ORAL HISTORY INTERVIEW WITH Elizabeth Livingston, MD
Duke University Libraries and Archives
Submitted April 20, 2024
Researcher: Gemma Holland

COLLECTION SUMMARY

This collection features an oral history I conducted with Dr. Elizabeth Livingston on February 24, 2024, for the Bass Connections Agents of Change oral history project. The 1 hour 26-minute interview was conducted in Perkins B09. Our conversation explored Dr. Livingston's childhood influences, educational pursuits, career milestones, and advocacy efforts. The themes of these interviews include resilience, compassion, and the ongoing pursuit of equitable healthcare for all.

This document contains the following:

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

The materials we are submitting also include the following separate files:

- Audio files of the interview*
    - Stereo .WAV file of the original interview audio
    - Mono .MP3 mixdown of the original interview audio for access purposes
- Photograph of the interviewee (credit: Elizabeth Livingston, MD)
- Scan of a signed consent form

*At the end of the interview recording, we recorded a self-introduction and room tone for use in a production edit of the interview.

BIOGRAPHY

Elizabeth G. Livingston, MD is a physician in maternal-fetal medicine, specializing in HIV/AIDS infection during pregnancy and diabetes in prenatal diagnosis. Dr. Livingston grew up in Birmingham, Alabama and has always had a love a science. She says, “I think my cousin was more inspirational in that [path for myself]…[the] combination of science and being involved with people was really appealing.”

Dr. Livingston graduated from Duke School of Medicine in 1984. Following her graduation, Dr. Livingston completed her residency in Obstetrics and Gynecology at the University of California–San Francisco Medical Center from 1984 to 1988. “One of the reasons why UCSF looked so appealing was because there [were] a number of women residents, and they were they were nice people,” she states, reflecting on why she chose UCSF for residency. Soon after her residency, she joined the fellowship in Maternal-Fetal Medicine at Duke University Medical Center. This fellowship provided Dr. Livingston with specialized knowledge and expertise to address the context of infectious diseases like HIV/AIDS in pregnancy.

Dr. Livingston has dedicated much of her career to understanding and managing the effects of HIV/AIDS on pregnant women and their unborn children. In addition to her direct patient care, Dr. Livingston dedicates time to prenatal diagnosis and counseling for diabetic patients. She has been actively involved in major clinical trial groups since 1988, concentrating on issues resulting from medical and surgical therapies for HIV-positive pregnant women. Through these trials, she has contributed substantially to improving knowledge regarding HIV/AIDS management during pregnancy. She says, “Certainly, [the] HIV work will be [what I’m most proud of]. Yes, to see that come so far for our patients [until] now. I tell them 1% chance your baby will be infected. I used to say 30%, when we started.”

Aside from her clinical work, Dr. Livingston is committed to broader efforts to advance gender equality in healthcare through policy reform and community outreach. By voicing her opinion on crucial matters affecting women's health and supporting legislation such as the Working Poor in North Carolina, she actively contributes toward improving accessibility to high-quality healthcare services for all women. She has also served as a senior advisor to the North Carolina Obstetrical and Gynecological Society, where she has provided valuable insights into maternal health policy and practice. She has been a vocal supporter of informed infant feeding choices for parents living with HIV, recognizing the importance of empowering families to make informed decisions about their infant's nutritional needs. Dr. Livingston is a huge proponent for advocating for Medicaid expansion and ensuring that everyone has access to affordable healthcare.

Dr. Livingston's dedication to advocacy for HIV/AIDS infection during pregnancy and diabetes in prenatal diagnosis has changed and will continue to change the lives of countless women. She has advocated for women to have the ability to make informed health decisions, advocated for access to quality healthcare, and emphasized the importance of evidence-based medicine. Her advocacy will inspire future generations of physicians and researchers to strive for excellence in maternal-fetal medicine and commitment to improving women's health.

INTERVIEW TOPIC LOG (ELivingston.wav)

00:10 Introductions
00:36 Discusses her upbringing in Birmingham, Alabama
02:34 Reflects on familial influence on academic pursuits
04:13 Recalls what fostered her passion for science and laying the groundwork for her academic pursuits.
05:33 Shares her transition from high school to Harvard University, discusses new perspectives and academic challenges
09:16 Highlights her experiences at Harvard
11:24 Discusses her decision to pursue medical school directly after undergrad and her time at Duke University School of Medicine
13:21 Describes her experiences at Duke University and in Durham
14:30 Provides a timeline of her educational journey
14:47 Discusses her decision to specialize in obstetrics and gynecology (OB-GYN) during medical school
17:08 Shares her gratitude for supportive colleagues and mentors, speaks about occasional awkwardness and gender-related challenges.
19:17 Residency at UCSF, where she encountered diverse perspectives shaping her decision to specialize in maternal-fetal medicine (MFM).
22:04 MFM fellowship.
25:11 Returning to Durham for her fellowship
26:59 Reflects on her early encounters with HIV/AIDS during medical school and residency
33:25 Recounts the impact of actress Elizabeth Taylor's advocacy for HIV/AIDS patients
35:18 Evolving challenges and approaches to treatment of HIV/AIDS, including her participation in clinical trials.
39:26 The pivotal role of community advocacy and collaboration in advancing HIV/AIDS research and care
43:15 The importance of compassion and dispelling misconceptions among healthcare professionals.
44:23 Shares personal anecdotes illustrating the challenges and complexities of caring for HIV/AIDS patients
50:55 Concludes the discussion on HIV/AIDS, recognizes colleagues (Dr. John Bartlett and Dr. Catherine Wilfert) and their influence on HIV/AIDS
51:27 Discusses her involvement in organized medicine and the evolving perception of its role in advocating for patient rights
56:08 Shares anecdotes from her experiences at the North Carolina state legislature, Civil War reenactors
58:30 Discusses the historical context of abortion care within medical education and practice.
1:07:45 Speaks about navigating relationships with legislators and balancing multiple advocacy priorities
1:08:15 Transitions back to maternal-fetal medicine, Dr. Livingston discusses her motivation for specializing in the field, the challenges, and advancements made
1:10:24 Reflects on the changes in maternal-fetal medicine, emphasizing the lack of significant progress in certain areas such as the prevention of conditions like preeclampsia and preterm labor

1:13:45 Describes her ongoing involvement in patient care and ultrasound services within the community, highlighting the comprehensive approach to maternal-fetal medicine
1:15:06 Discusses her involvement with Duke University beyond patient care, including committee roles and interactions with the broader university community
1:18:01 Emphasizes the value of engaging with diverse perspectives within the university community and how it has influenced her outlook on advocacy and medicine
1:19:35 Recounts her transformative experience working in Tanzania and how it reshaped her perspective on healthcare systems and resource allocation
1:21:48 Expresses pride in her contributions to HIV care and advocacy, highlighting the progress made in HIV treatment
1:23:13 Acknowledges the positive shifts in institutional support for reproductive rights at Duke University and emphasizes the importance of leadership in advancing women's healthcare
1:26:14 Closing interview tasks

TRANSCRIPTION (ELivingston.wav)

Gemma Holland 0:10
My name is Gemma Holland. The date is February 24, 2024. We're recording in Perkins Library, and I'm interviewing Dr. Elizabeth Livingston for the Agents of Change oral history project. Okay, to get started, I think it's best to contextualize how you grew up. Can you tell us a bit about your childhood, and where you grew up?

