. I think that our Duke training gave us a lot of confidence because we knew it worked and we had a pretty good sense of how to get there.

ROSEBERRY: Do you think administration takes you from the physician-scientist goal that you had?

KLOTMAN: So administration is interesting. You know, with so many people in medicine it's a bad word. It's viewed as giving up on your real passion, whether it's clinical medicine or it's lab-based research. I see it very differently. I'm a big believer if you think you know how to do something and you have leadership skills, you are obligated to step in and do some of the heavy lifting. It's pretty easy to sit on the sideline and say, I'm just going to do my lab piece or I'm just going to do my clinical. But I've always felt that you can do so much more if you're willing to take on an administrative role and if you think you know how to do it. So I don't see being in administration as a distraction. It's a balancing act, Would I be a broader and more accomplished physician-scientist if I hadn't taken on administrative role? Probably. Does that bother me? No. I think in some ways my impact has been greater as a leader in infectious disease, particularly in terms of mentoring and training and bringing up junior faculty, and hopefully that will be my accomplishment as a chair. But I think administration gives an

individual the opportunity to make a broad impact outside of what I do in the lab, and so I really like administration.

ROSEBERRY: Well, can you tell me about the time that you've been chair of the Department of Medicine here?

KLOTMAN: I've been back seven months. Sometimes it seems, time has flown by, and sometimes it feels like, I've been here for thirty years, like I never left. The transition was pretty easy in terms of my comfort zone. I felt very comfortable coming back to Duke. I understood the institution in terms of its mission and commitment. The challenge was and remains that it is so much more of a complex health system now; it wasn't a health system then, and the size of the department is probably I would say at least five times what it was in the early 1980s. So how does that play out? On a day-to-day basis—when I was here in the eighties I knew every department member, and I pretty much knew what they did in terms of who were the lab-based scientists, who were the clinicians. If I had a tough clinical question I knew who to call, if I wanted to do something in the lab I knew who to call. Now that's really tough to have that kind of detailed knowledge. I've been working on it because I want to know the individual faculty. I don't only want to know the divisions, I want to know who is the top clinician in an area, I want to know who's got a good idea, I want to know who are the up-and-coming faculty that we need to take care of, and that's a huge challenge with six hundred faculty. And I'm working on it. In fact, one of my first hires was a director of communication because I really thought, How am I going to bidirectionally communicate with this many faculty who have such different missions and career paths? I needed somebody to help me do that—what tools are we going to use? There's lots of

opportunities to be very creative around communications now. We're working on a communications plan. I don't think that was ever an issue in the eighties. It wasn't about how—you communicated by face time. Everybody goes to grand rounds, everybody goes to research conference, that's how you learn who we are. You can't do it that way anymore. So that's challenging. But it's been a wonderful seven months. The good news is that everybody's passionate and everybody's committed to excellence just like they were in the seventies and eighties. The challenges: it's a big department with a complex mission.

ROSEBERRY: What—tell me a little bit more about what the director of communications does and how you do set that communications plan, what that looks like.

KLOTMAN: We have a very detailed actual strategic plan around communication that deals with first of all defining who our faculty are—not only in terms of number but in terms of what career paths they are on, how the faculty are distributed among those career paths—how many lab-based scientists, how many clinicians, how many are trying to develop careers around being clinical investigators, how many are trying to develop careers around being leaders, administrative leaders. So we're defining faculty around their groups that they identify with, then developing ways to communicate more specifically to those groups, because not everybody needs to hear everything, and there's information overload. E-mails become an ignored mechanism for communication. So defining our groups better in terms of who we want to communicate which message to, and then the next level is looking then at, What tools do we have to communicate with? We might have a science blog that the scientists can look at daily, we're talking about video streaming for some messages, so real visible face time between myself and the

faculty or between somebody giving a state-of-the-art talk and the faculty. Traditional e-mail certainly (*laughing*) will be a mechanism but trying to make those e-mails much more directed at who needs them, thinking about how we catch people's attention by making sure our message is short, to the point. So lots of different detail but a detailed communications plan, and then the next level will be implementing it.

