QUESTION: What inspired your interest in medicine?

CLAUDETTE DALTON: Well, I've always liked science, especially biology, not chemistry, never ever chemistry. But my dad was a general practitioner. And he would take me on rounds, sometimes, so that helped. But it was mostly because I just enjoyed being with people and being some help. But my dad was a big factor in it.

QUESTION: Why did you choose to attend the University of Virginia for medical school?

CLAUDETTE DALTON: Well, my dad actually tried to discourage me. I was at Sweet Briar for undergraduate school. And it didn't have a pre-med program, as you might imagine. And he tried to discourage me, I think mostly because when he was in Med school here-- he was in the class of '45, they were not very nice to the women in his class. I don't know whether they were shunned or they were actively sort of harassed. But he kept saying he really didn't want me to go through that.

But I kept insisting. And I said, "Well, I'll go to nursing school first. And I'll become a marine biologist." And finally, he sort of rolled his eyes and said, "Well, if you're determined to go, go."

Now UVA had a Post-Bacc. program. And I needed to take some of those courses before I was even eligible. So, it just made sense to come here.

My father was on the board of the Medical Alumni Association. So, it was sort of a no brainer. We knew people here. And I could get the courses I needed to get. So, that's why.

QUESTION: What were your initial impressions of the UVA School of Medicine?

CLAUDETTE DALTON: I think all medical students are sort of in awe of it. I think we're all a little bit scared. Are we good enough to do it? Or can we cut it?

But because the School of Medicine was kind of familiar to me because I'd had the undergraduate courses here, and a lot of the faculty, and in fact, the Dean at the time, Ken Crispell, was a friend of my dad's, it was not an unknown, a complete unknown. So, I was comfortable, I think.

QUESTION: How would you characterize the students of your medical school class?

CLAUDETTE DALTON: We were the Med school class that started the year that the undergraduate school went co-ed. And my class has always been sort of iconoclastic. We weren't the usual bunch. We'd had anti-Vietnam rallies and sit-ins and that kind of thing in college.

We kind of were anti-authority, but in a very benign way. It wasn't like we were very militant. So, it was a pretty easygoing bunch. It was benign, a benign good group of people.

And we had the most women and the most minorities of any class ever, so it was diverse. Or it was diverse for that day. Good group of guys-- I love them-- still, still love them.

A lot of my class-- I think if we did the numbers, you'd find that we had a pretty high percentage of people who've gone on to be the chairs of departments and Deans. I mean, it's not like we were a bunch of dummies. Almost everybody in the class has been pretty successful and has given back to the profession. I think I was just bloody awful lucky to end up with the group I did.

QUESTION: What was the sentiment about co-education at the School of Medicine in 1970?

CLAUDETTE DALTON: I think everybody was glad that the whole university was now a little more open. But I don't remember it being a topic of conversation really. I've always been sort of oblivious to really ugly things. And I don't have any memory of anything that was mean spirited or harassing.

I got a lot of kidding. There was the orange stool in histology, which was a big, tall stool painted orange. And when you sat on it, you had to almost bend over double to see in the microscope. And I was given that seat to sit in. But I think it was in hopes that my short skirt would reveal, but that's nothing.

QUESTION: What were the challenges that you faced as a woman attending medical school at UVA?

CLAUDETTE DALTON: Well, a lot of the faculty were what I would have termed, southern gentlemen. And there was a lot of holding doors open until I got through the doors. And that was always holding up rounds. And I was called "Little Lady" a lot.

But nobody meant anything by that. So, one of my rules of being a woman in a man's world, so to speak, is that you always forgive the unintentional. You don't ever forgive meanness or bullying. But I don't remember experiencing any of that.

And if I did, it was usually from the nurses, who felt awkward about dealing with a woman giving them orders. So, it tended to be more in my clinical years and it was the first two. I guess I was lucky. It was just a good group of friends and we all helped each other, and we all shared clinical pearls. And I just was lucky to have a really good group of classmates.

QUESTION: Were there any classes or experiences at the School of Medicine that had a lasting impact on your or your career?

CLAUDETTE DALTON: Oh yeah, well, obviously, the first time you deliver a baby, the first time one of your patients dies. I did and what we called an acting internship on plastics my third year. And that was a real learning experience.

I scrubbed on the first transsexual that we did here. And at the time, it was just weird. I kind of didn't know how to handle it. But I had a good mentor in Norman Knorr, who was the psychiatrist that worked with plastic surgery and later became the Dean.

And he sort of sat me down and said, this is how these folks get to this point. This is what they believe. This is what their culture is. And that helped.

And it's helped sense in that I understand LGBQT I think, a little bit better than I would have. I can obviously, never walk in their shoes. But it's helped to understand the psychology of some of those patients. And I think when you understand your patients, you can care for them better.

