# ANPT Inspirational Conversation

# Interviewee: Carolee Winstein, PT, PhD, FAPTA

Interviewers: Britta Smith and Deb Larson

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**Transcription of Full Audio Interview**

**Start of Transcription:** Timestamp 00:00:31

**End of Transcription:** Timestamp 01:01:32

**Interviewer (I):** Welcome to Conversations with Inspirations, the Neurology Section Oral History Collection. My name is Britta Smith, Historian of the Neurology Section and your host for an interview with Carolee Winstein at Combined Sections Meeting 2013 in San Diego, California. Joining me for the interview today is Dr. Deb Larson, Director of the School of Allied Health Medicine and Associate Dean in the College of Medicine at the Ohio State University. She is also the current president of the Neurology Section. Welcome to our program, Deb.

**Deb Larson (DL):** Thanks Britta.

**(I):** Carolee Winstein, PT, PhD, and Fellow of the American Physical Therapy Association, is a Professor of Biokinesiology and Physical Therapy, and Director of the Motor Behavior and Neurorehabilitation Laboratory at the University of Southern California. She is internationally recognized for her work concerning the functional neuro and behavioral basis of motor control and learning, and its relationship to neurorehabilitation, especially for the recovery after adult stroke. Dr. Winstein is a member of the Research and Neurology Sections of the APTA and has served as guest editor for *Physical Therapy*. Beginning in 2002, she was instrumental in helping to establish and direct the first clinical research network in physical therapy, funded in part through a grant from the Foundation of Physical Therapy. She co-chaired the program committee and IIISTEP, a conference sponsored by the Neurology and Pediatric Sections in 2005, that linked basic scientists with clinical scientists and practitioners. Dr. Winstein is co-principle investigator for the first National Institutes of Health clinical trial for Upper Extremity Constraint-Induced Therapy Evaluation, known as EXCITE. She is also co-PI for an NIH interdisciplinary study of neuroplasticity and stroke rehabilitation. She has over 75 publications in revered journals and just as many invited presentations. In her career, Dr. Winstein has been honored with some of the best and most prestigious awards in the physical therapy profession, including the Research Award from the Neurology Section, the Eugene Michaels New Investigator Award, the Marian William Award for Research, the John Maley Lecture Award, and the Mary McMillan Lecture. In 2012, she was honored with the Anne Shumway-Cook Translating Neurologic Research to Clinical Practice Lecture Award at Combined Sections in Chicago. Welcome and thank you very much for taking time out of your busy schedule, I’m sure, to be here.