ROSEBERRY: Well, what are some of the things, initiatives, that are going on in the Department of Medicine that feel exciting to you?

KLOTMAN: So we're in the first—we just finished the first six months. The first six months was sort of me getting a handle of where we are now in all of our missions what are we doing in education, what is our research portfolio, what do we look like clinically? Also, with each one of those missions really getting to know what our institutional counterparts are because I want to make sure what we are doing in the department is firmly integrated and complementary to what the school's doing on the academic side, to what the health system is doing on the clinical side, that a key component of my leadership is being a partner and not being a siloed department. So six months was really trying to get that whole view. What we've done now is say, Okay, around each of those missions where is the exciting opportunity? So research. Part of the exciting opportunity is saying, How can we be really good partners? So I sit as chair of the biggest department at Duke and the biggest clinical department. That is a huge opportunity. We see in our clinics almost 300,000 visits per year of patients coming in and out. Our doctors are really great at knowing their patient populations, knowing their diseases, and knowing what are the key questions that need to be answered. So to be able to take that clinical enterprise and connect it with all the wonderful scientific resources in the

department and outside the department, that's the opportunity—building the partnerships, and then the next step is really being able to answer some exciting clinical questions. So one big area is personalized medicine. I didn't discover that. And we talk a lot about whether that's the right name, but the idea that medicine is going in a direction where we can really, really, specifically define, based on individual's history, based on their genetics, based on their lifestyle, start to define what is the best care of that patient—whether we're preventing a disease or we're treating a disease, being able to make it an individual decision. So there's a lot of science that has to go into that, and science is going to be the interface between lab-based investigation and clinical medicine. And so a Department of Medicine sits right in the middle of that, and to me that's the exciting next five to ten years, and how I can make that happen is my challenge. And so I'm—we are meeting with lots of groups. I've probably met with most of the basic science chairs, most of the institute directors, certainly know all the clinical chairs, and constantly having a conversation is, How can we work together? So—and this is really from the dean down. She has defined that for me as one of my goals and has structured a lot of the resources around accomplishing that: looking for partners across the campus and then joining together, whether we're recruiting a faculty member or we're approaching a critical scientific question. So that'll be fun, because the resources are here, the material is here. We have fabulous scientists, fabulous clinicians, and my job is to connect them.

ROSEBERRY: Do you feel like that sense of partnership exists across Duke? Is that something that's—?

KLOTMAN: I think more and more. And this is one of the principles I think of in creating institutes. Institutes are not department based; they go across departments. So I

think that, yes, it does exist in principle. I think what everybody struggles with is—taking that principle and really making it work, so getting the right faculty in the room to plan an initiative. Try to figure out, Well, who are the faculty? Who have skills in areas that we need if we're addressing a question? So I work with Mike Merson in Global Health [Institute]; that's a great fit for us. Whether I'm talking about a research mission or a training mission, that's a huge area of interest. And so Mike and I talk a lot about it; we have a global health residency here. One of my jobs is making sure my residents that really want to go into global health know about that opportunity. We have mutual research interests, whether it's in infectious disease or cardiovascular medicine or oncology, there's a real global initiative around those areas that we also have very local, really high-level talent and interest. Across campus all the leaders understand that we're not siloed in departments anymore and that we need to build bridges across campus to be able to really address some of the complex challenges in health. And that's fun and wonderful to do at a place like Duke. So the research, it's building partnerships. Our challenges and opportunities in clinical medicine, it's growth. A single word in clinical medicine is *growth*; we have to keep growing but deciding what areas make sense. Again working with the health system to look at what the health system is trying to accomplish and then as a chair saying, Okay, they want to grow transplant medicine. What does that mean to the department? What areas of medicine do I have to start looking at and thinking about to complement where the health system wants to go? It is clinical growth in areas that are strategic—strategic for the institution but also complement our research mission, and so trying to think across our missions in terms of clinical growth. What's always underlying clinical growth is how do you support it, what's the career path for my