QUESTION: What was the medical curriculum like during your years as a medical student?

CLAUDETTE DALTON: Well, our curriculum was what we call an organ-based. So, we'd have the pathophysiology and the pathology and all of the heart altogether. And then we move on to something else, the GI tract, for example. And for me, that was very logical. And it helped me put new information in the right pigeonhole.

And we got away from that over years, and we actually came back to it, not too long ago, three or four years ago. I heard that we've actually come back to this sort of organ-based outline. You study the lungs, then you study the heart. And then you study the GI tract.

Histology was always a fun class. Anatomy, I could tell you stories from that for a week. We did some things we really shouldn't have done. We behaved badly at times, not with the reverence that we should have shown.

It's a real revelation. And it's a real privilege to be able to actually practice on a real human, as opposed to a plastic or just be looking at it on a computer. Virtual reality, I can't imagine would be anything like what we got to do.

QUESTION: Did you have mentors at the School of Medicine or particular faculty members who supported and encouraged you?

CLAUDETTE DALTON: Yeah, I was very, very lucky. My dad died about two weeks before med school started. And Ken Crispell was the Dean at the time. And one of my dad's classmates, a guy named Shannon Allen was in the pathology department. And then I had a cousin who was in endocrinology-- very, very distant, John Dunn.

So, I had sort of folks looking out for me. And then over time, John Owen, George Craddock, Dick Lindsay were three particular friends who just were just good to me, especially Dr. Owen, who sort of adopted me in a sense. And the four of us still get together.

We haven't of course lately because of COVID. But for years, we would meet for lunch once a week. So, it's good to have folks who've already been through it who can say, well, maybe you should handle it this way, not that way. They've been mighty good to me.

QUESTION: During your student years, what were your impressions of Charlottesville?

CLAUDETTE DALTON: That was the hardest question to answer. I don't think I went beyond Barracks Road and the Corner. My life just revolved around here. And I lived at the Ivy Garden Apartments. And I would come to med school, and then I'd go home.

And I don't think I ever went downtown, even though that's where all the shopping was. I certainly love to shop. But I don't think I ever went down on Main Street or Water Street or any of that. Very dull I guess. Lived my life going to the Hardees on Route 29. That was the first fast food place that we had here. Very circumscribed social life.

QUESTION: What areas of medicine did you choose to specialize in and why?

CLAUDETTE DALTON: Obviously, from the plastics externship, I really wanted to do surgery or maybe reconstructive plastics. And one of the nice things about UVA at that point was that we had a lot of faculty in surgery who would let the students do a lot of the procedure, obviously, with them hanging over us.

And so we got to do a lot. And then I got married. My husband was two years ahead of me and was going to do an ophthalmology residency in Durham. And so we moved to Chapel Hill for my senior year and for him to do his residency.

And it turns out that the students at Chapel Hill in surgery didn't get to do as much as we did here. And I didn't feel like I was going to get what I needed to get. Now all surgeons should, and almost all do, take an anesthesiology rotation because you need to know what the person at the head of the bed is doing, just like the person at the head of the bed needs to know what the surgeon is doing.

And I really liked it. You got to do things with your hands. You got to do procedures. And you were a really integral part of a team. And you had to get to know your patients pretty quickly. You had to have that kind of outgoing personality that you had only maybe 10 or 15 minutes to really gain their trust and to do something to them that was pretty scary.

When you talk about putting somebody to sleep, it sort of smacks of putting a dog down, or sort of mortality. So, it was a good fit for my sort of carrying-on personality, I thought. And the anesthesiology department at Chapel Hill was just superb. So, it was a really good fit. I've never ever regretted it.

A lot of people say you go into anesthesiology, a lot of women do because you can make your own schedule. Well that's-- that's a blatant lie. You get assigned a room, and you do that room until it's done. And it could be 2:00 when you need to pick the kids up, or it could be midnight. You don't have much flexibility. But I've always loved it.

QUESTION: How did you balance your career with your personal life and goals?

CLAUDETTE DALTON: There at first, my only real goal was medicine. But then my son was born at the end of my internship year. And that put a whole different twist on things. Being pregnant was hard. That was one of the few times I actually got pretty much harassed, when I was almost to term and my feet were swollen and I was on call. And the doctor who was supposed to come in to relieve me decided he wanted to play tennis instead, and I'd already been up for 72 hours at eight months pregnant.

So, when my son was born, it kind of became very, very clear that there was going to have to be a really interesting balancing act. And for the next two years, while my husband and I finished up our residencies, it was probably not fair to him because it was either work or the baby and not much energy or anything left over for the husband.

Not a lot of cooking done, a lot of takeout, a lot of frozen food, a lot of getting up early, getting the baby ready, getting the nanny there. And then I was on call. He was not, often, because ophthalmologists don't take as much call as anesthesiologists do. So, he ended up having to do a lot of the nighttime, weekend caregiving.

