Dr. James Gilman

August 16, 2022

Barr: Good morning. Today is August 16, 2022. My name is Gabrielle Barr, and I'm the archivist at the Office of NIH History and Stetten Museum. Today I have the pleasure of speaking with Dr. James Gilman. Dr. Gilman is the chief executive of the NIH Clinical Center. He is board certified in internal medicine and cardiovascular disease and is a fellow of the American College of Cardiology. Thank you very much for speaking with me about your career as well as COVID at the Clinical Center. To begin with your early life and training, will you speak about growing up in Hymera, Indiana, including your family life, early education, and experiences that would have a profound impact on you as an adult?

Gilman: Hymera is a small town of about, when I was growing up, 900 people. It might even be a little bit smaller now. It is one of the coal mining towns of southwestern Indiana. Essentially, almost all my friends grew up on farms, or their fathers worked in the coal mines in one way, shape, or form, or they drove 25 miles to Terre Haute, Indiana, to work at a Charles Pfizer plant. My father owned and operated the grocery store in town, so I grew up working alongside my dad in the family business almost from the time I was about nine or ten years old. I do think that had a pretty profound impact on me. This was a grocery store. It wasn't a supermarket. Our family livelihood was dependent upon repeat business, and so treating people fairly and treating people well was really important. I watched my father deal with a whole host of situations. I think much of what I learned about treating people well and trying to treat everybody with dignity and respect came from that.

My mother taught school. She's a high school English teacher—very intelligent and went back to college. My parents both grew up during the [Great] Depression. My mother was one of five children raised by a coal miner during the depression, and so she was very frugal. She didn't have the opportunity to go to college after high school. She worked for a couple years during the war [World War II], as young women did, and then when she had three little boys actually went back to college. She did very well in college and graduated with a degree in English and a minor in health, and then got a master's degree as a guidance counselor. Most of her professional career focused on her career as a guidance counselor—not in the school system where I attended, it was in the neighboring school system. I got the benefit of my mom's background in English. She was very well read and had thought critically about the things that she read, and so I had the benefit of that. I also had sort of the guidance-counselor-for-a-parent kind of thing. I have an older brother and a younger brother, and so one who made sure I stayed humble and one who looked up to me. I had a really good group of friends from my hometown. I actually went through school from kindergarten and first grade all the way through high school with the same group of people, and I think that was all great as well.

Barr: As an undergraduate at Rose-Hulman Institute of Technology, what made you focus on biomedical engineering as opposed to other types of engineering?

Gilman: I don't really remember why I chose that as a major. It was at the time when I had to select a major, frankly. I hadn't really settled on medicine. I wasn't even seriously considering medicine. I do remember that my college roommate was sort of headed in that direction. I think you had to declare a

major at the end of the freshman year, but it didn't make much difference until the end of your sophomore year. I think it was sort of undecided. Of course, almost everybody who goes to Rose-Hulman majors in engineering—there are a few chemistry majors, there's those who major in mathematics, and there's a group that major in physics. The closest thing we had to a liberal arts program was a math economics major. Whether I wound up in chemical engineering or whether I wound up in bio or even chemistry, it didn't make much difference when I made the selection. But when I made the selection, I hadn't really thought a lot about medicine.

Barr: How has your engineering background influenced how you've looked at medical and administrative problems that you have encountered throughout your career? It's a different background compared to others.

Gilman: It is. It's a really good question, by the way. This is something that I don't think too many people have spent a lot of time talking about. All engineering education is four years of learning how to solve problems. Frankly for clinicians, that's all clinicians do. People walk in the door, they tell you what the issue is, you look at what data is available, and what data you would like to have. You never have all the data that you want, so on the basis of the data that you do have, or you can get easily, you make a problem list, you try to identify a potential solution, and you pursue that solution and then you see how it turns out. This sort of empiric problem-solving iteration is really what engineering is all about—and it's what clinical medicine is all about. It's not the best background for people who are going to do research, but I think it is actually a pretty good background for clinical medicine. I've said that many, many times.

Frankly the problem-solving skills and the problem-solving approaches work pretty well in administrative roles as well. It is "Okay, let's identify the problem, and let's see what data we have that might impact or be relevant to the problem, see what solutions we can come up with, and then pick the best one of those and see how it turns out." I think that the engineering background actually is very important.

The second important thing about the undergraduate time I spent at Rose-Hulman was obviously that I'd done pretty well in high school, but Rose-Hulman was a place where actually students who graduated from my high school often had struggled in the past. The fact that I could still make pretty good grades and I could compete successfully in that environment, also encouraged me to not be too self-limited in terms of what I was willing to try, and it gave me a lot of self-confidence.

Barr: Great! What inspired you to join ROTC [Reserve Officers' Training Corps] and then later the military?

Gilman: I didn't want for much when I grew up—[although] we were not wealthy by any stretch of the imagination. The place where both of my brothers went to school, my mom went to school, and most of my friends went to school was a state-supported school that was pretty inexpensive. When I decided to go someplace else to school and that I wanted to look beyond that college and look at places like Rose-Hulman or even schools that were farther away and out of state, I really felt like I should try to find a way to help pay for it. That's the way it started, and that's why I applied for the Army ROTC scholarship for college. I did receive that. By the way, at the time I applied for it, I didn't know that my father would die right after I graduated from high school. My mom was teaching school and earning a pretty good

living, but our family income did drop significantly there. I applied for it before those kinds of things happened. I believe I'd have still been able to go to Rose-Hulman without the ROTC scholarship, but it certainly made it much easier and much better for us, because that scholarship pays for everything except room and board. It paid all tuition, books, and fees, and even gave you a little stipend every month or so. That's the way it started.