**Carolee Winstein (CW):** Thank you, Britta.

**(I):** So, what inspired you to become a physical therapist?

**(CW):** That’s a difficult question; I don’t think I took the natural route into physical therapy. During my undergraduate days at UCLA I was a joint psychology physical education major and sort of wrote my own package. They had this opportunity you could take classes in psychology, so I took classes in experimental psychology and then the physical education program later became the kinesiology program. So, it was very sort of infused with the science of movement, so I was kind of inspired as an undergrad. And I had a extremely inspiration teacher named Judy Smith who had just sort of started at UCLA from Wisconsin and she taught anatomy. I got totally, totally hooked on human anatomy and physiology, and I learned great deal from her. Anyways I graduated from UCLA and I sort of was thinking how do I take what I’ve learned and use it? And about a year before I graduated my father passed away, he had a major coronary at the age of 57, he was at the height of his career. And I saw my mother just sort of deteriorate I mean her whole life was my father and this was the fifties where women didn’t have careers and they were very much functioning for their husbands and I grew up living a very different kind of mindset and was very career minded myself and very independent and part of the whole Vietnam era and I did not want that to happen to me. I sort of thought to myself, that I need a career and what can I do with this knowledge and enthusiasm for anatomy and physiology and one route was go to graduate school in Biology, and the other route was to go to physical therapy school. I could have a career relatively quickly and, in those days, this was in the seventies, PT school was, in UC San Francisco anyways, was fourteen months. You got a certificate program, or they had a baccalaureate program. So, I was going in with a baccalaureate. I applied to two PT schools at the time, Duke and UC San Francisco and given the fact that I wanted to sort of stay near home and watch my mom I wanted to be close I decided to go to UC San Francisco. So, I went up for PT school thinking I would be able to have a job and be relatively independent making my own money in about a year. Went up there and was taught by some of the most influential people. Gait control theory, this is pain, pain people and Renee Caya, the whole sort of gait analysis but these were not PTs teaching those classes, the physical therapists were teaching more the management courses. I think about, I got inspired, I went through PT school, it was relatively easy for me. I had such good background in neuroanatomy I ended up sort of tutoring my classmates. We had a class of 20 people (14-15) and we finished. I had 3 clinicals they were a month long and one of my clinicals was at Rancho on the Spinal cord injury service, where my first job was. So that sort of started out I got totally hooked. I went to Rancho in a very unique environment, so I didn’t really know what was happening in the general field of physical therapy around the world around the country. I worked there for 10 years and I worked my way up and I decided that this is my last opportunity to really travel broadly. so, I left my job, I sold my car, I teamed up with a friend of mine who was an OT and I bought one of these around the world tickets that you could buy. And I said okay I’m going to work in England, work in the UK for six months and then I’m going to travel the world for the other six and then I’ll come back and settle on something. So, I did that and worked as a physio in Britain at King’s College hospital. I had some great experiences, one of the ones I remember the most is they were doing nothing, but NDT and they didn’t allow anything else, they absolutely didn’t allow it. So, I was in their rehab gym and everyone was walking around like this with their arms clasped forward and rocking and standing up, and the gait looked quite good, but it was extremely slow and nonfunctional in terms of getting across the street. And I remember recalling what I’d seen at Rancho during all my days there and people were more functional, we used orthotics and they didn’t use any orthotics and they barely used any equipment. And my sense of this comparison, like a little experiment was that the gait that I saw in England there was much better hip control but not good ankle and dorsiflexion control. At rancho there was better ankle control people got their leg forward and put their weight on because they had braces. So, I kind of said to myself a combination of these two things would be the absolute best thing. I really learned a lot; it was great working in a different healthcare system. Then I came back to Rancho and I was hired as an instructor, so I did a lot of teaching but right there in the clinic. And at the same time, I decided to go back to my master’s degree. It’s a long answer to your question but its all sort of related. I go inspired to go back to further my education in large part because I wanted to be challenged to understand how to best facilitate learning in my patients.

**(I):** So, you had a clinical motivation to go back

**(CW):** I had a very strong clinical motivation, after 10 years of clinical experience and the experience I had abroad and when I came back I had a supervisor, Jacques Montgomery, who really empowered me who really would put me in situations where I had to figure out how do I do this? And I was trying to create learning situations for the new clinicians, and I was able to interact with people with the different services like the neurology service and I just was in a situation where I was craving more knowledge, I’m a very sort of analytic person. I wanted to understand where’s the science where’s the evidence, how can I do better? And I got very interested in this concept of motor learning which was not part of any part of the curriculum at any physical therapy schools at this time. So, I went back and got my masters at USC in the eighties and got it sort of part time. While I was still working with patients. During that period, I went to a pre-conference in Washington, I think. the preconference to an APTA meeting that Ann VanSant had put on. She invited several key people to that meeting to talk about motor learning. So, she invited Eric Roy, did a lot of work on apraxia, she invited Ron Martinek, I think Dick McGill. So, these were not physical therapists but people in the field of motor behavior motor learning to talk about the application of these concepts in these fields to the practice of physical therapy. I got so excited so then someone said to me Dick Schmidt is in your backyard. And he’s like the father of motor behavior, motor control, motor learning and I didn’t know. Turns out he was at USC at the time and was just transitioning over to UCLA. And so, I was really really excited that I sort of found someone who could potentially be a mentor for me and so the rest is history. I left Rancho in 1982 and I started full time as a graduate student at UCLA with Schmidt, who I just had dinner with here by the way.

**(I):** So, your dissertation was on disordered locomotion?

**(CW):** No, my master’s work was on inhibitive casting in locomotion but my PHD was on feedback and motor learning. For UE motor skill in healthy normal people.

**(I):** So how did you come up with that?

**(CW):** I had been studying the effects of feedback on learning and at the time this was in the early eighties, there was still this notion that the more feedback you gave the better someone would learn. But as you sort of unpacked this and started looking at the guidance hypothesis which dick had just proposed in the early eighties. That actually too much feedback could actually inhibit learning and that people will depend like a crutch on the feedback and not develop an internal reference of correctness, which is what you really wanted to do. You want people to develop an internal sense of what was correct so that they could apply their own sense of what they should be doing and wouldn’t just rely on that information. So, in my dissertation I tested this hypothesis that less frequent feedback could actually potentiate better retention of the motor skill. And I ended up showing this and publishing the work finally in experimental psychology human movement behavior in 1990 after I’d left and gone on to my post hoc. So, this was the evidence around this idea that less feedback is better for learning.