And he's a great guy. But he's not the warmest and fuzzy sort of parents. So, I think he felt put upon.

So, the balancing act-- I used to say to women medical students, sure, you can have it all. But you can't have it all at the same time. And when you have children and you're still either in med school or you're practicing, you need not only A and B plan, you need a C and a D and maybe an E plan, because nothing ever goes like you think it's going to go. And you can't you can't just put children in the dog crate with a bowl of water and come back in eight 8 hours. That just doesn't work.

So, it ended up putting a big hole in my career because my husband left us right after we finished residency. And I had a two-year-old. And I was single, divorced in my husband's hometown. So, there was no way I could work. There wasn't a job.

And my child deserved one parent full time if he couldn't have two. So, it was a very-- dangerous really, isn't the right word. It's not the word I'm looking for. But it was a very difficult time.

There were times when I didn't think I was going to make it. I didn't think I was going to be able to pay the bills. I thought I was ruining my child-- who, by the way, has turned out to be a superb young man. Although now, he's getting close to being a middle aged man. So, a young man. A good dad, he is. So, it all worked out in the end, but it was touch and go there for a while.

QUESTION: During that time, what did it mean to you to be a woman pursuing a career in medicine?

CLAUDETTE DALTON: I don't know that you think with that kind of clarity in the midst of the crisis. The crisis was just to keep us afloat. That meant I had to I had to take part-time jobs as he got older. I moved back to Charlotte, which is where I was from, so that my mother, who also worked, but she could help some.

I couldn't sit for my boards, because, in what I refer to now laughingly as my maternal retirement, the rules to sit for your boards had changed. And you had to do four years of residency, and I'd only done two. So, I would have had to go back in my late 30s, early 40s, and do two more years of-- which wasn't going to happen.

So, without boards, a lot of people didn't want to hire me. And I certainly could never be a partner. So, I was always doing part time work, sort of patching it here and patching it there.

That was certainly financially OK. It didn't make us rich. But it kept us from having to use food stamps. But I don't think I thought so much of it as being because I was a woman, although it absolutely was. If I wasn't a woman, I wouldn't have been a mother. But it was more that I was single and I didn't have that safety net. I think if I'd been a single father, it would have been the same thing.

Again, I tend to look for the solution and not for the blame. There's just no point in whining about it. Get on with it, for God's sake. So, that's what we did.

QUESTION: What brought you back to UVA, and how did you join the medical faculty?

CLAUDETTE DALTON: I had just been told by the group at the big hospital in Charlotte that they were going to-- that they wanted to hire somebody who could do neuro and could take more call and all that kind of thing. So, they were going to really cut me back. And I thought, geesh, this is like the second or third time this has happened. And it's getting kind of old.

And I was on the board of the Medical Alumni Association, which has got a lot of funny stories attached to it too, I think. I think I was the first woman on it. Maybe not, but maybe.

And I kept talking about how one of the things that had been the hardest for me when I went into practice was that I had no idea of the business of medicine. I didn't know how to bill. I didn't know how to hire and fire. I didn't know how to do all the things that keep the office running, that underpin your practice so that you're free to look after the patient.

So, I kept sort of fussing about it. And finally, Bob Carey, who was the Dean, said, well, why don't you come here and teach that? Well, I thought, well, OK. My son was 13. And he'd been sort of acting out like 13-year-old boys do. And I thought this would be a good way for him to start over, sort of reset, which he did when we came.

So, in January of '89 in the middle of a snowstorm, we moved back to Charlottesville. And again, the Dean couldn't pay me much. He was sort of making this job up. And then there was a freeze on state salaries for the next two years. So, it was a little tight. But Bob Carey often had very good ideas.

So, he had made me the Assistant Dean for Medical Alumni Affairs, which meant I was the first woman with a Dean's title. And we always met every Thursday. And at first, there were just six of us. It was the Dean of Admissions and the Student Affairs, and one for Research, and me, and maybe one or two more.

And we would meet in the Dean's office. We'd all crowd on the couch. And you had to be careful if you sat next to Ed Pullen, because he was another one of those who talks with his hands. And if you were on his left side, you were sure to get smacked at some point.

And we would talk about what was going on and what kinds of problems we had and what we needed to do to sort of fix that. And everybody would chime in. Later there were 12 or 13, 14 of us. There was a Dean for Diversity and a Senior Associate Dean and we would have to meet in a much bigger space.

But it was always a very collective team approach to things, until later, until Bob Carey left and some other deans came. And then it became a series of what I refer to as urinal conferences. The men would meet in the men's room beforehand and decide what they were going to do or say or what they wanted to have happen. And the three or four of us women wouldn't be in on that.