Barr: After graduating from Indiana University School of Medicine in 1978, you went on to complete an internship and residency in internal medicine at Brooke Army Medical Center on Fort Sam Houston. What was the transition like from an academic medical center to one of the largest military medical facilities in the United States?

Gilman: It wasn't really a hard transition. Indiana University (IU), especially when I was there, is a very clinically focused program for the medical students. I had very good preparation for my internship and residency in the Army from the time that I was at IU. I had great third year rotations and my senior year was mostly elective, but I pursued a program called the "senior honors program in internal medicine" because I knew at the end of the third year that internal medicine was the route I wanted to go with. So, I spent a lot of time doing things in my fourth-year medical school that were sometimes harder than what I did even as an intern.

Barr: What were some of those things?

Gilman: I did two months as a senior in medical school as what they called an acting intern. It might not have the same size of service as the interns, but all my orders had to be co-signed and everything else, but I still had patients where I was the one who did the history and physical, and I was the one who wrote the orders, and I was the one that ordered the labs and x-rays and medications. I also spent time in the emergency room, both on the surgery side and the medicine side. Then the other rotations were a little more, I would say, academic and a little less hands-on, but the hands-on work is what really prepares you for what you have to do in the middle of the night as an intern.

Barr: What were your duties as a staff internist and chief of internal medicine service when you were stationed in Nuremberg, Germany, and did you have the opportunity to travel when you were in Europe?

Gilman: I did general internal medicine. I took care of active-duty service members, their family members, and there were a modest number of military retirees that lived the ex-patriot life in Germany that we took care of. We're talking Cold War Europe, not after the wall came down. At the same time you're doing that, you also have another job that you're sort of training for, which is in case hostilities begin. Anyway, I spent a lot of time taking care of relatively common military medical problems—things like asthma and diabetes and a little bit of heart disease, but not that much heart disease, and some pretty serious infections. So, again, mostly a young, relatively healthy population, but people who occasionally did get ill. We did get a chance to travel. When were there, we worked really, really hard, but my family and I did get a chance to travel quite a bit in Europe. My wife and I had one little girl when

we went over, and she was a great traveler. We didn't fail to go places because we had to stay home and take care of her—because she liked running around and doing all this stuff as much as anybody.

Barr: What was it like to be in Cold War Germany? Can you talk a little bit more about that experience?

Gilman: First of all, I don't think you can describe it in monolithic terms. Nuremburg is located in Northern Bavaria, and so as I indicated it was pretty close to the Czechoslovakian border. It was a place where the continued American presence was appreciated and welcomed. We worked with some host nation personnel that worked with us in the hospital, and many of them had relatives that were in East Germany. They were very appreciative of the fact that when the war ended, they were in the right zone. Anti-American sentiment was pretty low. My wife, my family, and I lived on the German economy; we were in a German neighborhood; we had German friends. We didn't speak the language all that well, but we got along pretty well, and we were always treated with courtesy and treated well. Our daughters spent one year attending German kindergarten in the morning and American kindergarten in the afternoon. We had a wonderful time.

The other thing about overseas assignments is that, for those of us who spent a long time in the military, you actually make the longest-lasting friends in those assignments because even if you're in a place like Nuremburg, where the locals are very courteous, in those overseas assignments you actually socialize with the same people you work with. When I was in San Antonio or when I was here at Walter Reed, people go home at night, and they go attend PTA meetings, and they go watch their kids play sports, or they do this, or they do that. They sort of leave the workplace behind. When you're in the overseas assignments—what we call OCONUS, outside the continental United States, you don't really fit in all that well with the local population. You'll do some things with them, but when you get together in the evenings or you go out to dinner, it's with the same people you work with. So, you do form these very long-lasting relationships. When you're new in a country, you're very dependent upon the people that have been there a little longer to tell you how to do certain things and give you advice. You become semi-dependent upon them, especially until you can get a driver's license and get your car and do all that kind of stuff. You do develop these close personal friendships. Those friendships we made in Germany 40 years ago are still active today. In fact, I got an email the night before last from one of the nurses we worked with there, who will visit my family in Florida here soon.

Barr: That's wonderful. How did you choose your fellowship in cardiovascular diseases at Brooke Army Medical Center and then a further specialty in cardiac electrophysiology at the University of Texas Health Science Center in Houston?

Gilman: I have had contact with excellent teachers who happened to be cardiologists both during the time I was in medical school and also during the time I was an intern or resident of Brooke Army Medical Center. That consciously was the driver. It's also true that cardiology appeals to kind of the engineer mind that I have left. There's a lot of quantitation in cardiology and measurement that I think appeals to my engineering training, but it is very much true that my father died of heart disease right after I graduated from high school. I'd been a cardiologist for several years before somebody asked me the question of whether that influenced my decision to go into cardiology. Frankly I never thought about it, but as I've thought about it more over the years, I believe that subconsciously it was very much a factor.