faculty? I value what I call master clinicians, and I want to have very visible leaders in clinical medicine. So that's career mentoring, and that's a big part of it as well. What are the opportunities and challenges in our education mission? We're blessed with talent. We always have talent coming up. My goal is to make sure I identify that talent as early as the second-year medical students and start thinking about developing that talent all the way through future faculty members. So the challenge is making sure I know who are the talented students that might have an interest in internal medicine, getting them into internal medicine. Once they're in internal medicine making sure they have good career mentoring so that they can go to the next step, so it's connecting that career path across our education and training mission. One of the things that we're doing is developing a mentoring plan to make sure that at each step in development our trainees have a structure that helps them progress along that career path. A big practical problem in training is we are mandated to limit the work hours for our trainees. These are national mandates. So our traditional training philosophy has been the more you're here the more you'll learn about a disease evolution, we know that model of training very well. Nationally we are told that residents can't be in the hospital more than sixteen hours a day. So a challenge is addressing, how do we meet our educational and training mission under constraints that are very different? We don't spend a lot of time arguing about whether it's right or wrong; it's a mandate, so you've got to do it. We have to step away a bit from our old model and think about a new model where we have limited number of hours with our residents and with our interns, but we still want to train the best physicians and academic leaders we can, so we're doing a lot of looking at our educational goals within our residency and asking how can we do that under this new mandate. Another

big challenge for me is making sure that our students understand the excitement in a career in internal medicine. It's not always viewed as the best lifestyle or the best payoff in financial terms, but we're all in the department because we're passionate and we love what we've chosen to do, but how do we communicate that? We have our work cut out because it's in the context of a lot of other things that play into students' decisions about what they do and what choices they make. But this is all—these are all things I like thinking about.

ROSEBERRY: Well, I want to back up just a little bit to what we were talking about, those partnerships, and wondering if you could articulate just a few more of those key partnerships for the Department of Medicine, like in the overall—?

KLOTMAN: So certainly there are partnerships in science. For instance, Dean [Nancy] Andrews came out last spring as I was arriving with an opportunity to basically have the dean contribute to a faculty recruitment in terms of resources, but that faculty recruitment had to be a faculty member that was of interest not only to the Department of Medicine but to an institute or a basic science department across campus. For Medicine that's easy, so we—I and several of the leaders got together and asked, Well, what areas do we think are really exciting that would go across disciplines? With Microbiology we decided that an area of excitement and interest would be somebody that's really looking at the microbiome and that is the normal bacterial flora that live within individuals. There's a whole science around understanding that and how that influences health and disease. And so we successfully put together a proposal to the dean, and we are jointly recruiting a new faculty member in that area. And that's a win for us, for genome science, for microbiology. Another area is in metabolic diseases. Chris Newgard, who leads

Stedman Center [Sarah W. Stedman Nutrition and Metabolism Center], contacted me very early and said, “You know, I think we really could use somebody that is looking at the metabolic basis of diabetes at the very basic level.” Well, obviously in the Department of Medicine that’s a huge issue. We have a very robust Division of Endocrinology, we have a huge clinical need, and having a basic science presence there would be great, so that’s another partnership. We are jointly recruiting somebody in that area. Other partners, we’re sort of the partner for everybody. The DTMI, [Duke] Translational Medicine Institute, obviously our department has a huge presence there. We have the clinical cohorts, we have the clinical faculty that understand what are the translational questions. We have some of the physician-scientists that are key to that, so DTMI. DCRU, the Duke Clinical Research Unit are partners. We’re probably the largest department in terms of clinical trials, so we’re a great partner for the Clinical Research Unit where we want to embed some of our clinical trials. DCRI [Duke Clinical Research Institute]—our faculty have a major presence in DCRI, particularly cardiology, but now we’re building those relationships outside cardiology, some of the other subspecialties wanting to really develop faculty that can be lead investigators in multi-site trials in other areas, in infectious disease and pulmonary medicine. We have partners everywhere. And so far everybody wants to be a partner with us as well, so it works.