**(I):** You pursued this kind of inquiry for a while

**(CW):** I pursued this line with patients with this notion of feedback frequency and what happens on trials when you don’t give feedback getting into this idea that people are evaluating their performance and they are challenged to develop this internal reference of correctness. Whole notion of faded feedback starting off early in practice with a lot of feedback to guide them in what they are doing and gradually reducing that was what I had done in my dissertation work. We took that and then went further, and I have a number of earlier papers with students looking at guidance and motor learning. Telling people where they need to move and putting a stop there and showing how that that improved manual performance really well but its horrible for learning. People don’t learn anything. I did a study on partial weight bearing where we actually gave people the amount of weight they put on the scale, we were trying to train them this was you know supposedly for an orthopedic task. They’d had a total hip or something and they had to rehab and people are horrible about figuring out what to do but if you give them too much feedback if you tell them on the scale, they show good performance, but the minute they have to perform on their own without the scale they do horribly. And at that time the standard practice was that you give someone crutches, you know they are in the emergency room, and you give them crutches put them on a scale and show them what they are doing and you send them out the door. You assume they get it. And they don’t. So, this had implications for practice.

**(DL):** These concepts were sort of the mind-blowing part of IIStep

**(CW):** Yes; good point.

**(DL):** Tell us a little bit about how that, I mean I remember just starting my academic career and using the IIStep compendium as a bible, because this was really incredible change in thinking

**(CW):** Yes, so IIStep, I was kind of in the role of, I can’t even remember how they did this? I was fresh out of post-doc in Wisconsin and IIStep was a long time since, NUSTEP was in ‘67 or ‘66 and this IIStep was in ‘91? ‘90? So there had been a long period of time between those two meetings and the goal of the neurology and pediatric sections was to do this sort of every ten years to really chronicle the changes in thinking and also the growth of the physical therapist who is now giving most of the talks. So, if you go back to IIStep, we had basic scientist, people who’s disciplines we’d studied who we thought would inform our practice but there were very few therapists on the program. And the big shift at IIStep was now we had a few people in our profession who had gone back for doctoral work with mentors that were not physical therapist but were in the field of motor control, motor learning, development, the early people did PhDs in anatomy but we began to see people doing doctoral work in fields that were more movement related and could be related more to what the therapist does and what the therapist has to assess. That was one of the big changes when you looked at the program for IIStep, they were almost all physical therapist. And I fought very hard to get Dick Schmidt on the program with me and there was a little bit of resistance to that.

**(I):** Why do you think that was?

**(CW):** I think it was because we were in this mode of “no no no we only want to hear from physical therapists” we’re worried that the basic scientist, behavioral scientist, movement scientist is not going to get what the physical therapist needs. But I won and I convinced people that we could do this thing together and that it would be more translational. He could talk about the questions he has as a movement scientist and I could ask how do we translate these principles to motor learning that could be applied in a clinical setting. And I remember when I first when to work with him as a graduate student. I was his first physical therapist, so he had gotten graduate students from kines or other movement science, but I was the first person who came with a clinical background. So, here was this sort of person that he didn’t really know So he said to me, “why would a physical therapist want to study in this area?” and that tells you something that in ‘83 he was like you know. So, I said to him “what do you think physical therapists do?” So he says well they work with hardware problems and his concept of hardware was broken bones, total knees, total hips, so I said well there’s a whole other field out here which is in neurology where we have to deal with people where the software has a problem and we have to create the right environment to get these folks to relearn or learn new skills. So, skill acquisition is a big part of what we do, and I think it would be useful for me to understand. And he was like Oh, he hadn’t thought about it that way. So, he said that makes sense and he actually learned something about what physical therapists do that he later incorporated into this books and there was a mutually beneficial situation. At IIStep we did just that, he talked about conditions of practice and motor learning and I talked about my work and feedback and how we can be incorporating this and that we can have this whole learning performance distinguishment which is that when you watch someone during performance and you are giving them all this feedback all these bells and whistles going off with some piece of equipment. That you are confounding what they have really learned with the boost you get in performance you get with all this feedback and its difficult to unravel all this at that moment to know whether or not they have actually learned. So, you need a retention test, you need them to come back to know what they can do on their own without all the bells and whistles and all this feedback. So, this concept of the retention test and performance learning distinction which now is sort of fundamental and anyone who studies learning knows this intuitively. But it was very new. We had people thinking they would see learning right there at the moment. So, this was a little you have to think about it in order to understand it. And that relates how you treat a patient and how you evaluate whether or not they got it. So, something fundament that came out in IIStep that people began really incorporating and including.