Elizabeth Livingston 0:36
Yeah. I'm Elizabeth Livingston, and I grew up in Birmingham, Alabama. Certainly, been in the news lately— sometimes not in such good ways. But I had I had a wonderful childhood. I had two parents who were very committed to learning. And so, I got a wonderful education and had a very warm household. I'm the youngest of four kids, and the only physician in my family, although my grandfather was a physician, and my uncle was a physician. And I had a first cousin who lived nearby who was a physician, and he was at UAB [University of Alabama at Birmingham] when I was in high school. And that's probably what inspired me to go into medicine, because he got so much joy from his learning. I was a good science student and doing biology. And so that's what got me into medicine.

GH 1:31
And what did your parents do?

EL 1:34
My dad was an actuary for a life insurance company in Birmingham. And my mother was— this was the 1960s, so she was a stay-at-home mom, volunteered, and did lots of things. And [she] was very involved in the Birmingham Art Museum. She helped make the museum grow from a little room in the public library to having its own building. And so, she was very involved in that. She had a Master's in math, she was very involved in learning, she was on the board of [the] local school that I'd end up going to. She was very involved civically. And I think there was always an expectation that you do something with your life and that education was the cornerstone of that.

GH 2:34
Did you ever go and volunteer with her? Do you think that her volunteering impacted the work that you do now?

EL 2:45
She would take us to the museum and teach us about art. She was a well-educated woman and had a lot to say on different things. I don't know that I'll ever be as smart or well-versed as she was. She's 99 now and is mildly demented, which [is] hard to see. My cousin in the science[s] [took] a different [route] than that she took. I was lucky to have grown up in the 1970s. Going to

high school, I graduated in 1976. The women's movement was really kind of taking off. And there was a push for that [idea that] you could be everything then. My sister was 10 years [older], [and there] was certainly much more channeled towards [the idea] that she needed to look for create a home and take that route, although she didn't do it either [laughter]. She's a professor of psychology at Louisiana Tech. So, I think my cousin was more inspirational in that [path for myself].

GH 4:02
Can you talk a little bit about your cousin? Did you ever see them [working] in the science field, and how did that inspire you?

EL 4:13
His name is Wiley Livingston. He went to UAB and had a little apartment on the south side of Birmingham and had all his books and aquariums lined up. And he was very nice to his younger cousin. I just [heard] his talks of meeting people in the emergency room. And he had the Krebs cycle on the back of the door of the bathroom [laughter]. So those things— being the young nerd I was – that combination of science and being involved with people was really appealing. He went to the London School of Tropical Medicine and then came back and did an ID [infectious disease] fellowship. He's been in private practice, and he's now 72 and still takes calls in the middle of the night. He's a traditional physician, he sees patients in the clinic, follows them to the hospital. He's still an inspiration.

GH 5:23
Can you talk a little bit about your love of science in high school and how that carried over to your college life?

EL 5:33
Oh, so there was a wonderful biology teacher named Lois Hannah, who had done some research at UAB, and came back to teach high school, and she was just an amazing teacher. [She] made science so accessible, and made it come alive. So, we had some hands-on projects. I would say she was part of it. The other backing up even further [at] my middle school they had project-based learning called ISCS [Intermediate Science Curriculum Studies]. So, you did little experiments all day, which may not have been the most efficient, but it sure was fun [laughter]. [For example,] making hydrogen tubes blow up in the classroom [laughter], and it was it was good fun. So, I do think that hands-on with the program in middle school and then having a really excellent biology teacher. Okay, I was a nerd. I was in the math club [laughter] and did some math tournaments, but the biological sciences for a lot more fun for me.

GH 6:50
Okay. And so after high school, you went on to college?

EL 6:58
Yeah. So, my parents were very involved in learning, and I knew I wanted to get a little further away from home growing up in Birmingham, you can imagine had some expectations and was a little regimented [laughter]. So, I had an excellent high school guidance teacher who encouraged [me]. I did well enough on the SATs [that] they encouraged me to apply wherever I could imagine going. I got into Harvard, and it was the first joint class of Harvard Radcliffe. I [spent the next] four years in Boston, which I'm not sure I was completely prepared for.

GH 7:37
Yeah. What was that like going from Alabama to Harvard?

EL 7:42
It was a little overwhelming. I think the diversity of thought [and] having to defend almost every core value to someone else was something new. It was pretty cozy and cushy, at my little school in [my hometown]. [I had never been] pushed in school which has been pretty easy for me [throughout] high school. I had lots of support [but] if I got caught up on something having to push through on my own was a new experience. Living in a tiny room about this size [laughter] with somebody I'd never met before was tough, and I found that a little challenging. I was on the tennis team, and [it] was fun getting out there. I took up jogging just for the relaxation and getting out of [my] tiny room and library. So, I enjoyed running along the Charles in Boston. I probably enjoyed exploring Boston and that was as much of an education as anything. Going down, I would ride to the Museum of Fine Arts. I loved to go to see the Isabella Stewart Gardner Museum; I dated a man from MIT, and it was a huge transition and very opening.

GH 9:16
How did your love for science evolve while you were there?

EL 9:22
I had an excellent [professor] George Wald, who did the biochemistry of vision was my biology teacher [my] first year and was an excellent teacher. I think by that point I decided that pre-med was the way I wanted to go. Maybe because I needed a path [and] a goal. I loved those early biology classes. While I was there one of the upperclassmen in my dorm at Kirkland House had a lab, she was working with over at the Harvard Medical School. When she graduated, she introduced me to them. And so, I started working in Ken Ryan's lab, doing hormone metabolism, and Jack Canick was a man who was there. He was a wonderful mentor, and I learned some lab techniques and got some projects done, so that was just a great introduction to the scientific process [of] a real lab and being able to generate some new knowledge. So, I enjoyed working with him. Also, I spent my summers back in Birmingham, and there was a man named Dr.[Buris] Boshell who had built a diabetes hospital and had research labs on the top floor, and he was

wonderful. So, I got a really wonderful introduction to the benchtop scientific process, which is slow and, and incremental in its progress, if you're thinking of doing a benchtop project [laughter].

GH 11:15
Okay. After Harvard, what did your education look like after that?

EL 11:24
So opposed to now, where I'm on the admissions committee for the medical school, and [now] almost everybody has some gap years. It's hard for people who are applying right out of undergrad, even if they know where and what they want to do. [And] the CVs are so impressive now, where people have done some very rich experiences. Experiences volunteering, research, and clinical exposure. It's hard to get a good transcript, do well on your MCAT, and have that experience. Almost everybody now has a year or two gap years. I think it's a good idea because the medical students coming in today are much more mature than I was going into medical school.