The cardiac electrophysiology, which is basically cardiac arrhythmia work, was just coming into its own when I was deciding to go get some additional training. Implantable defibrillators were a brand-new thing. The other brand-new procedure that was coming into vogue was something called radio frequency catheter ablation. It was a really hot topic. It was a sub-specialty that was missing at Brooke Army Medical Center. We had interventional cardiologists, and we had some people who were very interested in additional training and echocardiography, but we didn't have anybody who was really interested in arrhythmias, and I was interested in arrhythmias.

Barr: What made you interested in arrhythmias?

Gilman: I don't know. Since medical school I've been very interested in being a really good EKG [electrocardiogram] reader and looking and extracting the maximum amount of information that you can get from an EKG. Again, I think that goes back to medical school and the senior honors program in internal medicine. Two months of that senior honors program were spent at the elbow of one of the best electro-cardiographers who's ever lived and reading EKGs with him every single day.

Barr: What's his name?

Gilman: His name was Charles Fisch. He was the chair of cardiology at Indiana University School of Medicine for years and years. I don't have a better explanation [to explain interest in arrhythmias].

Barr: Were there any particular people who supervised you or whom you worked with that impacted you? Any particular cases that you dealt with during your fellowship that really stuck with you?

Gilman: Again, there are two fellowships. We talked about Dr. Fisch, but there's a guy who was the chief of cardiology in San Antonio at Brooke Army Medical Center for years and years named Joe Murgo, M.D. who I think had an influence, and then when Joe was no longer the chief of cardiology, there was a guy named Joe "Mark" Moody, Jr., M.D. Mark became in many ways a big brother to me. He was just a few years older than I am. As a matter of fact, he's probably about the same age as my older brother except he always treated me really well—my older brother sometimes not so much, but he's still a good big brother. Then during the time in Houston, there was a guy that I was working with and I was working for, but I don't think that he had that much of an influence. I knew that I was going back to the Army when I finished there, and I was happy to be going back to the Army after my year in Houston.

Barr: Over the course of your military career, you've been stationed throughout the country from Madigan Army Medical Center in Washington state to an Army community hospital at Fort Wainwright in Alaska, to the Office of the Surgeon General, to Walter Reed, to Great Plains Regional Medical Center in San Antonio. You've worked as a clinician. You've helped train medical students, and you've also been an administrator. What are some of the leadership skills and lessons that you felt like you gained in those positions that you apply to your current position?

Gilman: When I talk about leadership philosophy—or "philosophy of leadership" is the term the military uses—first of all, I go back to talking about things that happened a long time before I was in the military. I talked to you about growing up alongside my dad in the store, and I believe those experiences were very formative. I spent a lot of time in Methodist churches over the years, and that includes church committees and lay leadership in churches. Frankly, I think those experiences also have a lot to do with my philosophy of leadership.

The military is all one leadership laboratory. They don't have a monopoly on good leadership, but they would say that it's a core competency. That there's no other organization that probably emphasizes leadership at all levels every single day. You're not going to find the military outsourcing their leadership training and development education. You do get some chances to study leadership in a formal way, but mostly what you get a chance to do is to listen, watch, and observe and see what works. Periodically, you're served up examples of just toxic or horrible leadership as well, and you say, "I'm never going to do that." I have credit for all the formal military education up to and including the U.S. Army War College by distance education, but I think mostly it's about watching and listening and seeing what works for other people.

But sooner or later you actually have to take what works for other people and say, "Okay, now will that work for me? Because I'm not like them. I can't be successful doing it their way, but they are successful, so let me try to figure out why and work on that." I'm actually not a fan of the word "mentor" because it means many different things to many different people. First of all, I could never have been successful if I had one mentor. I always had to have a bunch, and the military always provided me with a bunch. There are one or two people I worked for in the military that I would never work for again, but there are far more that I would willingly work for or work with them. They were good people and they sometimes made hard decisions make sense when others might have just said you have to do this because the boss said to. Even though you have to be able to do that in the military—you can't get away from that—you actually don't do it very much and understanding why something that may not be very popular still needs to happen is something you have to do almost all the time. Leadership is first and foremost about listening and trying to understand where people are coming from.

Barr: You said that your time at Methodist churches has also had an impact on your leadership style. Can you describe that? It seems very different than the military.

Gilman: Yeah, well, it is different than the military. It's not so much different from leadership inside a hospital, though. Even as a general in the Army, I didn't issue too many orders. It is about understanding where the organization needs to go. It is about building consensus and encouraging. There's a lot of education and explaining what needs to happen and why. Working in the churches you are never paying anybody and you can't give an order. It is all about trying to build a consensus and trying to get people to think about what works for the collective good and not just what is best for them individually. It is about the art of persuasion. There's a lot of opportunity to establish a good example. It is about trying to focus on a common goal and common purpose, and it's also about working in a values-based organization. I think all of that actually translated pretty well.

Barr: Definitely. Will you discuss your responsibilities as the head of the United States Army Medical Research and Development Command that's headquartered at Fort Detrick? It's a little different than some of your other posts.