**(I):** You are well known for your work in strokes. So, when did your early work and knowledge of results and feedback start translating from a normal population to abnormal entities? How did that happen?

**(CW):** That’s an interesting transition and so when I first got to USC and I was an assistant professor I started working with students, these were entry-level students because our doctoral program was still getting started. But I did have a PhD student right as I started at USC named Pat Pole. So, I was sort of building my lab and mentoring her at the same time. She really took the ball and ran with it and we started working with these students and doing this sort of guidance work. And then we decided we really needed to transition and test some of these hypotheses in our patient population. So, my next graduate student was Kathy Sullivan and she was very interested in applying this work in stroke. And we developed a collaboration with Alma Myrans she had gotten a grant, so we took this work and we said okay we are just going to look at this in the less involved limb. Have people learn this skill and give them different levels of feedback and so that was sort of the beginning. That the stroke patients learned just as well, their performance wasn’t quite as good interestingly enough, with the uninvolved limb but they learned just as well, and they did equally well in the less frequent feedback condition than in the 100% condition. So, it didn’t replicate my dissertation findings where the less frequent feedback would have actually done better, it showed that we didn’t need to be giving as much feedback as we’d been giving, and we could get the same level of learning. But this was with the uninvolved limb so everyone started saying “you got to look at the involved limb” and that’s when I transitioned and I started doing studies more with the involved limb and my later graduate students did some really nice work, people are still working in this area of motor control, the involved the uninvolved asking different permutation, different questions. And then the EXCITE trial came along and I can remember Helen Hislop was my chair at the time and I was doing a lot of different work but this was the first sort of clinical trial that I had an opportunity to participate in and led by someone I considered to be one of my mentors, Steve wolf. And I wanted to learn “How do I do this” How do I coordinate the people and participate in this phase three NIH funded trial. My concern was, I though that it was unfortunate the first approach that was put to the test at a phase three level was this constraint induced movement therapy. Flew in the face of everything that I believed, and thought was valid. This sort of real operate conditioning approach where this came out of. But I decided that this would be a good experience for me, I’d learn a lot and we all did. This was ground breaking really and learning how to interact and work with NIH and work with colleagues that maybe don’t think about things in the same way that was a challenge but at the same time it really taught me a lot about working with people that had different opinions about things and managed to get the job done and move it forward. I think it was fundamental to the growth of our profession to the fact that you could have purpose leading a very large, the first NIH funded phase three level trial in stroke rehab. All the phase 3 were in drugs and devices and this was standard in the medical profession, but we hadn’t gotten to the point in rehab where we had enough evidence to support anything that we were doing. This was a time where people were building evidence for things and trying to define who they were and what their contribution was and how can we rehab people? Deb probably has other thoughts on this, but I think we all learned a huge amount.

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**(DL):** So how did it influence what you did next? And what did you take from it that you learned not to do in the next round?

**(CW):** I really learned a lot about collaboration and how science is done and how the culture of cynicism about results and how that can be turned into a positive.