So, a lot of the decisions were made beforehand. And there were a lot of times when either I or one or the other women would make a suggestion. And there would be this silence in the room. And then about 5 or 10 minutes later, one of the men would make the exact same word-for-word suggestion. And everybody would think that was a great idea.

So, the real distinction about being a woman didn't really come for me until I was in a position like that. It wasn't in med school. It wasn't in residency. It wasn't in practice. It was in the boardroom where it really became pretty overt, which is a shame.

QUESTION: Were there other women physicians who influenced or inspired you?

CLAUDETTE DALTON: The one who springs to mind the most is a woman named Carol Shapiro, who was the first woman president of the Medical Society of Virginia. She's in her 80s now, still working In Northern Virginia. She's a plastic surgeon. But she now runs the hyperbaric chamber at her hospital.

Carol was one of those people who listens to everybody's opinion, is not afraid though, to take her own line if she thinks that's what she needs to do. But she does it in such a gentle way that nobody feels like they've been let down.

She understands people. She's very, very patient. And I want to be her when I grow up.

She's not here. But every so often, I just call her on the phone and say, this is what's happening at the AMA. What do I do? What's the next step? And she's always there for you. There weren't many here because I was the first one.

QUESTION: What was your experience serving on the School of Medicine's Committee on Women?

CLAUDETTE DALTON: Sharon Hostler ran that with an iron fist. Sharon is a remarkable woman. She was not a role model for me because her attitude for getting what she needed to get done was more aggressive than I kind of wanted to be. I think I disappointed her in some ways. We fought for child care, didn't get it. Fought for pay parity, didn't get it.

But she did make the most important first step, which was that she got everybody's salaries out in the open. And then it was clear. And then there was some parity. But my time on the Women's Committee, I very quickly learned that there wasn't any going up against Sharon. Best just to be a good soldier and keep my mouth shut and try not to get in trouble. Sharon eventually became the Senior Associate Dean. A very, very powerful woman.

QUESTION: Did the work on the Committee of Women lead to any changes in the medical school?

CLAUDETTE DALTON: I think it led to some. I think there was a little bit of a parity. And parity is not just your salary, it's the space that you're given for your lab, it's the time off, it's the articles, you know, that you're given the time to write so that you can get tenure.

The whole tenure process needs to go out the door. You can't run a medical school, I don't think, unless you have people that are willing to just teach or just do clinical or just do research. You can't in many, many cases, do all three superbly well. There are a few folks who do that.

But here, to get tenure, you've got to do all three still. That's sort of medieval, isn't it? And you shouldn't be disparaged because you're the one who likes to teach.

And that old phrase, that "them that can do and those who can't teach," is really the reverse is true. You can't teach it if you can't do it. So, we've gotten a little bit that way.

But the report didn't change that. Again, it led to some parity in space and time and money. But we're still paid less than the guys. And I'm not sure that'll change any time soon.

QUESTION: What was your experience with Robert (Bob) Carey as the Dean of the School of Medicine?

CLAUDETTE DALTON: Bob Carey is a very diplomatic-- to my mind, he doesn't have biases. He sort of listens to everybody's opinion. And then he does what he thinks the majority want him to do.

Sometimes that makes others think he was a yet a "Yes Man." But there were times when he went against the grain. But he was very, very supportive to the people that he hired. He wasn't going to hire them and then hang them out to dry. He's just a good guy.

And we need more of those. Because deans tend to be-- now, I haven't met the new Dean. I'd love to. And I'm excited that we've got a woman. But a lot of the deans that I have known both here and elsewhere have been very, very competitive. They want their school to be the best.

Well, sometimes you can't you can't change everything so that you wear the crown. Sometimes you have to let things go along for a while, see what works, see what doesn't work. Some people aren't willing to do that.

QUESTION: What was your involvement with the Generalist Initiative at the School of Medicine?

CLAUDETTE DALTON: There has been, in the past, a great push to produce more primary care physicians. And there still is. But the Robert Wood Johnson Foundation came up with this Generalist Initiative. And it was a lot of money.

And we applied for it. And we got it. And one of the things that research has shown leads young physicians to either pick a primary care specialty and/or go to a rural or underserved area to practice, which was also important to UVA, because a lot of our referral area is Southwest Virginia and pretty rural underserved parts of the state.

So, as that was evolving and we were applying for that, it was clear that if the students were allowed to go to practices in those areas and see how those doctors did what they did, that that was often an inspiration to do it themselves. So, I was handed a printout that had a list of every primary care physician in the state. It was yards of paper.

I thought, my God, how in the world am I going to do this? I did talk to the folks at VCU and EVMS. And we decided to sort of divide the state into three pots. And we would take the western end of the state, except where we had alumni. And then all bets are off. We didn't want VCU touching our alums, so I wanted our students to be able to go.