Gilman: Yeah, the Army's the only place where you can never be a researcher but be put in charge of research. When they say you're a general officer, and I was a two-star general officer when I took that job—or when they gave me that job; I didn't take any jobs, they gave it to me—they do think that you have the background to understand what's going on, although you're not going to be like a branch chief at the NIH at NCI [National Cancer Institute] or something like that. Secondly, understand that the Army's research and development efforts are focused on those things which the military needs, but there may not be efforts ongoing in the commercial sector or in academia. Stopping bleeding on the battlefield would be something that the military has a very unique interest in. There are lots of infectious disease problems that the military has a very specific interest in, and those are all things that are specific to care of a combat casualty. Those are the kinds of things that the military would be very interested in. Or things that might relate to the psychological trauma of being in a miliary operation—of seeing things that nobody should see and sometimes being under an egregious amount of stress for long periods of time and learning how to deal with those kinds of things. Those are problems that are not absolutely unique to the military, but they are pretty unique to the military.

In terms of oversight, first of all I had a lot of professional scientists who were my direct reports, and so you learn. You spend a lot of time listening and learning, and at the same time you have to know enough about the problems and enough about the people to know you have to be very careful about their power. They're powerful advocates for the things that specifically interest them, and you have to figure out when they're giving you the straight story and when they're blowing smoke. I told my boss one time when I was in this job—he said, "I hear things are going pretty good, Jim" and I said, "They've got professional smoke blowers up here and I'm still learning how to deal with some of them," but all in all it worked out pretty well.

The other thing that was important about that job was that I also was in charge of medical logistics for the Army all around the world. I got along really well with the people who did that work—they're very pragmatic. They're never the people that—in Texas we would say "they were never supposed to be the show ponies." They were only support, but I got along great with them. You have to be pragmatic; you have to understand. You have to be able to translate things for senior Army leadership. There is some politics that's involved—there's a modest amount of domain-specific expertise, so again you spend a lot of time listening and learning and trying to provide top cover for people that you feel like are doing a great job.

Barr: Will you speak about your overseas deployment to Tahiti in 1995 as part of supporting Operation Uphold Democracy?

Gilman: Yeah, that's actually a very important thing—that it's part of my career. In 1995, and I won't go into all the background, I basically deployed as what we would call a general medical officer, so I was responsible for helping to provide primary care for about 2,000 soldiers. I slept in the tent, and I had a great PA [physician assistant] who did most of the work. He told me to just show up at the end of sick call and he'll tell me if we have any problems they needed for me to take care of. I saw some interesting

things—a couple patients with dengue fever and a couple other interesting kinds of things. I spent a lot of time trying to make sure that we killed mosquitos and had safe places to live. I spent a lot of time with young medics and with some of their leaders, but mostly served as kind of a staff officer to the squadron commander, who I actually outranked but that's neither here nor there. It was an experience that made me decide that staying in the Army past my 20-year mark, which would have come up in 1998, was okay. It sort of led me down the path of leaving cardiology and going out to provide executive leadership of hospitals. I missed all the October-November-December-January key events with my family, but I learned how to stay in touch with my family and how to help them know that I still love them and cared for them even though I was a long way away. It was a pretty peaceful time. There wasn't much going on. We were there on kind of a police-keeping kind of mission in Haiti, but it did remind me of why I was happy to be an Army doctor and that I could thrive in all kinds of environments.

Barr: Did it make you feel like you could relate to some of the men and women who you helped care for who get deployed overseas and are separated from their families more often than a medical person would be?

Gilman. Yes, more than a medical person. Before I did this, there were a lot of people who worked for me that I had to send on these deployments, and I always felt bad about sending them off and telling them they were going to have to leave their families for the next three or four months and go do this kind of thing. I always felt kind of bad about that until I did this, and then I didn't feel nearly as bad anymore because I had done it. So, there was that aspect of it.

Barr: In 2013, you retired from the military, and you moved on to the Johns Hopkins Military and Veterans Institute. What was your key mission that you were set to accomplish during those three years there?

Gilman: The main thing that the folks at Johns Hopkins wanted was to understand military medical research and development better. I think they thought that there was an untapped source of research funds that they didn't have. They're incredibly successful at competing for NIH dollars, but they hadn't been successful in the DOD [Department of Defense] realm. My main job was to help them understand the way DOD does business and how it's different medical research and development than what the NIH does. Once they found out about that, there wasn't much left for me to do and so we parted ways, but they were actually very kind to me, and I still have some friends from up there.

Barr: What made you apply to be the CEO of the NIH Clinical Center—the first position of its kind—and were you involved in shaping the scope of the role?

Gilman: In the job at Fort Detrick, I'd worked with folks from the National Cancer Institute at Fort Dietrich. I'd also worked with some NIAID [National Institute of Allergy and Infectious Diseases] folks, both Dr. [Clifford] Lane and Dr. [Anthony] Fauci. The NIH made a decision to establish the CEO position. I had nothing to do with that. That followed the Red Team Report. If you're not familiar with that, it would be good to go back and look that up. You can still access the Red Team Report online. First of all, I

was unemployed, and I needed a job at least for a few years. I was contacted and they said they were going to do this CEO thing and were probably going to look outside the NIH for the first one. I was contacted in the kind of beating-the-bushes process—that before a formal search is launched is pretty characteristic of the way the NIH fills senior positions. That's how I became interested in the job, but I had to work through a headhunter. I did have one sort of teleconference with them.