**(I):** I’ve heard it said that the friction between people is what creates the sparks of ideas

**(CW):** Yes, and I think that is very much the case. And I think that letting go and being able to laugh at yourself and not taking yourself so seriously is a very important part of collaboration and success in science. So, I wanted in the next round to create an environment where people felt comfortable being critical and challenging and that was going to be the thing that pushed us forward. And so, I began discussing with my colleagues the next Step. Steve wolf was instrumental in saying to me, do you want to take this ball and run with it? And I had to do some soul searching because it’s a huge responsibility and it also takes a huge commitment and you have to assemble a group of people that you can work with effectively. I knew I could work effectively with Steve and then we had had some interactions with Alex Dromerick who is a physician but he’s a neuro rehab physician, so he has this mindset. I think that he himself had a head injury or some neurologic injury early in his life that motivated him to appreciate the rehab side of medicine. He comes from a very personal sense of that. So, the three of us began talking about what’s next and we began talking to NIH folks and putting some specific aims and questions together an coming off of EXCITE. I had a small study that had been funded at the RO3 level pilot study from NIH which the results of which were just getting published. This was a single site study at Rancho, it was an inpatient rehab study. We were comparing strength training, functional training, in usual care. I had the experience of trying to put an intervention into an already packed schedule for patients since they were in patients. But at the time stroke patients were seen as inpatients in inpatient rehab for about 4 weeks and while I was doing that study it started getting shorter and shorter. So, I learned a lot about the logistics and practical issues so as a consequence we decided we would intervene in the recovery phase. We wanted to intervene earlier than EXCITE but we didn’t think that it would work if we put it very early. Alex had already done a study in acute care. So, we thought this gap of knowledge was this early 1-3 months post stroke but as soon as the patient gets into outpatient therapy. So, we decided both from a conceptual and a practical standpoint that this would be the time frame for this intervention. So, we designed a study, it went through NIH review and had a reverse site visit. Which is where you go to Washington and the study section or in this case the special emphasis panel interviews you. So, I think preparing for that was a real growth experience for me. Dan Hanley was the chair of this special emphasis panel. There were two statisticians on it and two clinical…I’m blanking on who else was there

**(I):** That’s okay if you think of it, we can just add it in!

**(CW):** Anyway, our team went including our data management center and Stan Asen and Phil Miller and we went to Washington. We got a score that was not fundable, but it was clearly a message that was “we want to see this back” and they had a number of very constructive suggestions for us. We then put in a revision and it got a very high score but just under the threshold and now with only one possibility for revision, we would d have never done the trial but at the time, this was in 2007, I talked to my funding officer Scott Janice and said does this mean I need to put in a revision and He said yes. So, I put in a revision with very very small changes and we got in the 1percentile and it was funded. We started this ICARE trial in 2008. So, this has been a big, we are in our fifth year and we are just about ready to finish the last, we have 7 more people to go out of 360. We have seven sites in the United States this is a multiple PI so Steve Wolf and Alex Dromerick are the guys along with me, we’re the primary site and administrative core. I had an opportunity to just work with some unbelievable people, we have teams each site has their own team and its been fabulous and no matter what we find, my sense of this is that it’s been a real growth for myself and everyone who’s been involved in this and the profession.

**(I):** So, the ICARE study does that focus on strength training, motor learning and “usual care”?

**(CW):** So ICARE stands for Interdisciplinary Comprehensive Arm Rehabilitation Evaluation. And it is a three-arm study, it’s got the punitive intervention which we call accelerate skill acquisition program. And this is really a hybrid of the components of that were part of the EXCITE trial but are more modernized and we have three major constructs that we bring together in this intervention. Capacity building, which includes strength training, motivational enhancements which includes all of the fundamental psychological needs that we just gave the session on this morning, and skill acquisition. So those three major components are the foundation for the intervention which is structured, so that’s how it is somewhat different and that is being compared. So, there are 30 sessions that we play out those three constructs. It is a principle guided intervention so our manual of procedures basically plays out we have 8 fundamental principles that the clinicians that are administering this are paying attention to and those have just been published in our protocol paper so in BMC Neurology we actually list the eight principles and little bit about the structure of the intervention. The details of the intervention are in embargoed for reasons that we do not want to get contamination of the usual and customary care group, so we have not disseminated those pieces yet. But we do have that information in this recent paper that just came out about a week ago. There’s that group, there’s a “dose matched” usual and “customary care” group so they get 30 visits of outpatient therapy and we have a “usual care” group where we monitor them during the same time period, and they are getting whatever we get. Actually, NIH was very interested in that group. We were like “we don’t want to waste people in that group” and they said no we want to know what’s going on. We think the number of visits is going to be all over the map and it’s going to depend on all kinds of things. Who their physician is and what part of the country they are in so we are going to have findings from that. There are 120 people in each of the groups. We have baseline, post 30 weeks, 6 month and 1 year follow up. Our outcomes are being based on the one year follow up. WE are really interested in do these things make a difference in the long run and not just do we get these short-term changes.