It was pretty clear that if I wanted to go to medical school and enjoy the continued support of my family, I was going to need to go straight [into medical school]. So, I applied. My sister had [gone] to Duke as an undergrad and loved the experience. [She] thought it was just the greatest place on earth. And so, I got into Duke and decided to come here for medical school. So that was a pretty straight shot. I was thinking about [being in medical school] today, and [it is] so pretty outside, and spring break [is] coming up. I can remember [during my] spring break I was sitting in a little house library at Kirkland House studying for the MCAT. Yeah, I did well on the MCAT, so it helped get me into medical school. So, it was a good investment of time.

GH 13:16
What was it like at Duke or in Durham in general?

EL 13:21
Oh, it was wonderful. I still have some of [my] best friends. And I hope you're accumulating some best friends. Yeah, I've got two trips planned with classmates later, and I keep up with some of my classmates still in Durham. There wasn't as much to do back then. It was a much sleepier place. There was a barbecue place, there was a fried chicken place, so that was about it. So, we had lots of potlucks. It was a very tight class, and there [were] people from all over. So, I learned a lot from my classmates. And the medical school curriculum is very fast-paced as opposed to Harvard, where things were very laid out and incremental. I had lots of time to learn things. Here it was very fast-paced, and it was academically challenging for me but [there were] some great professors and wonderful classmates.

GH 14:27
What year was that when you—

EL 14:30
I graduated from high school in 1976. I graduated from Harvard in 1980 and graduated from medical school in 1984. So, we're coming up on our we're big reunion here 40th reunion [laughter].

GH 14:47
During medical school, what kind of got you thinking about going into what you do now?

EL 14:58
I thought that when I came in because Cousin Wiley was [in] internal medicine and I had done the diabetes work over the summers and work[ed] with the hormones with Ken Ryan's lab. I thought, I'll be a diabetologist, [and] I'll go into endocrinology. So that was how I started [and] did my internal medicine rotation at the VA. It was very discouraging [to see] older male [physicians] who thought, Well, gosh, if we really wanted to help their health, we should have had them stop smoking 40 years ago, we should have helped them stop drinking 30 years ago. It seemed like starting earlier on somebody's health trajectory would be more important. My sister was having babies then, and I saw how engaged she was with her provider, how much she trusted her provider, and how important that relationship was. My roommate who ended up going into peds [pediatrics] was initially interested in OB. So, I heard a little bit more about OB [because of her]. I did my OB rotation last. So, I was so comfortable in the hospital by then, and I think it was [these experiences] that probably led me [to choose OB].

[However,] my friends say it's because I lived at the Poplar Apartments [in] Louise Circle, and they weren't air-conditioned. Since it was summertime being awake at the hospital was more comfortable than being at home [laughter]. So, the call didn't scare me. We had a wonderful chairman back then, Charles Hammond, who was very encouraging because then many women weren’t going into OB [both] Dr. [Roy] Parker and Dr. Hammond were very supportive of women going into OB, so that was helpful. When I first came to medical school, most of the women on the faculty were in peds [and] there weren't many women faculty outside of peds.

GH 17:08
What was that like being a woman in OB? Did you face anything like adversity or people push[ing] back?

EL 17:18

It's interesting. I have not had that problem, and I don't know if it's not looking for it. I had some friends in my class who said they experienced terrible comments and sexist things that happened. I have to say [that] I am very grateful because most of them were men who decided to bring me into the fold and teach me their craft. I just didn't experience that kind of, I mean there were awkward things. I was 22/23 years old when I started medicine at the VA, and you can imagine how embarrassing things could arise [when performing exams]. It was awkward, but we got through it and I was never harmed or threatened. I have heard stories of people being reduced to their just female state. My colleague, [Andrea] "Andi" James said that her daughter on her ortho [orthopedics] residency that there were three women in the program, which was their commitment to diversity. [These women] were called the vaginas. I think it was done in an off-hand, glib way, but still not a nice thing to be called. I don't think I'd like to be more than my vagina on an ortho service [laughter]. So, I have been blessed. I don't think there have been doors closed.

GH 19:07
After med school, you said you graduated in 1984. So, where did you do your residency?

EL 19:17
I looked all over the country again. I thought it was probably good to train someplace different than the medical school. Now, I don't think it would have mattered that much. I could have gotten good training here. I went to UCSF [University of California, San Francisco]. Back then, you had to get on the airplane and go all over the country. God bless all those people who let me sleep on their couch [laughter] and stay because you'd have to stay overnight to get the cheaper flight. This dates me but my dear friend Jayne Tobin from my class So, we both bought the Eastern Airlines 60-Day fly anywhere for $350 [laughter]. We spent the last weekend of all our flights [in] Bermuda and ate toast because we didn't have any money. [At] bed and breakfast, we probably each ate half a loaf of bread [laughter] because we didn't any have money to buy any other food to wrap up our interview trip.

I got to UCSF, and they did have more women there, and [I] got to meet with them after [at] San Francisco General in the cafeteria. It just looked like someplace I could fit in, and it ended up being a wonderful place to do a residency. [I did] get one sexist remark when I went to Utah, understand it's become much more progressive in recent years. One of the places you would rotate through would be the LDS Hospital, Latter Day Saints Hospital. I did have [a] man but not in a mean way ask me about rejecting my nature to work and not stay home to be with my family. I thought it was this [inaudible] question from him. So, I answered it sincerely, which was an: I think I could do it all kind of response. When I was interviewing most of the programs had had no women residents yet and some had one or two. I didn't want to be the pallbearer, not [the] pallbearer, but the flag waiver as to represent my entire sex as well as learn a residency. I

think it's one of the reasons why UCSF looked so appealing was because there [were] a number of women residents, and they were they were nice people.

GH 21:57
How long did you stay there? Did you—

EL 22:01
Just the four years.

GH 22:02
Okay, so what do you do after residency?

EL 22:04
When I went to residency, I was thinking I'd go into reproductive endocrinology, [which has] been in the news lately. But [in] OB, they had a huge maternal-fetal medicine faculty. Reproductive endocrinology was interesting intellectually because [of] all the hormone metabolism and the different derangements. Now, reproductive endocrinology is mostly just infertility because that's how people support themselves, not maternal-fetal medicine.

Also, I didn't realize how much I would enjoy operating, deliver[ies], forceps, and breech extractions. Their work seemed so important. I had some just amazing professors there, named JT Parker and Russell Laros, and they were excellent. One of my senior residents, Linda Van Le is married to Glenn Jaffe in the ophthalmology department, they live right around the corner from me, so I get to see Linda, who was one of my teachers. So that's, that's terrific.

GH 23:32
So after UCSF, what did your life look like after residency?