Then I was scheduled for an interview down here on campus. It was over in Building 31. It was on the sixth floor, not too far from where NIAID's offices are located. I got here early—I'm perpetually early, by the way—and I was sitting downstairs in the Clinical Center having a cup of coffee. I knew they were going to ask me why I want this job and I better have an answer for them. I thought about it for a few minutes and then I knew what I was going to say. Basically, it was this: For 35 years I got up and went to work in uniform in the Army and the best part of that job was the fact that I was taking care of service members and their family members and retirees and their family members who were doing something for all of the rest of us. I still feel that people who do that should get really, really good care and they should be treated well. I loved every minute of it until the Army said after 35 years that it was probably enough. Frankly, the patients who participate in NIH clinical research protocols kind of fit the same bill—that many of them are really, really sick and they come here in the hope that whatever intervention we're going to employ, they will benefit from. But we never promise that, and if we did, it would stop being research. They come only with the promise that we're going to take good care of them, and we'll provide their care in a way that we'll learn something that may not help them but will help the next person who has the problem. Sure enough, I walked into the little room on the sixth floor, which had about 25 people there to interview me. That was the first question, and I gave them the answer I just gave you. I was pretty sure I had the job as soon as I was finished, I became convinced later. I didn't know I had the job then—they asked me a few other questions before they were done. But when I came back for the round robin, which was two full days of interviews, I sort of got some indication that I probably had the job pretty early there in that interview process.

Barr: What were your priorities when you assumed your role at the Clinical Center, and what were some of the initial issues that you faced?

Gilman: My application for the job—my "vision statement" they call it—is all about patient safety and high reliability. What the Red Team Report indicated was that sometimes we let our zeal for science get out ahead of our patient safety and what we call "high reliability in the provision of healthcare." That's the way I applied it. I had to decide whether the team that I had here on the sixth floor of the Clinical Center was the right group to do that and I quickly became convinced that I didn't have to change them out. Then I had to work with the medical executive committee and some others. I had to just demonstrate that what I said should be the priorities were going to be the priorities. I tell people that I understand about 75% to 80% of the science here, but that's all I need to understand. What I do understand is how to treat people and how to take care of families, how to support staff and how to provide top cover when top cover is what's necessary—because the staff want to do the right thing.

Frankly, it was not as hard as I thought it was going to be. Those were the priorities. The staff in the Clinical Center were pretty bummed out by the Red Team Report. It's very painful for the staff here to read. Sooner or later, we had to work through the recommendations of the Red Team Report, which we kind of did but we kind of didn't. All we really did was went to work doing the things we all agreed needed to be done without referring to the Red Team Report—because the quickest way to take all of

the oxygen out of any room when I arrived was to talk about the Red Team Report. I'd been here almost a year and a half and then I had to go report to the institute directors on how we were doing with the recommendations of the Red Team Report. I figured I'd better go look at those recommendations. Then we looked at it and we started checking boxes. Even though we never referred to them, we've taken care of all this stuff, and we were pretty happy with that.

Barr: One of the things you did in your first years at NIH was implementing the Safety Tracking and Reporting System, known as STARS. Can you talk a little bit about that in particular?

Gilman: There is a part of STARS I find very funny. There was a system here used before it. STARS replaced the old system. Due to the energy and enthusiasm of Laura Lee, who was in charge of the Office of Patient Safety and Clinical Quality, and some pretty clever marketing—and the fact that the system is largely intuitive—when we switched from the old system to the new system, we had no drop off in reporting. Everybody got it right away. The hardest thing about STARS was naming it. The name that was first proposed for it was "Hippocrates." "Hippocrates," in my mind, made a lot of sense because at least people ascribe the statement to Hippocrates of "first do no harm." That's what patient safety is all about so that seemed like a pretty good name to me. But the nursing department didn't want "Hippocrates" because Hippocrates was a physician, and by and large much of what we do here is driven by nurses. Nurses are with the patients all the time. There are 600 nurses in the Clinical Center. About a third of our staff is the Clinical Center Nursing Department. They didn't want it—they didn't want a physician's name ascribed to the system. So, I told them to tell me what they wanted, and they came back with STARS. To a guy who used to wear two stars, I thought that was okay. If they'd named it "Two STARS," that would have been even better. So, the system was named. It is a surveillance system—and it's never completely right. STARS entries are fairly brief and terse and sometimes they're wrong. We do find people who use STARS to get their comments in first, so it's not always used the way we want it to be used, but it has been a hugely important and powerful tool in what we've been trying to do.

Barr: Now we're going to turn to COVID. Will you speak about preparing for the first COVID-19 patients that came to the NIH Clinical Center to take part in the remdesivir clinical trials in March of 2020?

Gilman: At that time, we sort of thought the patients would be hospitalized in the Special Clinical Studies Unit and so they would be taken care of by NIAID staff. We didn't have to do much in the way of preparation. A lot of us had spent some time doffing and donning PPE [personal protective equipment] in sort of a test environment starting even in January, but the remdesivir protocol was the first. We may have had a patient or two who showed up—they were our patient anyway and had COVID-19—but the remdesivir patients were the first ones. Rick Davey and the folks from NIAID had those preparations pretty much in place. There wasn't a lot that we had to do from the Clinical Center leadership in order to get ready for those.

Barr: How are resources reallocated for COVID expenditures so quickly?

Gilman: We sort of started early on keeping track of what we were spending just on COVID, and we relied on the NIH to pay those bills. I don't know that we took money away from anything else—we just opened up a new account, and we had confidence that the NIH would support the additional COVID expenditures, whether it had to do with the purchase of PPE or whether it had to with testing or any other COVID-19 issues.