**(I):** Now have you had an “Ah ha” moment in the area of motor learning in relation to stroke rehabilitation?

**(CW):** I think I continue to have ah ha moments. I think the most recent ah ha moment. I do research and I publish these things, but it continues to sort of evolve in my thinking over time. As I think of these constructs and how they fit together and as the science is dynamic and changing. I think what’s exciting and where I would like to move my research. We now have the tools to look in the brain and see the different patterns of activation, that occur when people are under different conditions when they are learning or in flow or being controlled or not by the therapist. I think we are going to begin to combine the behavioral and physiological even better than we have done in the past to build the evidence of or what is happening in the brain. We talk about plasticity and creating interventions that enhance plasticity but we really don’t know what those are and we are going a lot on animal studies and I guess the ah ha for me is that science is so dynamic our field is so dynamic and the story is never ending. It’s not like oky we have done it I close the book on this, its like unpacking layers of an onion and we are in that process. Our profession has been doing that beautifully and I think we are coming of age and I don’t know if that’s an ah ha, but I am very proud of where our profession has come from. Makes me proud too.

**(DL):** Well you’ve been a big part of it, look you are one of the first to do motor learning, you have really brought a big part of that to the field. You should be proud.

**(CW):** I am, and I am not done yet by the way

**(DL):** Good!!

**(CW):** I am getting kind of worn out, in addition to this ICARE trial I direct a rehabilitation engineering research center that is funded by Nider that’s a whole other side of what I’m doing. It deals with a whole different set of people, dealing with biomedical engineers and getting them to understand this beautiful interface and that’s been challenging but really rewarding. I’ve watched things VR exercise-based VR kinds of things and robotics and I’m very much a part of that and very much a part of saying yes but this is not just a piece of equipment we are interacting with a human being! How can we as a profession stay ahead of this? We don’t want to be driven by the engineer, we want to be interacting with the engineers and taking this to the next front in a reasoned way that we are proud of.

**(I):** How do you see technology impacting physical therapy in the future?

**(CW):** As an almost a subfield of rehabilitation where we work as a team with the engineers and with our patients and with community programs. We’ve got to get out of the hospital setting, we do things in the hospital setting but our population is aging. In 2050 there’s going to be 70 million people over the age of 65, this is happening rapidly and at the same time we are having major changes in technology. I mean just think about the last time you bought a computer, these things last maybe three years and then all the bandwidth problems are solved and you have more capacity and there’s more memory and there’s higher speed, all of that is going to influence and it already has influenced what we do, and we have to embrace that. There’s an exponential rise so I think we have to be, this is what tour rehabilitation engineering research center is all about, we just had our State of the Science Conference and I had folks from all over coming and talking about the future. We have to be writing our proposals for the future not stuck back. So, people are using their apps for everything, we have to be part of that leadership though. We can’t just be the technician that takes, so you are seeing that. You are seeing people in our field that are taking leadership and moving this forward.

**(I):** Your list of students and PhD students reads like a “Who’s Who” of the neurology section. So, pick one of your students and tell me a story about them.

**(CW):** I’ll tell you a funny story about Laura Boyd So I meet with my students once a week regularly and they come in and tell me what they are doing and it’s an intense discussion, but I think it’s really really important. So, she was coming doing her regular meetings with me and I used to have this bowl of chocolate espresso beans on my table and I didn’t notice but she would go in there and she would be popping you know like four or five of these things. And she didn’t’ even realize she was doing this! So after about 6 months or something, she only told me this later, she would get these major stomach aches after her meetings with me and she didn’t realize it was because of the chocolate covered espresso beans, she thought that it was that she was getting stressed having this anxiety reaction. So, then it got to the point that before the meeting she would get a stomachache!

**(I):** Is that learned behavior? Operant conditioning?

**(CW):** Exactly! So, she then figured it out and told me later. She said I just have to tell you I used to get these anxiety attacks and would get these stomach aches and I finally realized it was the chocolate covered espresso beans, so you should warn people! When they are sitting here having meetings with you, they shouldn’t be popping these things automatically, that’s a story about Laura.

**(DL):** You have to have similar stories about EXCITE and some of the other work that you’ve done.

**(CW):** Yes, I do! I’m wondering how many of them are share-able!

**(DL):** One comes to mind, about trying to find a martini bar in Birmingham, Alabama

**(CW):** In the heat of the summer, we were all just sweltering. We were unbelievably just sweltering. And we decided to take Sara Blanton, she’d never had a martini before a vodka martini and so I was going to introduce her to vodka martinis.