So, it just it took months and a lot of phone calls, because email wasn't used that much then back in the old days when dinosaurs walked the earth. And a lot of it depended on of a personal interaction and saying yes, you can do this. And we're going to support you. We can't make up for your loss in revenue because it takes probably two or three extra hours a day to have a student in your office, because you get behind on the paperwork and it takes longer to see a patient.

So, instead of finishing up at 4:30 so you can get your paperwork done, go home and have your dinner, you're still there at 7:00 o'clock. But we were going to give them a stipend. And then we thought, well, we want to be sending some students way away from here. So, we're going to need housing, we're going to need transportation. We're going to have to work the curriculum around.

So, it really probably went amazingly well, considering all the things that we had to do that had never, ever been done before. But it all comes down to those docs who were willing to take a student into their office. And sometimes the students weren't all that appreciative, let's just put it that way.

I would have students come into my office and say, "I can't go to Wise, Virginia because I have a goldfish I have to look after." That's a true story.

I said, "Well, it's your turn to go away. You got to stay here the last time. And bring your goldfish to me, or give me a key to your apartment. I'll feed the damn fish. Don't worry about the fish."

And we had to make arrangements for married couples. And a couple of times, a student was due to go somewhere way away, and their wife was going to deliver like tomorrow. So, it was often a balancing act. But we ended up with, I think, around 14 or 15 courses.

There was a first-year course that was a week. There was a second-year course that was two weeks. Then we had the Family Practice and Internal Medicine and Pediatric clerkships had four weeks each. You had to work with the curricular guys for those.

And then we had a bunch of electives. Everything-- wee would find somebody. There was a whole lot of derm. And again, some of the students wanted to go back and be with the doctor that they'd been with.

But the payback, it's interesting how being a parent and working with the preceptors, and all that comes back in a weird way later to be a plus for something entirely different. So, getting to know all of those doctors, it meant that when I was doing Medical Society of Virginia stuff, I already knew 2/3 of the folks that I was working with.

And we already had a good relationship, and we could work out policy. And we could get things done because there was this mutual trust and a sense that we were both trying to help each other. So, it's interesting how those things work.

QUESTION: What led to the creation of the Remote Area Medical (RAM) Clinic?

CLAUDETTE DALTON: So, part of that was that I ended up on the board of a group called the Graduate Medical Education Consortium. So, just like it helps to have students go to rural, underserved places in hopes that they'll like it and maybe go back to practice, it works even better if it's a resident because they're getting ready to pick up a practice. So, this group, the Graduate Medical Education Consortium, was way down in Southwest Virginia. And it was bringing residents from Tennessee, Kentucky, West Virginia, and Virginia residency programs to do sort of a preceptorship kind of thing.

So, I was on that board and we were having a meeting. And somebody mentioned that the dentists, the Virginia Dental Association, had been coming to Wise in the summer for a long weekend and doing dental care. Because there are no dentists in Southwest Virginia-- zero, none, or at least then, there weren't.

So, they said, but we had to turn away a lot of patients because they had such severe medical issues. Their blood pressure was 200 over 160, or their blood sugar was 400. And there were all these reasons why they felt that they couldn't give them an anesthetic. And they really couldn't do what they needed to do.

So, I thought, well, maybe we can help with that. So, I came back, and we had a new vice president who had just come, I mean literally just come the day before. And I was asked to present a budget to him for something that we really hadn't completely worked out yet on his first day of meeting with people.

I thought, well, this is not going to go well. Because one, I'm scared to death of this guy. And two, this is not a well-formed plan. And I understand he doesn't understand the need down in Southwest Virginia yet. And surprisingly, he gave us the money.

And of course, UVA has a branch at Wise, so we could put our team up in the dorms in the summer. So, that first year, we took maybe 15 or 16 people. And the thing was held at an airport, the Lonesome Pines airport. The line of people waiting to be seen was a mile and a half long of people standing in the sun, waiting to see either a dentist or a doctor.

But it was a chance to work with the head of the health department down there, with a nun named Sister Bernie Kenney, who ran a thing called the St. Mary's Health Wagon, which has since been featured on *60 Minutes* three times, as an outreach medical group. They're in a great big van.

And eventually, our team from here grew to be 40 or 50 people. We took an emergency team with us. We had a lab, we had a pharmacy. You name it, we could do it.

We had a mammogram van, which is a story all of its own. We had a truck with X-ray machines in it. And we moved to a fairgrounds, and we would have roughly 8,000 medical encounters in 2 and 1/2 days.

That's a lot of people. Of course, if it was a patient that we saw for a general medical exam and then a mammogram, that counted as two. So, it wasn't 8,000 people. But it was doggone close to that. It was thousands of people.

They would come and camp out to wait to see us. That is the single best thing I've ever done with my diploma. And I headed up that team for 9 or 10 years. And then when I left here, I had to turn it over to somebody else.