Barr: Can you speak a little bit about your role in developing and implementing policies to ensure that Clinical Center staff and patients remain as safe as possible?

Gilman: There are a lot of people. The hospital epidemiology service that was being led by Dr. Tara Palmore at the time had a big role to play. Dr. David Henderson—the first hospital epidemiologist here at the Clinical Center—even though he was retired, he was employed on contract. David and Tara were people that helped guide those efforts along with setting up the screening stations and everything else. Captain Ann Marie Matlock of the Public Health Service, who's one of the three service chiefs in the Clinical Center Nursing Department, was a huge help. Somebody once said there are about 70 ways to get into this building, and we had to cut that down to three or four in order to get people to be screened. So, Dan Lonnerdal and the executive officers had a lot to do with that. Our materials management and environmental services group had to basically put all of the PPE that we had under lock and key because we found items—and sometimes bunches of items—were disappearing. They were being stolen. They worked tirelessly to source the PPE that we needed. Since April 2, 2020, which is the time we all went to masks, there had been a time or two when we became a little concerned about whether we had all the right PPE, but they've always come through and we've never had to tell people we wish we had gowns or masks to give them because we didn't have enough. We never had to do that, which would have been really devastating to me and even worse for the people that had to endure it. That was a big hospital team effort. We started the pandemic meeting up to three times a day and then after a while we'd meet a couple times a day. Then we got to once a day and then we'd get to a couple times a week. Now we talk for about 10 minutes once a week because we haven't had to make very many adjustments.

Barr: Can you speak about the challenging conversations around setting aside a significant portion of non-COVID research cases for safety reasons and how those choices got made, and how and when those non-COVID trials got to return?

Gilman: In March of 2020, I actually was out of town with my family. I had communication with Dr. Henderson who's heavily networked all across the country with hospital epidemiologists. He contacted me and said COVID was getting ready to break out and go wild. He recommended that we basically stop all elective admissions to the Clinical Center. So, that's what I did—from Disney World. There were a few eyebrows raised, and I apologized to a number of people, including Dr. [Francis] Collins and Dr. {Lawrence] Tabak, for the way it was done, but within a couple of days, Dr. Collins had said they wished it had been done a little bit different, but what the Clinical Center had done was actually the right thing. It was about that time that everybody was being sent home from the campus.

Barr: How did they wish it had been done?

Gilman: Oh, they would have liked for a lot more conversations before you take a precipitous step like that, that's all. When I was talking to Dr. Henderson, I said, "David, they're going to be really mad." He said, "Yeah, they'll get mad, and then they'll get over it." And that's exactly what happened. Dr. Henderson was the guru here. From mid- to late-March through April, our inpatient census at the Clinical Center was down in the 30s or 40s and the place was like a ghost town. We basically dealt with outpatients the same way we were dealing with inpatients. Basically, the ICs had to get approval directly from me in order to bring a patient in. Then in early May I contacted Dr. Collins and Dr. Tabak. It was pretty clear then that we didn't have lots and lots of COVID-19 in the Clinical Center and that whatever we were doing to try to keep it at bay was working. I asked if we could begin bringing patients back and they said yes as long as we establish the staff testing program. So, that went into place.

Barr: Can you talk the asymptomatic and staff testing?

Gilman: Again, there's a group that deserves way more credit for that than me. Ann Marie Matlock had a lot to do with it again and Jon McKeeby and the folks in Occupational Medical Service, Karen Frank, Adrian Zelazny of the Department of Laboratory Medicine, and some folks down in the Department of Transfusion Medicine as well. I would say they're the ones who set that all up. Now [once that was done], we can start bringing patients back.

Then we had to establish a few priority categories. If it was COVID-19 related research, we definitely wanted to bring those patients in. If there were non-COVID intervention trials, then that got pretty high on the category list as well. The things that were lower priority were studies of healthy volunteers—and there are a lot of studies here at the clinic that involve healthy volunteers—metabolic studies—and the other big group, which was natural history studies. We wanted to bring patients who needed to be in the hospital back first. Again, everybody cooperated. All the ICs cooperated with that really, really well. Then we basically asked to bring the inpatient census up to about 90 if we could and also added outpatients as well. So, during that late summer of 2020, we sort of implemented all that and sooner or later we started adding back the natural history studies as well. So that's what we did.

In the meantime, the asymptomatic testing and the contact tracing for the few patients who did turn up positive certainly pointed us in the direction of [we're] not spreading COVID-19 around inside the Clinical Center. The way the building's built—the engineering controls, so-called first pass air, wearing a mask, wearing face shields when we're with the patients, social distancing—that all seems to be working. When we did have somebody who would test positive, our contact tracers almost invariably—and when I say, "almost invariably," we're not talking about 90% of the time, we're talking about 99% of the time—were able to trace the exposure that probably led to infection to something taking place outside the Clinical Center. If it was inside the Clinical Center, it often involved somebody who let their guard down. That's pretty much the way we've operated ever since early in the pandemic. I wouldn't be here and Pius Aiyelawo, the Chief Operating Officer, wouldn't be here at the same time. We didn't want both of us to be exposed and sick at the same time. But by the late summer we'd sort of stopped that because we became convinced the evidence was pretty clear that it was safe to be here and that the Clinical Center, building 10—at least our end of the building—was one of the safest places to be during the pandemic.