**(I):** What happened?

**(CW):** We had an unbelievable time finding a place that would even know what it was!

**(DL):** You were instructing the bartender, weren’t you?

**(CW):** That’s right! How to shake it and what to do and where the put the ice and how many olives you needed. Yeah how to shake it and finding the right vodka that was also difficult. I remember that, we had a hard time!

**(DL):** We went through a whole list before finding one that was acceptable

**(CW):** We did, I think we finally settled on Ketel One, which was not my first choice, I first asked for Belvidere, and they didn’t’ know what that was. Then Gray Goose and they didn’t have that. I think they had Ketel One, so I said to Sarah, this isn’t the best but ya know.

**(I):** Did she like it?

**(CW):** Yeah, she did like it!

**(DL):** In the heat, we all liked it

**(CW):** You just wanted to go numb at that point, we were fried. Two weeks in Birmingham, Alabama in the summer and we were in session all day and then we had evening sessions. It was brutal!

**(I):** And what was this for?

**(CW):** Pre-sort of training for the EXCITE trial, it actually got started in 2000. So, we were all involved back in 1998-99.

**(DL):** Six actually, we did the pilot work in 1997.

**(CW):** Ok alright, so we did pilot work and submitted the proposal in ‘98 I think. It got reviewed and they wanted revision they turned in revision in ‘99 and it was funded in 2000. So, we were in, hard to believe 13 years ago.

**(I):** Well I hear I’m also supposed to ask you about your tattoo?

**(DL):** It’s not a tattoo.

**(CW):** I don’t have a tattoo, but I do have a navel ring. Yeah so, this parts back of course to my days during the anti-war anti-establishment flower child upbringing. And I was actually now that I’m’ thinking about what motivated this there are some people that had to do with this. So, I was about ready to turn 50 and the CSM, combined sections meeting, and we were in New Orleans, so this was in …anyway. So, we were in New Orleans and a number of my students were also there and colleagues. Kathleen Ganley said to me. she was a PhD student at the time in the program, she was not my student. Laura Boyd was a student of mine then, Pan Somporolanor was a student of mine from Thailand at that time. We were all in New Orleans together and Kathleen got a group of people together and said to me “We have made appointments at the piercing store, this famous piercing place in New Orleans called “rings of desire” which is no longer there. And there was this women there who was very well known in the piercing community, by the way there is a professional association of piercers, you probably are getting more information than you want and her name was Angel and she ran this place and it was top notch. They did highly professional, sterile, everything was well done, if stars were associated. So, Kathleen said we made an appointment so if you want to come and have a navel ring then you are welcome to come. And I thought wow this might be interesting, celebrate my 50th so I decided I was going to go. So, we were having dinner the night before this appointment and my student from Thailand was there and she said to me well if you do this, I’ll do it, then she found out I was going to do it. So, then she said okay I’ll do it! So, we all went in and got pierced and I went home and showed my husband and he loved it. They did a great job. So I came back to the session and you have to kind of sit like this so I was sitting in the back of the room and I remember telling Joe Gordon that I had just got my navel pierced and he’s like... that was fun, we had a good time.

**(DL):** We’ve had a lot of good times.

**(CW):** Yes, we’ve had a lot of good times, we have. And really, it’s friends and colleagues and students who have gone off and just done such wonderful things, and that’s really great to see and I’m very proud of that. And I love seeing my friends and colleague when I come to these meetings. Those of us who have been around for a while, there is sort of a camaraderie or a shared experience and that’s a beautiful part of our profession as well.

**(I):** So other than your professional endeavors, what do you do for fun?

**(CW):** Some of what I do for fun I can’t speak publicly about but other things I really enjoy travelling. My husband and I have a home on the Oregon coast that just nourishes e we try to go up there for several week sin the summer. Its on the ocean its beautiful it s relaxing ands where I decompress and its really important for me, I obviously lead a very intense professional life living in LA is intense and so I need a place where I can reflect and relax and cook and hike and look at the beauty of nature which I love and I don’t get to do that as much as I like so I really that’s part of what I do.

**(I):** Any last questions?

**(DL):** If you could go back, rewind, is there anything you would change?

**(CW):** I don’t think there is anything I would change. I think every experience I had even maybe at the time that it was challenging or uncomfortable or frustrating, as I look back on it taught me something and I grew as a person from it. So, I don’t view it as something I would change at all.

**(I):** Well thank you very very much for meeting us today and sharing your thoughts. I look forward to seeing you at next year’s CSM.

**(CW):** Well thank you very much I really enjoyed this, it was fun!