ROSEBERRY: You were talking about some of those clinical initiatives. You mentioned transplants maybe being a direction that the health system was looking to go. Are there other—?

KLOTMAN: Absolutely. And what I try to tell my leaders in the department is, Even if you have a great idea that you’re passionate about, if the school and the health system

aren't interested or don't see that as a priority area, that's going to be a problem. That just doesn't make much sense. So we need to understand what the priorities are across our institution and build around that. So transplant is a great win for everybody. The health system has just determined that that's probably a strong area for us to grow in because we have a lot of very specific expertise there, there's certainly a huge clinical need, there's a research agenda that's extremely important. I love talking to the leadership about growing transplantation; it makes sense for all of us. It's a wonderful opportunity. Oncology is another good example of that. We have a new cancer institute. For medicine, that's a great partnership. Medical oncology sits in the department, cell-based therapy, two major divisions in the cancer institute. Obviously I'm going to be a great partner for the new cancer institute director. He or she and I will be hopefully talking on a regular basis about career mentoring, about opportunities for research, about what areas in clinical medicine we need to start recruiting into—do we need somebody in lung cancer, do we need somebody in breast cancer? That will have to be a strong partnership. If I ignored it, that would be a mistake. The good news is it's an obvious win-win. So whether it's clinical or science, it's really figuring out what are joint priorities and then developing our plan around those priorities.

ROSEBERRY: And are there other keys—such as personalized medicine, are there other kind of keywords that, that are—?

KLOTMAN: Well, personalized medicine, as I said, I'm not even sure that's going to be the word of the future.

ROSEBERRY: Okay.

KLOTMAN: You know, the *omics* era, which is part of personalized medicine but really using the tools we have now in terms of—an ability to look at protein expression, RNA expression, and genetics to determine not only the causes of disease but determine the best treatment. So *omics* medicine and using *omics* to drive our basic and translational research is not unique to Duke, that's a tool that we had, or tools that we never had before. So that's a big part of our planning. Another big part of our planning is trying to figure out how we use statistics real time for decision making. We have the ability to really have a living dataset. Within an electronic medical record we are collecting data as patients come through our enterprise. How can we use that data? How can we use it from a statistical standpoint? How can we use it in terms of making decisions for our patients? So we talk a lot about biostatistics in many, many levels of conversation—how do we take that tool and use it? Do we train all of our docs to be biostatisticians? Probably not, but we want a certain level of expertise, but we also want to be partners with the high-level biostatisticians. And so again, How do we build those partnerships so that we can use these datasets to drive our mission? We do a lot of planning around biostatistics, bioinformatics. Whether we're talking about our clinical operations or our science, it's a key toolset that we struggle with because it's becoming more and more specialized. That's probably another area that's sort of a buzzword now. And certainly translational medicine—but I would argue that internal medicine has always been about translational medicine, it's just that it's a bigger opportunity now because we have all these tools to work with.

ROSEBERRY: Can you talk a little bit about funding in the department?

KLOTMAN: Yes. I lose sleep over funding. Six hundred faculty—450 MDs 100 PhD's, 165 trainees in residency, probably two hundred fellows. That's just my professional constituents. And how do you finance that operation? We are in evolution in terms of the financial models for clinical departments. I don't have a lot of the answers. The old model is that clinical medicine produced such a revenue stream that we were able to support some of the other parts of our mission that were more difficult to support, like education. Education, supporting faculty that are focused on education, even some of our research mission. That is no longer the case. Clinical medicine can, if run properly, probably support itself in some areas, although that's even more of a challenge now. And so how do you support this complex mission? As I said, I don't have all the answers. I have a lot of ideas, but it again gets down to partnership. So making sure that when we're working with the health system, where fortunately the health system does very well presently, that part of our conversation is, How do we support our missions? And being a good partner so that what I want to do in education and research complements what the health system is trying to do in clinical medicine. That's a financial partnership as well. And so a lot of my job is looking at the finances, looking at where there are opportunities financially as well. But it is a challenge and it is a very different model than I would say late seventies and eighties where clinical medicine could generate revenue that was quite helpful for the rest of our missions. Keeps me awake at night.