Barr: How did you make accommodations for COVID patients in the community to receive care at the Clinical Center?

Gilman: That didn't come along until the Christmas of 2020. By federal statute, we're sort of limited to patients who are on research protocols, but there is kind of a provision that says as long as we expect them to participate in research, we can admit them to the Clinical Center. So, with the support of NIH OD [Office of the Director], Dr. Collins, Dr. Tabak, and some OGC [Office of the General Counsel] opinions, we were able to provide care for a handful of patients. It was never very many that required critical care, at a time when medicine was really at a loss for critical care beds because there were so many COVID-19 patients. We worked with the group in Baltimore, the Maryland Institute for Emergency Medical Services Systems. They're the ones who regulate patients—who move patients around from place to place that don't have the resources to take care of them to places that do. We worked with them and took a handful of really severely ill patients from around the state. We did the same thing at the end of 2021, but there were not very many patients. The crunch was not quite as bad as it had been in 2020.

Barr: How did you deal with the staffing at the Clinical Center, especially at times when the virus was high, rates were high, and people were sick, or times when recommendations were that if you were just even merely exposed to the virus you could not come into work for a number of days?

Gilman: Really, we have not had terrible problems. Early on, we had sort of a crunch in our nutrition department. We had to basically contract for meals to be delivered because we had a lot of kitchen staff and others who were out. Then in December or early January of last year—so 2021 to 2022, that sort of time frame—at one point we had something like a hundred of our nursing staff that were either impacted or infected. It coincided with the arrival of the Omicron variant. We had about a hundred nurses who were either infected or had high risk exposures and had to stay away from work. But for the most part we did not have difficulty with staffing for the patients that were here. We probably used our beds differently than might have been the case before the pandemic. We try to get people discharged maybe a little bit more quickly. We tried not to bring patients in the hospital who didn't have to be in the hospital but might have, in the past, been here. Say they were here for a deep phenotyping kind of visit. They might have a bunch of tests and in the past people would have put them in a bed just to make it easy. We might not have done that as much in the last year or so. I would say, for the most part, staffing has not been a problem because the staff have been very good about doing the things that we advise them to do in terms of public health measures—masking, etc. There have been very few mass exposure kind of events at work. People get exposed or infected one at a time, usually when they're away from the Clinical Center, often in big social settings or family gatherings or travel. That has been the issue.

Barr: Will you speak about your role in establishing some of the technological solutions to issues presented by the pandemic, such as the expansion of telehealth and the e-ICU that was put into being?

Gilman: All I did for telehealth and for e-ICU was procured money—procured the funding to pay for it. The telehealth work was done by our Health Information Management Department and Department of Clinical Research Informatics. And e-ICU would have been our ICU staff as well as Critical Care Medicine [Department] staff and the Nursing Department. I don't think I should pretend to take credit for any of that.

Barr: What steps did you take to get NIH's healthcare workforce vaccinated quickly, and have you encountered any pushback by any staff, and how did you deal with that?

Gilman: First of all, the vaccine clinic is not a Clinical Center initiative. We've actually pushed really hard to get the Clinical Center staff vaccinated even more quickly than they got vaccinated. You might remember that the vaccine event took place on the 21st of December—that's when Dr. Collins, Secretary Azar, Dr. Fauci, and Colleen McGowan were vaccinated on the stage in Masur Auditorium. Then not very many people got vaccinated over the Christmas holidays, but we actually pushed to try to get more of the Clinical Center staff vaccinated even then. We never had a problem filling slots that we had for vaccination. We've had very, very little pushback. First of all, I would say that in the Clinical Center, we are big fans of Dr. Fauci, and if Dr. Fauci recommends that we all go get vaccinated again, we'll all go get vaccinated again. We're very attuned because he's been here a long time. Number two, the staff here have watched him take care of patients. We have a lot of trust and confidence in the things that he advises healthcare workers to do, and we're not going to have too much of a problem doing any of those things. So, I don't think we had any real reluctance. By the way, it's also true that if there was reluctance, it was people who weren't going to talk about it.

Barr: How do you seek to maintain the morale of Clinical Center staff, a lot of whom have always had to come to work—and some of them have treated COVID-19 patients?

Gilman: You've seen my messages with my "main things." So, communicate often. We've maintained the usual methods of communicating—we've been doing quarterly town halls since I arrived. We actually threw in an extra town hall or two especially early in the pandemic. Then depending on how fast things were changing, we used the "three main things" to communicate over and over and over again. When we could find something humorous to put in there, we put something humorous in there. One of these days my mom will figure out I've been writing things about her, but so far, she hasn't. She doesn't know yet—it hasn't gotten to her. So, we did that.

Secondly, we've tried to continue other activities that we thought were important, but we adapted them to the COVID-19 environment. One of the things we did in the town halls—when we could actually get together for a town hall—was we would give out length of service awards. We still display those in the town halls quarterly. The town halls are now virtual, but we go ahead and give them out. When I say, "give them out," I mean that I personally find a staff member and hand them their length of service award. I'm trying to stay in touch with the staff, and I think that's been significant. We've been pretty generous with CEO awards and both monetary and non-monetary awards for people who made contributions during the pandemic. There was an issue that cropped up at the end of 2019 where a bunch of the staff thought they were getting a huge monetary award for coming to work during the pandemic because of a miscommunication that fortunately I was not involved in, but unscrewing that

lightbulb was painful. I went around and visited every nursing unit personally with the chief nurse and explained things and we survived—although I think there's still people that are not all that happy about that. You listen at every forum that you can, and you communicate more. You're willing to be vulnerable, even as a leader—I think that's important—and encourage people to get help and use the help. I think that's about it.