So, Scott Syverud ran it for a while. Mo Nadkarni ran it for a while. Good people, to give up a long hot or soggy weekend in July to go down and help those folks.

And eventually, we would bring back folks to here. I got us some travel money for them. At first, it was when we would come back, the lab results would finally come in. They'd be spread all over my dining room table. The charts-- we would be matching them up, and that would take a couple of days.

But it was-- we saved an awful lot of lives. We gave an awful lot of care. It was good.

And it still goes on. But it's sort of handled locally now. There are enough folks locally that they can, which is better for the patients. Because if you're too poor to afford medical care, you probably don't have a good car to come all the way here.

And it's expensive. Look what gas costs. If you have to come here to have your colon polyp out that we found, that's not easy for those folks. We have to help them get here. We have to help them survive while they're here.

So, the more that you can handle locally, although that is the most expensive option, but it's-- good people. Again, it always comes back to the people that you work with. It comes back to the team. If you don't have the right team, give it up because you ain't going to get it done.

Now there was there were a bunch of other little things. It was like every time Bob Carey or Dan Mohler, who was his Senior Associate Dean for many years, had a little something. I used to do the Bowman Award weekend cause Dick Bowman was a classmate of mine. So, I was in charge of that.

There was something called "Day in a Medical Center," where all of the Virginia colleges and universities were invited to send their pre-med students here for a day. And they could have a tour. And they could find out how you study for your MCATs and what courses do you need to take and that kind. There were a lot of little, one-day events like that, and if Bob Carey didn't know what to do with them, he gave them to me. Now, they're mostly done by the medical alumni office. Bless them, so they handle most of that now.

QUESTION: What are some of the changes you witnessed at UVA during your career?

CLAUDETTE DALTON: Well, again, the curriculum morphed away from the organ system. And we cut out half of the lectures at one point. But then we didn't see that through before the new Dean that came changed it again and cut it out some more. He wanted a Public Health course put in, because that was his thing.

And it kind of, I think, kind of lost its way there for a while. The thing about Medical Ed. to me is that you have to be sure that you teach in a way that the student knows what they don't know, so that they'll go and find out. When you leave it all up to them, when you just give them a list of videos or a list of sites to go to and they sort of have to organize that material themselves, I'm not sure that it serves them all that well.

Plus there's a tendency to let technology replace interpersonal skills. And I don't care whether you are a caveman sitting around the fire or you're Buzz Lightyear on a strange planet, it's that personal interaction between the doctor and the patient that's the core of everything. And I'm not sure we do such a great job of that these days.

There was a tendency there towards standardized patients, which I thought was a good idea because it prepared the students for the clinical skills exam. Number one, because there was an art to taking that exam that was separate, just like there's an art in taking any exam, a written exam. You kind of have to have test-taking skills.

But it also, the standardized patient thing allowed them to interact with somebody who had a really defined issue. And it was not always medical. Sometimes it was psychological or cultural. It gave them a chance to think about health literacy.

And my understanding is that that's been sort of pushed back too-- the community-based stuff has gone, right at the time when, again, we're pushing for primary care docs. So, it's like they're taking the reality out of it.

And medicine's not virtual. I'm sorry, it's just not. It's real nitty gritty interactions with people and all of their pluses and minuses. And I'm not sure we're doing a bang up job of teaching that.

I could be wrong. Because again, I don't know everything about the curriculum. So, I hope I'm wrong. Because we certainly have bright people. But smart ain't always everything. There's book smart, and then there's people smart. And I'm not sure we're doing the people smart part.

QUESTION: What are your thoughts about being a leader in the field of medicine?

CLAUDETTE DALTON: I think the bottom line becomes accountability. A leader has to be accountable for the outcomes, good ones, bad ones. If you're talking about a team, a clinical team, it's the leader that's got to be sure it all gets done. Nothing falls between the cracks.

If it's the AMA, God help them. I know there's a lot of political jockeying. And I don't get off on that. It's a lot like Congress. Everybody's worried about the next role, the next title they can put on the door, and the next office that they can hold.

And we've got things we need to get done. Doctors' practices are failing because they can't pay the bills. Doctors' well-being, especially after COVID-- there was already burnout. And COVID just threw everybody over the edge like a bunch of lemmings. Everybody just drove right off the edge of the cliff, doing the right thing, looking after their patients.

But to risk your life for insufficient compensation, without the products that you need, without PPE, and without masks, and without ventilators, and without a med, without a vaccine, and I mean, the list is huge, seems a lot to ask. So, the way that the AMA, in particular, got away from doing what we should be doing, which is figuring out how not to have this happen again.

I'll give you an example: gun control. We debated gun control about five years ago. And people screamed at each other and were rude. And I thought, this year, it was going to absolutely come up again because we were there right after the Uvalde and the Oklahoma shooting, which was a physician.