ROSEBERRY: Where does—some of those partners, where does their funding come from?

KLOTMAN: Our research funding is a mix of NIH and nonfederal funding. What's changed over the last couple of years is that nonfederal piece has grown. So we look for partnerships sometimes in industry, particularly if there's a trial that we're particularly interested in. NIH funding is becoming more of a challenge, so we are looking for research funding opportunities outside the NIH, and I think Duke has done that very well. Some of it's industry, some of it's with nonprofit organizations like Gates Foundation. And one of my jobs is constantly looking for those opportunities and making sure my faculty know about them. Clinically, the financial opportunities are around making sure our clinical programs run efficiently. So we talk a lot about efficiency now. That wasn't even in the language thirty years ago. We talk a lot about incentive-based compensation so that busy clinicians know if they work really hard and deliver high-quality care they will be compensated directly proportional to that work. That's very different now, but it is the language of the day. We also look for opportunities where if we build a program clinically and the health system will benefit from that there can be financial opportunities there. So it's knowing your operations and knowing where the opportunities are to grow them efficiently. The finances of education are tough. There are many teaching roles that we do in clinical medicine that aren't traditionally funded, so we look for education grants if they're there. There aren't too many of them. We make sure that faculty define their roles very carefully so they're not spending a lot of time doing things that we can't support. And those are sometimes difficult conversations, but it's part of the reality of today. So we make sure as much as possible that faculties' activities are aligned with where we can get support for what they want to do, and we hope that everything in the end of the day is aligned. Sometimes—I would say most of the time it is, but sometimes

we have to really have very serious conversations about maybe—maybe we can't do everything, maybe we can't support this part of what somebody wants to do, and those are reality checks occasionally.

ROSEBERRY: Well, let me ask you about being a female department chair. There are other female department chairs, but it's not a huge number here at Duke, and I wondered if it feels different to be a female department chair than maybe a male department chair would be or if there's—?

KLOTMAN: You know, I've thought a lot about this, and I must say thinking even back thirty years ago at Duke in the Department of Medicine, because some of the departments are different, when I was training, even though there were only five women in our internal medicine group, which was about thirty-five, I never was aware that there was a difference. One reason is because I was so focused on the academics and really trying to learn internal medicine that I might have been blind (*laughs*) in some way, but I wasn't aware that there was a difference. There was a culture of excellence, and that's what drove everything. Now, there were some practical issues that they didn't deal with back then. I didn't get pregnant during my residency, but there was no accommodating. I mean, there were no maternity policies, and so on a very practical level it wasn't dealt with. Nowadays we are very aware of the challenges to our young trainees whether they're male or female, and we deal with them. We have policies around maternity leave, paternity leave, that's all great, and I'm sure there was nothing in the 1980s. But I wasn't aware of being one of five women because again, I think we were all focused on the same thing. I was aware that all the chairs were male at the time. I was fortunate that there were some very visible female role models. One was Cathy [Catherine] Wilfert in

Pediatric Infectious Diseases, an amazing role model. And in some ways I did sort of look at her life and career and think, Wow, that's really great. When I came back to Duke they made a lot that I was the first woman chair of a major top twenty or what Department of Medicine, and you know, I was kind of thrilled by the excitement over that. I got a lot of communications nationally, and I realized—I never thought of it, it was important for many women that that was happening. And I felt great about that, even though it wasn't a driving force for me, but it felt great, and I thought if I can be seen as a leader in that regard, great. Because for the last twenty years I've been involved with mentoring women. They gravitated towards me, I was raising a family as well as being a leader in medicine, and I really enjoyed that role of having one-on-one conversations about challenges and how you do it, even though I can't say that the way I happened to do things may not be right for everybody else. But I enjoyed it on an individual level, and then when I got national support for that, I thought, This is really great, and it's exciting, and it made me very happy that I had that other dimension. When I got here it was similar to when I was a resident, I kind of rolled up my sleeves and said, I've got a job to do. It didn't seem to bother me that at the time I was surrounded by all male clinical chairs. They were all focused on what we need to do and were extremely welcoming to me—wonderful reception from the other chairs. I'm thrilled that there is now a second chair [in a clinical department], a female chair, and that'll be fun. Do we bring something different to the table? I think we certainly—we certainly bring visibility for our trainees, and I think that's important. In medicine now over half the trainees are women, and so I think having senior role models that are leaders is extremely important. On a day-to-day basis when I sit around with my other chairs do I bring something