EL 23:43
So at UCSF, there [were] a lot of people subspecialized, and I wasn't quite ready to jump into a practice. Clearly, I'm in a room of people who like to learn [laughter]. So, continuing to be a learner, maybe it's my own lack of confidence, but I felt like I needed to learn more. So, I started applying for fellowships. Maternal-fetal medicine was a fairly young subspecialty of OB-GYN, and I loved being [in Durham]. My new husband [that] I had met during medical school was finishing medical school and wanted to do his psychiatry residency [there]. I applied for MFM [maternal fetal medicine] and worked with a lovely group of people and was probably taken in more as a junior partner than as a learner. They were gracious and taught me [a lot] and hired me after that. So [in my] fourth year of residency, I applied to fellowships interviewed a couple of places, and got here.

GH 25:06
What was that like coming back to your old stomping grounds?

EL 25:11
[laughter] Well, I loved Durham. It was starting to grow a lot at that point. So there [was] a lot more opportunity [and] things to do. My then-husband was building a house out in North Durham, and he had a little shack out there [from] when he was an undergraduate. He was building a house so that was fun. There were still some people [like] Jeff Baker, Laura Schanberg, and some [other] classmates still around. So, I had [a] ready-made group of friends here.

I'll tell you one story, Sam Katz, who was the chair of the pediatric department had no reason to remember me. I was walking through the hallway, and he said my name, it was the most amazing thing. He said [that] when he was a resident the chairman didn't remember his name. So, he made a point to remember everybody's name, and he was just smart enough to be able to remember mine [laughter]. So, there are days we would sometimes forget [the] neighbors' names, you know, I saw that he was actually like Ulysses coming back at the dog remembering. Certainly, Sam Katz was not the dog, but it was nice to be remembered. All the people [in the] department that I'd worked with remembered me too. So, [it was] very comfortable coming back.

GH 26:48
So, you said you did maternal-fetal medicine, and I know that you do work with, HIV/AIDS infection, too. Where does that come in [your] timeline?

EL 26:59
When I was a medical school [in] 1984. We had seen in [my] fourth year of medical school, [that] the MMWR [Morbidity and Mortality Weekly Report] from the CDC, which publishes disease reports and things popping up, had a report that gay men were dying of opportunistic infections at a higher rate. One of my classmates, who is probably would have been better for you to interview, is named Diane Havlir. She's an HIV expert now [at] UCSF and was my intern year roommate. I remember jogging and talking a little bit about but what could have caused this. By 1985, they had identified the virus. By 1987, we were using or maybe 1984 or 1985 that they had finally had a test for it.

I do remember the fourth year [of my] ID [infectious disease] subspecialty rotation for one of my fourth-year rotations [that] we were looking for people because they wanted to find their first case. You don't want people to have a terrible disease, but they were—. So, we didn't we didn't find anybody then, but [positive cases] came pretty quickly after that. One of the things you do is rotate through different areas of medicine. When I was an intern, I did some pathology. I did two

months in internal medicine and sometime in the ER [emergency room], which were great educational experiences. And I was rotated through San Francisco General, which had the biggest AIDS ward [in] the country at that point, 5B.

When I first got there, they were working everybody up for every fever, you know some people would come in and then people thought you could treat every opportunistic infection. Now, we know your immune system is pretty good by the time you start developing opportunistic infections. By the end of the year, I rotated back through medicine, and they had pretty much stopped [working everyone up for everything]. [At this point,] they were just trying to keep people comfortable. Azt [zidovudine, drug to treat HIV infection] was started, and they were looking at in vitro, but nothing much had happened [on that front]. By my fourth year, we'd start working everybody up again to try to get them [the drug]. They had some medications, and clinical trials where some people were responding. So, they're trying to keep people alive to get the promise of the medication. I think we started at 5A, and then they moved to 5B, and then they moved to a different ward. I can remember the call room I had was in 5B and when I was a chief resident, I could remember thinking, "I'm sleeping in the room that Mr. Smith passed away in during my intern year," which was a pretty intense thing to think about. I do sometimes have flashbacks to some of the men that I cared for. If you look at some of the pictures on the internet of people dying of AIDS in the 1980s, you know [it's] just wasted and sick. And it's such a sad thing.

So, Dianne Feinstein was [the] mayor of San Francisco then. While I was there, she shut down the bathhouses, which was an outrage because these men had worked hard to gain their sexual freedom. This seemed like a restriction, which, in retrospect, was probably a good public health measure and probably saved lives.

Okay, so I lived in Boston in the 1980s. This was the Ronald Reagan era, everybody was wearing button-down collars, preppy shirts chino, and boat shoes [laughter]. The first week in Durham was very conservative, you know, [a] wholesome place, rah, rah, Blue Devils. I got to San Francisco, and it was in June. I had a day before my residency started, and I went for a jog because I was a runner. I lived in Noe Valley, and I headed north, but that put me into the Castro, and it was the Gay Pride weekend. So, it was quite a little run [laughter]. I thought, "I think it's time for me to turn around and go back home [laughter]."
So, I cared for HIV-positive people in San Francisco. I didn't get sick, [and] It didn't frighten me the way it did some people at that point because people didn't know. There was certainly a lot of prejudice. Haitians had a higher incidence and IV drug users, So, there was there was a lot of prejudice about HIV. I was at San Francisco General one of the days that Elizabeth Taylor came and brought plants and visited with the men in 5B. Do y'all know who Elizabeth Taylor is?

GH 33:25

Do you? [asking others in room]

EL 33:27
[laughter] When I was growing up, I was a little horse crazy, as many little girls are. I read a book called National Velvet. There was a movie made [in] the 1950s starring a young woman named Elizabeth Taylor, who was an English actress. She was great at it. Then, she married Richard Burton, and they had a very stormy relationship. If there [would] have been a People Magazine, she would have been on the cover. In the 1980s, she had kind of gotten less attractive and wasn't acting as much. [She] was still famous for all the husbands she had had. She had made a perfume, and at that point, it seemed people [weren't] wearing as much perfume because I think they realize they're gonna give everybody an asthma attack [laughter]. We were seeing her [in] TV ads, and so she [was] in the public view again. As an actress, I'm sure she interacted with a lot of people who were gay and had a gay lifestyle. She was an icon and she came [to the hospital] like Princess Diana [at] the Children's Hospital in Philadelphia and visiting and holding kids with HIV. Bringing gifts and sitting with people with AIDS was just an amazing thing to humanize what was going on and to show that even people who had lots of choices [in] life would choose to spend time with people with AIDS.

GH 35:18
Did your work with HIV/AIDS continue when you came back?