Barr: How have you managed other aspects of running the Clinical Center during the pandemic? You've had a lot of other kinds of events that have gone on—you've had some construction; the pharmacy was relocated. Some things never stop.

Gilman: It's a good thing that we made the pharmacy moves before the pandemic hit because I'm not sure what we would have done. In reality, with fewer people in the Clinical Center and less traffic on the campus, it's actually been a little easier to get some of the things done that needed to be done. Again, you can't say enough good things about the people who, for three years, have worked under kind of an interim leadership arrangement and distributed locations. Frankly, we have accessed some really good mid-level pharmacy leaders over the course of the last three years that are doing a wonderful job. Now we need to find the next chief of the pharmacy, who will make sure to take care of those folks. We still have to get the permanent IVAU (intravenous admixture unit) stood up and get that part of the operation moved back. That's not a small task but again, we need a great pharmacy chief, one that's going to look after the staff well.

Barr: What do you feel you've learned from your pandemic experiences that you'd apply to other situations?

Gilman: I would say the pandemic experience is much more like the military operation than it is running a hospital. You sort of reduce—there are fewer meetings, there are fewer things away from the campus that you feel like you need to do. Part of my philosophy of leadership we talked about is that I care more about what the people who work for me think about the job that I'm doing than I do about the people I work for. You don't make major general in the United States Army without the people you work for thinking you're doing a good job. But it's always mattered to me more about what the people inside the Clinical Center think of me. The pandemic means that I can be even more internally focused. It's about understanding the different layers of leadership. It's about supporting and encouraging people who are having a bad day or a tough time, and it's about holding people accountable who seem to want to let some of the big rocks slip. I don't know that I think there's anything different about this. I just looked at the "after action review" that's being led by Courtney Aiklin. Will there be more things to do in preparation for the next time? I absolutely believe there will be a next time, but I have some thoughts about that in terms of preparedness—or what the military calls "readiness" but what the civilian world calls "preparedness." I have a few thoughts about that but I'm not sure that we would do things much, much differently.

Barr: In addition to being an administrator, you're also a person who's been living through the pandemic. What are some personal challenges and opportunities that you've had?

Gilman: First of all, my family is in Florida most of the time. My wife is in Florida. In 2019, we sold our house in Howard County and bought a house in Florida. My wife is down there with our youngest daughter most of the time. That plan did not do very well during the early portion of the pandemic when people were afraid to travel. That was no fun, but after things loosened up a little bit and we could travel, either I could go to Florida or she could come here, or we could both go to Texas, which is where our two grandchildren are. It's been harder to plan to get together. In June of 2020, one Saturday I drove 900 miles to go to our house in Florida to give my wife a hug—and then the next Saturday I turned around and drove back. That was different. I never knew that at this point in our married life we would have to go to those great lengths just to be together for a little while. We have lost family members during the pandemic. My wife lost her mother and her uncle and then [I lost] a very close family friend of mine who I was very close to all the time I was growing up. All three died with COVID-19—at least two of the three. They were all 90 years old or older. I didn't go to Texas for my mother-in-law's funeral and burial to be with my wife because of the pandemic, and that was hard. The other thing that happened was I had a very bad fall in January of 2021 and nearly completely ruptured the quadriceps tendons in both legs. I had to have surgery and the pandemic made it hard to get it taken care of. I became very dependent upon other people because my family couldn't be here—I fell the day after my wife's mother died, so she couldn't be here to help. There have been some personal challenges that have either been caused by the pandemic or exacerbated by the pandemic. Especially for my wife's mother. My wife's mother was in assisted living, so the last year she was basically isolated, and no family could visit. She died by herself. There are a lot of people that have had the same experience. My experiences are no worse than anybody else's, but they're definitely experiences that we didn't anticipate and that do have some impact on us at the deepest part of our souls.

Barr: I'm sorry about all those personal issues. What are your hopes for the Clinical Center going forward?

Gilman: I hope that the census begins to come back up, so that's one of the things that I hope. Secondly, I've sort of spent a fair amount of the last year plus trying to see whether we could do more research in pediatric age group patients here in the Clinical Center. That would be a good thing for the NIH. That would be a good thing for the intramural research program. It would be a good thing for children as well, so I really hope that happens. I hope that at some point we can say the pandemic is behind us. I also have great hopes for this new wing that we're going to break ground on here in a month or so. There's a lot to look forward to in the Clinical Center. Before I applied for this job, I often wondered whether I really had another big job in me. I'm happy with the decision I made. This has been a good place for me for the last five plus years.

Barr: Is there anything else you'd like to add about your career experiences or your COVID experiences?

Gilman: I don't think so. You've done a pretty good job of getting me to spill everything that I can remember. I think we've covered it pretty well.

Barr: That's great. Thank you very much for all your service and work, and thank you for allowing me to capture your experience.

Gilman: Sure. Happy to do it.