different to the table? I bring my style, and whether that has something to do with me being a woman or not I'm not sure, but it is a different style. So I like the role, but it wasn't a driving force. The driving force was to be a leader in medicine and to bring to the table my vision which is really a vision I started when I was at Duke thirty years ago. But it's nice. I have to say on a personal note, my mother-in-law was the first dean of women at Indiana University, a school of 30,000. She was a great role model. And I used to watch what she did and say, she's a leader. And it was very gratifying to be able to share—she's still alive. The other big influence in my life was my mom, who is still alive, and they were both champions of my career, and they were very gratified, more so I think than I was. So that's been great. It's been a very personal thing for me. But I always try to tell young women that our challenges are similar to men, that we are challenged by balancing career and family. We do tend to take on a different role, particularly in family, but at the end of the day we're going to be judged on similar accomplishments. And so I try to really work with women as well as men in terms of how you can meet those benchmarks that we're judged on. And some of it may have to do with juggling or making career decisions that are appropriate at that stage. I would have never taken a chair position if my kids were still in high school. That was a personal decision. I feel great about that decision; I never missed anything in their lives. That's obviously a personal decision but that may have something to do with me being a mom, although I must say my husband made career decisions based on wanting to be around during that middle school and high school year as well. I try to mix the messages more about balancing, and some of it may have a gender-specific challenge, but I think we all are dealing with balancing careers with family and with other issues. It's fun to talk to

young trainees about how you do that and listening to what their challenges are and then trying to figure it out. But I must say it was very gratifying to be the first woman chair of Medicine at Duke and I'm sure not the last.

ROSEBERRY: Well, are there any questions that I should have asked you today or that—anything you would like to—?

KLOTMAN: The one thing I think we didn't quite finish is why Duke. On a very personal level, I made a decision about—I'd say about ten years ago to get back involved in Duke and the Alumni Council. One of my old friends, another woman, called me up, and she said, Would you like to be in Council? I was still pretty busy with my boys and my life but I said yes, and I got back involved, and more because I wanted to learn what they were doing here so I could apply it to my job. About five years ago I had the pleasure of meeting Dean Andrews. And so she, on a very individual level, is one of the reasons I came back. I really thought, She is thoughtful, smart, leader. She's a woman but that—again maybe I connected with her so much because she is, but just a person I wanted to work with. And I've always made career decisions based on who I want to work with and for. When I went to Mount Sinai there was a wonderful chair of medicine, Barry Coller, who is still my mentor, same sort of connection. So on a very individual level it was connecting with who I would be working with. Of course it was Duke, and the opportunity to come back to Duke was almost overwhelming. It was too good to be true, but it's true. But it really started with a personal relationship, and we—(my husband), we both said, This is a person we would like to work with, and that was great. So that's why I came back, and the fact that she happened to be a dean at Duke made it all the better. And then when I really started to look there was obviously the attraction of

leading a department that was still great, the opportunity of direct the department for the next couple of years, and I felt there was some tweaking that needed to be done so a job needed to be done. It all made sense. The only challenge is I'm commuting and my husband is now CEO of Baylor. So we have—we have our weekend commute. But it is—it's been great being back, and I feel very fortunate to have this opportunity. Hopefully I'll live up to it.

ROSEBERRY: Thank you very much, Dr. Klotman.

KLOTMAN: My pleasure. Thank you.

(*end of interview*)