EL 35:23
So, this was just something I did on the medicine service. I wanted to be an obstetrician. So, I came back to Duke [to do] maternal-fetal medicine. I will tell you in San Francisco, they did something called Bay Pack. By the time I was leaving, they had had maybe three or four women total, who were HIV positive. So, there was almost nobody who was female, and having children who was positive until 1987/88. When I came back, crack cocaine had hit, and the people were using a lot of crack cocaine, and there was a huge sect for drug trade nationwide. My understanding is even in prohibition, [Durham] was kind of a drop-off point between Atlanta and Washington. [Durham] was not spared during the crack cocaine times. We were seeing gay men, and people involved in sex for drugs. And we were starting to see some positive women, and they were testing extensively. The way you identify people, there wasn't a recommendation to screen, blood banks were the only places doing it in any sort of big way. A woman would come in intubated with respiratory failure and pregnant. They would do a bronchoscopy. Then, they would do what's called a silver stain and find the pneumocystis [which] would be her AIDS-defining illness. Some people made it out of the unit because you can treat the pneumocystis and some people didn't. So that was about the same time, they were bringing along AZT. As soon as AZT, I think it was like 1987, was approved. So, there were people starting to use it, and some clinical trials going on.

One thing that I think is amazing is the way the public pushed to have this disease prioritized, [and] moved along. And I'm not the expert to tell you about it but even here, you could see the government required people to have community members on board. It wasn't just the science driving it, but that it needed to fit what the community wanted. So, we had a community advisory board attached to the ID clinic at Duke, and the ACTG [AIDS Clinical Trials Group] started Act Up, a group that protested to get more involvement. So ACTG, once AZT looked like it was working for some people, wanted to look and see if it would help protect babies, which was very palatable to everybody to save the baby. So, one of my old professors at UCSF said you need to meet with Cathy Wilfert, who was a pediatrician here who was very involved with caring for kids with AIDS. And she was [one of] the grant holders for our first ACTG grants along with John Bartlett, I believe. He's [an] amazing person to get to talk to that.

GH 39:26
Someone else interviewed him.

EL 39:30
He's sort of he's an amazing man. Yeah, I'm glad you got him because I thought he sort of packed up his desk and left when he retired [laughter]. So, I'm so glad you got to talk to him. So, Cathy Wilfert had the infrastructure and she needed to [recruit] women who are HIV positive for drug trials. And we didn't have a lot of patient[s], but the patients were willing. And [it] takes some courage to go on these drug studies and have some faith that we weren't [misleading them]. Think about Tuskegee and other [studies] that we were misleading people. And she started the pharmacokinetic trials,[which] look[ed] at what doses were going to be needed. And they were a site for a landmark study called 076. And so, [I] was a site obstetrician, I can't take any credit for the science. So, we gave people AZT five times a day. I can't imagine taking anything five times a day, and IV AZT in labor, and then [gave] the baby AZT syrup afterward. We dropped the transmission rate from 30% to 6%, which was the first time anybody [had] been prevented from catching HIV. You can see the graphs of pediatric AIDS infections, [once] you get to 1994, and by 2000, it was almost zero. And we kind of put the peds ID clinic out of business for HIV.

Yeah, I'm so glad you got to talk to somebody who talked to Dr. Barlett. I can remember [that] there was an article in The Independent about what he [had] done to humanize and care for patients. There was a story about him at a fundraiser dancing with one of his gay patients. It was an amazing clinic that he ran in the basement of Duke South. I think it helped patients [know] that they could come, and [that] people would treat them kindly because people weren't so kind at that point to HIV-positive patients, who were scared.

I can remember one of the first patients who we were delivering. The baby was about to fall out, and my two residents, [that] were lovely people. One was a man [the other] was a woman, but

that didn't matter. They were putting on their second pair of shoe covers, the third pair of gloves, a second hat [laughter] because everybody was scared [of contracting HIV]. The baby was about to fall out, so I just put on a pair of gloves and caught the baby. And [the male resident] said to her, "She was in San Francisco, she probably has [HIV/AIDS] already anyway" [laughter]. I don't think so, but yeah. The baby did not hit the bucket underneath the bed. And I think I think yeah—. This isn't coherent. So, I'm sorry, I've been rambling a bit here. [Do] you want to redirect?

GH 43:15
Would you say there was still a stigma [among] physicians or residents concerning people that had HIV/AIDS?

EL 43:25
Oh yeah, and I think there may still be. I think there [are] some assumptions when an HIV-positive person hits the door. [Assumptions] that they're gonna be poor, they're gonna be black, they're going to be/have been involved in drugs or sex for drugs, and some assumptions that are just not fair, and will hinder their ability to care. Nobody gets [into] the situation on purpose. Nobody looking to get infected and so on. I see as my job and the drugs change, what will protect the baby changes and what will keep the mother healthy changes, but certainly teaching people to be compassionate doesn't change. So that's, that's if I'm going to teach your residents something that's going to be it.

GH 44:17
I saw that you did a bit of legislative work. Can you talk about that?

EL 44:23
Yeah, that's big. I'd like to stay on HIV a little bit longer.

GH 44:28
Okay, yeah we can! [laughter]

EL 44:29
Well, I don't think that we've— Okay, I'd like to tell another story. When we did deliveries, we used to check every baby's blood type. Now we just check if the blood is O positive just to see if see if the baby's risk for jaundice. When I was a medical student, it was the medical student's job to draw the blood check because you took the needle, and it was the easiest blood draw ever because the vein is the size of my thumb. And so you kind of got the angle the needle [but] amazingly, it can still miss it. But it was good practice. So, we used a needle to draw it and over time people realize[d] that the problem is [when] you're holding the cords like [demonstrating how the cord is held] it's so easy to stick yourself with the needle. Now, we usually clamp the

cord [and] let it run into either a syringe, and then load the tubes that way. So, it's gotten much safer. I had the sweetest resident, who was a second year [and] was operating doing a C-section on one of my HIV-positive patients. We [drew] the cord blood for a drug level for a study. She [had gotten] married the month before, and she stuck herself. We didn't have our loads at that point to know if the patient were. She broke scrub, washed her hands and went to Occupational Health [to get started on] AZT. She was using birth control pills but told her partner they were gonna have to use condoms because until she got beyond, I think three months was what they were using for testing because we didn't have viral loads. So, and she took the AZT for a week and said, “I can't do this, I won't be able to work.” I thought about all the patients that I had been [telling] take your AZT and pushing them so hard. And here was my resident who couldn't stomach it. So that was— she was negative.

I had another patient. I had Dr. Bartlett's clinic, the grants wanted patients to have one-stop shopping where they wouldn't have to go all over to get medical care. So, he needed a gynecologist and since I had been involved in the ACTG work already I started going one day a week as the gynecologist for the clinic, mostly an obstetrician, I didn't do a lot of surgery. For a while I was operating on them because nobody else would. Then other people started being more comfortable. I did have a patient who was getting a hysterectomy because she was bleeding so much it was affecting her quality of life and her health. She was getting [her] hysterectomy and one of the residents who was doing the case, threw up the suture because you would when you're operating in the vagina. You want the tail of the suture to go up here [demonstrating with hands] while you go and you anchor the stitch, and then you tie it down to tie off your blood vessels. So when she was throwing it up, she skewered the poor resident standing above. Then, it did make me worry that I had brought these patients into these residents' lives, and they didn't have a choice of whether to operate or not, and I put them in harm's way. So both of them [were fine], but it did make me pause and think about this as an academic course.