And Oklahoma's in the group I was the chair of. So, I thought, my God, we're going to tear each other's throats out again. And arguing about bump stocks and whether a semi-automatic or an automatic gun should be-- that's not our business. I'm sorry. It isn't.

Our business is to figure out who is likely to be a shooter and how do we keep them from being a shooter. It's medical, and it's psychological. And it isn't arguing about magazine sizes or the size of the bullet.

And we did manage, I think, this year, to sort stay in our lane. But that's the kind of thing that you tend to-- a leader can't let the team get off on that other stuff. You've got important stuff to do. And it's all huge. And there's no way you're going to get it all done, but you've got to knuckle down and get going. You've got to be accountable for directing your organization the way you can make the most change.

To me, that's leadership. It's not the title. It's not President of the AMA versus Chair of the Board.

QUESTION: How did your many leadership roles come About? Did you seek them out intentionally?

CLAUDETTE DALTON: Most of them, no. It was just being in the-- and maybe not the "right" place, but in that particular place at the time that it needed doing. Again, leading the RAM team is probably the one--

And that didn't have a title with it. I mean, people hated to see me coming, because they knew I was going to ask for something, something wild, like a mammogram van or something big and expensive. The AMA role, I was asked to do it. And then of course, COVID hit, and so I was the virtual chair of everything for two years, which was a learning curve.

Because none of us had Zoomed. We all had to figure that out. And it took a lot. I have Zoomed so many times, I feel like my middle name is Zoom. And we still do to some extent.

But all of those meetings that you normally would sort of have in the hall or in the bar or in the restaurant, you're having them on Zoom. And then you have to turn around and have another one because that conversation led to-- this went on and on and on. Most of them have just sort of evolved.

QUESTION: How has COVID-19 impacted your life?

CLAUDETTE DALTON: I had moved from my home in Earlysville, where I lived for 30 years plus to an over 55 community in Nellysford three months before we isolated. So, I'd moved to be closer to my family, number one. And I was just getting to know my neighbors.

And then none of us could be together. So, it was very, very isolating. It was probably not as isolating as if I'd been in the old house because it was set in the middle of the woods. And I couldn't even see people driving by. At least in this little neighborhood where I live now, you can wave at folks. They're just right down the street.

It was tough. I wouldn't say I was an extrovert. I'm an introvert that has to be outgoing at times. So, once I'd read every book in the house and ordered another crate full and read those too, I was A, blind, and B, tired of reading, which I thought I'd never, ever be.

It was just depressing. I think that's why-- if you're depressed, eat chocolate ice cream. That's the solution. Although, I may have gone a little overboard on it. But it's better now, even though I got it two weeks ago.

But the other thing, though, that it did, I volunteered to be a vaccinator. So, I got to do those-- do those clinics. And so I got to know a lot of folks in my county that I ordinarily would never have met, COVID or not-- farmers and vintners and one Sasquatch, a guy who claimed he was a Sasquatch. And he really did think he was.

So, it that was interesting. Got to go to some very small communities, Massie's Mill, and see some folks there. And it's good to feel like you're doing something that's positive and instead of sitting home with your melting bowl of ice cream. It was wild. We sort of had the same team over and over again. So, it was organized by the guy who runs our local rescue squad, who realized that we have so many folks who either don't have connectivity or who are old enough, like me, that they don't know how to get connected. They might have the computer, but they don't know how to use it.

And they were having trouble signing up, because the system, at first, was just nuts. I couldn't figure it out. So, he knows he knows everybody in the county, and he started calling up folks.

He started with the older ones and he sort of worked his way down. And he went to all of the vineyards, of which we have about 9 or 10. And he got them to bring in their workers. And we didn't care whether they were documented or not. Nobody asked.

The health department has to come in and bring the meds. So, we got to work with two or three of those folks. And we all sort of became a little vaccine family, making it work. We'd all pile in the car and drive to the further ends of the county. And somebody would go get lunch.

We ate a lot of pizza. That's the standard medical, go-to food. It used to be that if you had the students out to your house, you served pizza. If you had a meeting here at night, you ordered in pizza. It sort of has the five basic food groups, I guess.

QUESTION: What advice would you give to today's medical students?

CLAUDETTE DALTON: I think I've already touched on it. I think they've got to get back to the heart of medicine. I was asked to give the graduation talk one year. And I gave a talk called "The Shaman." And it's not that I believe in witch doctors.

But if you think back through all of medicine in the past and probably all of medicine to come, it's the personal touch that does the most to heal people. Students today strike me, and I could be being a bitter old biddy, as having a sense of entitlement and not wanting to do the hard work.