So for a while there before we had triple therapy [which] came in 2000, people were not living very long. One of my goals was to not have anybody die with a GYN diagnosis. So, I tried to clear up their pap smears, their vaginitis, and whatever else was going on. So that it was because it was like why are you following a pap smear on somebody who [has] AIDS? They're gonna die of something else, and I kind of felt like no [I] need to. They might not die, but we need to keep managing them.

One story I thought about walking over here that I hadn't thought about a long time was when I first started doing my GYN practice in the peds clinic because the mothers would bring the kids in. The nurses in the pediatric clinic weren't so happy about helping me with pelvic exams in the peds clinic. I knew that I was going to need to move from the peds clinic to the adult ID clinic the day that I found the speculum from the week before still sitting in the sink. The nurse said that she wouldn't clean it. I found a group of people who were very happy to help, and [I] still

[am] going to the ID clinic twice a month to care for patients. [This] has been very satisfying because they're all doing so well now. The meds have been great. I got to be involved in some PK [Pharmacokinetics] trials with medicine called didanosine that's no longer used. We worked hard to try to get all the dosages and to try to have an alternative to AZT. It didn't end up being a good one. But that was amazing working with people from all around the country on that. Then, I was involved in one called A5084, which now that there were better medicines [they were] trying to get medicines that were safer and had fewer negative consequences for people. So there was a class of drug called protease inhibitors, which were hard to take and had a lot of complications. So, we were looking at those complications in pregnancy so that was my academic claim to fame.

GH 50:55
Is there anything else about the HIV/AIDS that we missed? Or we have not—

EL 51:01
Oh, I think only to sing the praises of John Bartlett and Catherine Wilfert, that they— visionary is an overused word. But how we're farsighted and compassionate, and just model physicians in showing us the way.

GH 51:21
Okay, and let's go ahead and move into your legislative work.

EL 51:27
Okay, that's maybe a little different. [laughter]

GH 51:31
Yeah. Can you talk about that? Yeah.

EL 51:33
So, you know, Woody Allen said 90 or 70% of life is just showing up and sometimes that's true. The other thing [is] that I go to a lot of conferences, faculty development conferences, and one of the things they talk about is learning to say no. What I don't like about those lectures is, that if you don't say yes to some things, you're gonna miss out on some good opportunities, you just have to pick what's going to end up. That's true for y'all and your lives too because you don't want to close the door to adventures that might lead you someplace interesting.

I will say that throughout my life, I thought organized medicine was mostly self-serving. I don't know how you feel about that. But it seemed like they were always just working to preserve physician pay and for physician prestige or cut other people out of the practice of healthcare. Now that I've gotten a little further along and more involved in reproductive health rights, I

would say that I've [started to] think that organized medicine may be where it's at and that we need to claim it for advocating for our patients. I can remember turning my nose up at the AMA [American Medical Association] as being a bunch of guys who want to make sure they get paid. There was a time when AMA said they would endorse Sunbeam products but now they've gotten much more involved.

So another sideline of what I've done over time is education. So I ran the clerkship for a long time [and] stopped probably about 10 years ago. [I] enjoyed education and so got involved in a group running CME [Continuing Medical Education] programs. So, I got more involved in local organized medicine [and] organizing CME programs. So, I [was] involved in the OB-GYN Society in North Carolina running CME programs, which then led to [me] getting involved in leadership because once they see you could organize that then you get invited along. As advocacy becomes a big part of the agenda, and certainly in North Carolina reproductive rights has been a big problem. We have been really slow to expand Medicaid. SB [Senate Bill] 20 occupied a lot of time last year shutting down access to abortion for procedures beyond 12 weeks. So, this [has] been a busy time expanding Medicaid before SB 20. When I was president of the OB-GYN Society, we did some White Coats Wednesday's [and] went down to visit and work with the medical society to try to expand access to Medicaid, which has since happened. It happened in December finally. I'm so sorry it took so long, [and] I think of patients who struggled to access care and probably had worst health outcomes because they couldn't access care because they didn't have funding to get the care they needed.

Now, I'm section Chair of North Carolina ACOG [American College of Obstetricians and Gynecologists]. One thing leads to another and I'm going next week to the Congressional Leadership Conference in Washington, where we go and meet with our senators, our state representatives and get lessons on how to talk [about] difficult conversations. Talking about abortion is a challenging topic especially if you're dealing with people who don't approve of it as an option for women. So, they [go through] some coaching and help us with that. Okay, you'd ask what funny stories happened at the legislature?

GH 56:08
Yeah, can you give us an approximate time when this is happening? What years?

EL 56:15
Okay, so that [was] probably before the pandemic, so about 2017 through 2020 is when I was president of the OB-GYN society and [went] to the legislature for them. So, we went down wanting to talk to one of our representatives there. A group of people who were Civil War reenactors show up in full Confederate uniform, which was one of the most jaw-dropping things I've seen in the legislature [laughter]. Oh, my goodness. On a more serious note [we were] going and talking to the physicians who are there. They're not many physicians, and they've all been

quite conservative. So [it has] been a disappointment that they haven't been a stronger advocate for women's healthcare. I know they're probably representing the districts and may reflect the views of the majority of the people where they live, but it was still that they were strong [advocates] for having an evidence-based health care, or OB-GYN in general, [which] was frustrating. Phil Darney, in San Francisco, ran a family planning rotation. And so I was trained in abortion techniques, which wasn't widespread at that point. He helped develop some Ken Ryan funds, the man that I had done the endocrine work [with], to get his lab at Harvard. They created family planning clinics so that this could be taught nationwide. And I think [that's] been a big help [to] mainstream it. A few people [have] sidelined family planning is a GYN interest. There is now a subspecialty, and people are training in family planning.

GH 58:30
When you were in medical school, residency and fellowship, was talking about abortions talked about or was it kind of like, hush-hush?

EL 58:42
Oh, that's a very that's a very good [question]. I think that is an evolution right now. I'd say Duke and has come a long way. I can remember as a medical student, the dean, Dr. Christakos- Arthur Christakos, talking about [how] abortions were sometimes necessary and that if he does an abortion, he would have a tear in one eye, the other I completely focused on the field. [It] was a little melodramatic, but [it] pay[s] homage to the fact that it was controversial. Dr. Hammond who was the chair for many years was supportive of women having access to abortion[s], but you could tell he was nervous about pushing the private diagnostic clinic or the leaders of the medical center on this. So, it was kept very quiet. We would offer them, but it wasn't advertised as a service.

So, I helped some with that because I was comfortable with it from my experience in San Francisco. They would do something called urea abortions then, I mean, these are hard. Patients would come in in the second trimester, you would do an amniocentesis, pull out some fluid, and then put concentrated urea into the amniotic sac, which would kill the fetus. You do some prostaglandins and usually the patient would deliver over the weekend. The patient would be admitted to the GYN service and nursing wasn't always kind to those patients. They weren't near labor and delivery, [but] sometimes the nurses wouldn't give them pain medicine. Patients would tell me [these things and] just because [the nurses] didn't approve of it, the patients would deliver by themselves [in] the bathroom. You know, those were challenging times, but the service was there. And the nurses on the GYN service, some of them were supportive, but some of them weren't. I can [remember a nurse but] can't remember her last name. There's a nurse named Bev in the clinic who did such a nice job for those patients, but she couldn't follow them into the hospital.

When I was a fellow, we would do our own D&C's [dilation and curettage] in the clinic, we had a little vacuum aspirator, that [makes chugging noises] ma[de] a funny noise. Once we turned it off before we got started, so the patient could hear we would do something called an ME, which was a euphemism for abortion, called a minstrel extraction. So that was just a euphemism for early terminations of pregnancy, but it's also the same procedure we use for people who are having miscarriages. The hospital charged a lot for them. So, you could get it, but it was going to be expensive. I learned how to do D&Es (dilation and evacuation). I did a lot of D&Es, [well] not a lot, but I was able to offer D&Es in the main OR, yet it was a tough procedure.

With the D&E, you put dilators into the cervix the day before, and then extract the fetus. Usually you [use a suction which is] one thing I tell the patients. You put in a suction device, usually the cord will prolapse, [and] the fetus will get bradycardia and die. Then removing the fluid brings the parts closer and you extract the fetus. And if it's big enough, then you have to do it part by part. Then, you have to count the parts. It's a hard procedure, but I would tell the students, you know, this is hard for me. It was better than passing the fetus in the bathroom with a mean nurse. We were able to do it, but now it's gotten much more mainstreamed. We got a Ryan clinic. We had a wonderful director [as] the first one. The new chair at that point, Dr. [Haywood] Brown was very supportive. And [it's] much more mainstreamed, and I will say one-person y'all really should interview is Bev Gray. She has been so amazing at being a good strong advocate for access to abortion and making it a normal component of women's health care. She's terrific. She's been very strong advocate.

Yet to get something more controversial going on. We'll go ahead and talk about it, but I'm sorry that y'all can't reply or join in or you can that won't bother me. One of the big challenges for the CLC [Congressional Leadership Conference] next week with ACOG and for the State Society with the assault on access to abortion in the state is do[es] our advocacy work need to completely focus on that. If you are trying to get coverage for doulas, you are going to need to talk to a large number of people to get coverage for doulas. What if those people are definitely were anti-abortion access? Can you work with those people? Are you somehow compromising your integrity by being involved or sending your lobbyist to go work with that person? At ACOG [and] the CLC [this is] what their big things is. Medicare had a pay cut that we got so physicians are actually making for adjusted dollars 30% less for every Medicare patient they see than they did 20 years ago because it's never gone up. And then there was an adjustment that was made, and I don't know, all the [inaudible]. So they took away the adjustment. And anyway, that's been their big ask when we go and meet with people.

Last year, there was practically war because people wanted to go and talk about abortion with their Congress people. A lot of the Congress people wouldn't let them in their office if they had to talk about abortion, but they would talk about Medicare. So, they told people, that they couldn't talk about abortion when they went to their office if they were going as a representative

ACOG. People got very angry. How do you balance that? I think it's a real challenge, and I'm not sure. Do we?

We have PACs, you know, political action committees, and they raise money to support elected officials in their runs. Can your PAC support somebody who may not be completely pro-choice they're going to deliver something else for you? I would say that could be stuff sounds great. But it does get challenging. I went to a wonderful abortion talk the other day at the Orange County Medical Society. They were talking about the health benefits of having these available decreases maternal mortality. It was a very evidence-based talk, and it was great. But you know, prevention can't be— because you don't want to make it like it's anybody's fault. The talks don't include anything about prevention of getting people in for the regular GYN care and having access to contraception, helping them plan their timing of their families. And so it's troubling [and] it's hard to know how to be true to your values and work in this world.

GH 1:07:45
Let's see. I feel like we've talked a lot about your work with maternal fetal. Well, we really haven't talked a lot about maternal fetal medicine, but we talked a lot about your work with HIV/AIDS. So, can we go back to talk a little bit about maternal-fetal medicine? And how you still do that today? If that is okay?

EL 1:08:15
Yeah. So the mother is always first. We want to have an excellent outcome from them both. And mothers are a terrific group of people to work with, and highly motivated. You can tell a mother to stop smoking, and she will, which I'm sure you have found that most people can't [and] have trouble with that kind of a thing. So, there's tremendous demand because maternal mortality has gotten to be such an issue. We certainly see a lot of older moms, which have a higher mortality and we see people with medical complications.

Alright, this is a little off-glib, but I can remember telling one of those students that I went into maternal-fetal medicine because I was so sad when I saw people tell young women with diabetes [or people with cardiac problems], you know pet their hand and say, “You can't ever have babies because it's too dangerous.” I thought there are ways that this can be done safely. Now, I think I've kind of gone full circle there. Some people say, you know, I want you to be all the person you can be, but maybe this is too dangerous. So anyway, I've kind of come full circle on that one [and] I really wanted people to know I feel like they could do it [that] they could live full and happy lives, and all their dreams [can] come true. But [for] some people, it's just too dangerous. It is amazing the number of people who really show up with very uncontrolled medical problems and want to get pregnant.

GH 1:10:24

So how have you seen the field changed since you've been in it?

EL 1:10:29
So HIV has been one of the most satisfying things. There are other conditions, [like] preeclampsia, that we have almost very little information on how to prevent [it]. Baby aspirin is about it. It's hard to give medicines to pregnant people, especially for prevention. Treatment is one thing, but prevention is something else. So, exposing a pregnant person to a medicine that of unknown value. Preeclampsia is where your blood pressure shoots up, you get protein in your urine and then the only treatment is delivery, the definitive treatment, you can temporize and try to get the baby further along. But that hasn't been very successful, [in] preterm labor we treated people with asthma medicines would relax the uterus, like terbutaline and beta-agonists called Ritodrine. I spent most of my intern year learning how to run those medicines and to try and stop labor, but we've abandoned them because they don't work. In terms of improving birth outcomes, we've completely stopped. [When] somebody comes in [in] preterm labor, we give them some antibiotics and steroids and see what happens. So there's no treatment for it, which is very frustrating. We recycled a lot of things, like we would put a stitch in the cervix or somebody we thought had a weak cervix. Whether that really works or not either [is up for debate]. So I would say, the HIV story has been very satisfying. We've had one HIV-positive baby and 20 years so that's been amazing. The rest of it has been not having a whole lot to offer patients. We try to optimize their medical problems and treat their diabetes because there's a lot of diabetes [and] try to get things, they need to have surgical procedures done beforehand, trying to get things taken care of before they could get pregnant. All in all, it's been disappointing, and I will loop back around to the will of Act Up and the community people who had demanded that there be more scientific focus, and how much progress they made in HIV and how they push the FDA to approve drugs faster. Because that hasn't happened for the rest of maternal-fetal medicine. Maybe, the maternal mortality will change some of that [and] maybe the CDC [will give] some money for maternal mortality review committees, but there [hasn’t] been any money pushing back to look at causes of preeclampsia. There's no moonshot NASA push for trying to figure those things out.