For example, at the AMA meeting, out of the medical education policy resolutions that came through, there were maybe 30 of them. Seven of them were about time off for students-- time off to vote, time off to go to cultural events, and that they shouldn't have to ask for permission. They should just be able to decide when they want to go and go.

I have trouble wrapping my head around that. That's not accountable. When you practice medicine, you can't just, in the middle of your day, say I think I'd like a little break. Let me get in the car and drive up on the Skyline Drive.

Practicing medicine is hard, physical and mental work. And you need to toughen yourself up, I think. Now a lot of the students will say that my age group just says that because we had to do it. I shudder to think how I would have gotten through being a single parent or the drama of the operating room if I hadn't been toughened up, if I hadn't learned that I can pace myself.

I know when I am at the limit. I know when I'm not at the limit. And I know that the personal interaction is at the core of what I do. It's the thing that makes you, when you have a patient who is brain dead and they're bringing them to the operating room to get their organs out, and that's going to save 5 or 6 or 20, depending, people, and all that's done. And the surgeon leaves the room and the nurses leave the room, and you're sitting there with the patient.

And it's my job to turn those things off. I could turn them off, and I could leave the room. I won't leave the room.

That patient doesn't know I'm there. They're already essentially dead. But I need to look at me and say, I was there until that line went flat. There was somebody in that room holding that hand and being sorry that this person was going. I don't see that happen with a lot of the students these days.

And I despair of having a doctor who can look after me who's got that piece to it-- this is where my nose starts to run. So, my advice to students is find your soul. It isn't just about the books, it isn't just about the facts, it isn't about cleverness with making diagnoses.

It's not about knowing what the newest med is, it's not shoving them through the MRI machine. It's holding their hands and saying, I'm here, and however this ends, I'm here till the end. You're either well or not, but I'm right here.

QUESTION: You spent time researching Sarah Ruth Dean, the first woman to graduate from the UVA School of Medicine (in 1922). Can you tell us about that research?

CLAUDETTE DALTON: Oh, Sarah Ruth Dean, another of the assignments from Bob Carey. But I was the logical one to do it. Well, the first thing that I learned of course, was that we had almost expunged her from the UVA records. And the record keeping of the succession of the first four or five women was all garbled up.

But especially, and I feel certain, that it was because she was convicted. For those who are watching this and don't know, Sarah Ruth Dean was the first woman graduate of the UVA medical school. She was a transfer from the University of Mississippi. So, she only did two years here. She went on to do an internship and a residency in pediatrics, which was almost unheard of for women. She went to Denver and to Philly for those.

And then she went back to her hometown in Mississippi to practice pediatrics, where she eventually about five years later was convicted of murdering her surgeon lover. I mean, sex, lies, and videotape, you can hardly wish for more drama. So, we probably, to some degree, tried to forget she ever came here, I guess.

The second thing was when I went to Greenwood, Mississippi and went down in their very dirty basement of the courthouse and dug up the records, it was clear that the surgeon, Kennedy, Preston Kennedy, was a rake of some epic proportions. He probably didn't actually have a medical degree, probably had a mail order degree, probably used drugs, probably led her along a bit. And he certainly did not tell people that he had been poisoned, which was what he later claimed, at first.

So, he let himself get sick enough, and claimed it was either ptomaine poisoning or alcohol poisoning, then he died. So, that was a real revelation. It's not like this was a reliable kind of guy.

The third thing was, it clear from the medical records that I can get my hands on, and I've never been able to get them all, that he could not have died from what he claimed as a deathbed accusation, which was that she had poisoned him with bichloride of mercury. Because the labs don't fit that. The labs and the physical exam that I've been able to get my hands on don't match that. So, that's not what it had of.

He probably did die of ptomaine or alcohol poisoning, complicated by the fact that he had nothing by mouth or IV for four days. So, he probably died of renal failure. And then the last thing was that it was pretty clear that the death bed accusation, which he made hours before he died, it was probably not made by him, but was concocted by his brothers and a lawyer who was present. Because their testimony was word for word the same, and it was word for word for a textbook, a legal textbook.

And three people don't give the same testimony word for word, especially if it matches a textbook. So, conclusion-- she probably didn't do it. But she was convicted. She was later pardoned by the governor and went on to a life of obscurity.

But we think the reason that the governor pardoned her was the lawyer, who was supposedly present for the deathbed accusation, admitted that it had been made up to get insurance for the ex-wife, for the dead man's ex-wife. So, I'm sure that all means absolutely nothing to anybody watching the tape. But it was just it was sad to know that she had been essentially railroaded into a guilty verdict and that we were partially culpable in that.

We had tried to almost-- there were only like one or two pieces of paper in our archives about her. That's less than most. So, interesting case-- somebody with more energy than me needs to write the book. Maybe that's what I should have done instead of eat chocolate ice cream during COVID. I should've written that book.