GH 1:13:45
I know you said that you work/go in two days a week with the clinic. Is there anything else that you do within the community?

EL 1:13:57
Oh well, I like I continue to see patients, so I'm still doing OB clinic and ultrasounds because for maternal-fetal medicine, you deliver care as a package. So, it's a prenatal care delivery and postpartum care is a package. So it's for the division to make enough money to support research at all. We do ultrasound[s]; people love ultrasounds, and they get reimbursed well, so they're very useful tool. II do a lot of ultrasounds now, not much outside of that.

GH 1:14:56
Okay. Well, like we talked about a lot of good things.

EL 1:15:00
Yeah, we have covered a lot of ground. I'm sorry, [you] had to just listen to me drone on.

GH 1:15:06
Yeah, we're doing good on time, too. Okay, maybe we could talk about your affiliation with Duke and how that evolved after or during your fellowship? What does that look like now other than seeing patients?

EL 1:15:28
Well, I'm a committee person, [and] I've been on committees. I have liked being part of the broader university. So, I was on the Academic Council for a while, and ECAC, the Executive Committee for Academic Council. And [it] was really interesting to see how the university runs itself. The contrast between the university side of the medical school side was enlightening. The notions of academic freedom and the openness of the university side, versus the more sort of corporate organization of the medical school side, where you're organizing groups, and you're delivering a service, and the academic part is more dictated by how money comes in. It's not quite as loose. So that was interesting. I've now been on the admissions committee for a while, and that's we just finished another round of admissions. [On] Wednesday, I called six students to tell them they had gotten into Duke and so the quality of people going into medicine is truly impressive. You talked about the next 20-50 years; I think medicine is really attracting some of the brightest [and] the best. Goodness gracious with the talent pool we have, we can certainly figure out how to deliver high-quality care less expensively, improve access, and improve maternal mortality y'all are going to be our future. I think the future looks bright because [of] the intelligence of the experiences of the people coming into the field.

GH 1:17:30
Yeah, it must be really interesting to see because you went to medical school here and [now you're] on the opposite side. So, what do you think being within Duke University and the Duke community, how [has] that influenced your life or changed your perspective/outlook on things?

EL 1:18:01
I love having the medical school be so close to the university. I play pickleball at the Faculty Club, and I've met so many [other faculty members]. [For instance], I [met an] art history professor there and heard about her research, and seeing people from different walks of life [has] been a lot of fun for me. There [are] so many incredibly bright and interesting people. Sometimes when the advocacy part gets a little discouraging hearing people who are doing advocacy for

their fields has really been inspirational. It makes it less siloed. [And] being able to work with Dr. Bartlett and Cathy Wilfert and have that opportunity to accompany them on their efforts to get care to adults and children living with AIDS. You know, Dr. Bartlett and I got to go to Tanzania for a month in the work at the center. They'd set up at Moshe at Kilimanjaro Christian Medical Center. That was a really made me look at American medicine differently and just my whole life differently.

GH 1:19:32
When did you go to Tanzania?

EL 1:19:35
Gosh, it was a bit about 2000. So yeah, it was a lot [laughter]. Yeah, that 20 years ago. It was hard to pull the time together. I had small children. I'm divorced now and it might have something to do with going to Tanzania [laughter], but I get it. So, they took some vacation time, and they let me have some as conference time. [It] was just eye-opening to see people practicing medicine and trying to do the best for patients with very few resources.

GH 1:20:15
Yeah. And you said that it made you look at the American like medical practices in a different way. Can you elaborate on that?

EL 1:20:26
Oh, sure. You know, there were no resources there. You go there [and] there's a door that says pharmacy because the Germans built the hospital, and you open the door to the pharmacy, and there's one shelf with a couple of bottles in this big room. You go to the blood bank [and] they're two units of blood there that somebody has donated for a loved one. I was mid-round with the residents, and then we'd say, I think it's time for us to check a blood count. So, we'd write a little receipt, and the family had to go pay a cashier and have it stamped before the nurses could draw it. So, they made me think that this whole stack of carts, with insurance and co-pays and all, which seems so onerous, ridiculous, that may be working in the system. We need to support the system we've got into we come up with something better because do we get a simple fee for [a] service, they have is just not gonna work. Yeah, it's hard for people.

GH 1:21:37
And like looking back on all the work that you've done, is there anything that you're most proud of or just happy that you were a part of?

EL 1:21:48
Oh certainly, [the] HIV work will be it. Yes, to see that come so far for our patients [until] now. I tell them 1% chance your baby will be infected. I used to say 30%, when we started. Now, I

think some of the things, I think you may have alluded to it, you know that our hopes are for people who are HIV positive to live full lives and not let this define their life course. So a few years ago, the state legislature to go[es] you don't have to tell your sexual partner if you're detectable. Lance Okeke is doing his work to try to prevent long-term complications so that patients won't die of heart attacks and the things that are killing HIV-positive people now. The idea that there are people who, if it will make their heart sing to breastfeed [can], that we can come up with ways to make that as safe as possible. So, allowing people to live the fullness of life, and not let them be defined by their medical conditions [has] been immensely satisfying.

GH 1:22:56
Yeah. As we wind down the interview, is there anything that I may have missed, or we haven't touched on today that you think is important and should be included in this oral history project?

EL 1:23:13
So right now, we talked about whether [Duke was] welcoming, and we talked a little bit about the past. With Bev's leadership and our chair of the department, they and Tony Schwartz have have really stepped forward to be leader[s] and the medical school has been supportive. The PDC was supportive. I saw that complete ground shift [which] has been just amazing. When SB 20 came through, they found a nurse to help with all the owner's paperwork that the legislature dumped on. They went and said that if you had an abortion after 12 weeks, it had to be [in] a hospital setting. They found a ward in the hospital to put the abortion clinic, which I just can't imagine that happening before. Those are leaders as well for helping the institution stand up and lead in the state. I think he would see it certainly has some very open-minded some excellent doctors who have been leaders as well, but I think they're somewhat hampered in their setting. I know that Atrium and Novant in Charlotte are much more conservative institutions and have not been as open-minded about it. So, we should be really proud of what Duke has done. And Bev, Matt Barber, and Jonah Schwartz have been leaders in the state and have really put themselves out there as being supportive of women's reproductive choice.

GH 1:25:20
Okay, we just want to say thank you for your time, it was really inspiring to hear about all of the work that you've done. As we wrap up the interview, we do have to do a few closing things. We do have to get 10 to 15 seconds of silence. So we're gonna go ahead and do that.

[silence]

Okay, and then we do have to get a production-style introduction of yourself. For instance, I would say, My name is Gemma Holland, and I'm a current undergrad at Duke University.

EL 1:26:14

My name is Elizabeth Livingston. I'm a professor of obstetrics and gynecology in the Division of maternal-fetal medicine.

GH 1:26:21
I think we're all set and thank you so much.