INTERVIEWEE: E. Harvey Estes
INTERVIEWER: Jessica Roseberry
DATE: June 25, 2007
PLACE: Dr. Estes' home, Durham, North Carolina

ESTES INTERVIEW NO. 3

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. E. Harvey Estes. He's former chair of Community and Family Medicine, Professor Emeritus of Community and Family Medicine. It's June 25, 2007, and we're here in his home in Durham, North Carolina. And I want to thank you very much for agreeing to be interviewed, Sir. I appreciate it. We're going to talk a little bit about women in the department and in the medical center. So I wonder if first we might start—when you were in the Department of Medicine, were you familiar with Dr. Grace Kerby?

E. HARVEY ESTES: Oh, yes, very much. Grace was a very unique lady. I'm not sure she had a social life; her life was her work. She worked all the time. A very driven lady. (*laughs*) She was the keeper of all manner of information and schedules and things of this sort, which she carried in little booklets in her pockets. (*laughs*) She literally managed all the schedules in the Department of Medicine. Dr. [Eugene] Stead depended on her, almost exclusively, for setting up the schedules and making sure that they all fit. She was an organized and compulsive individual who made sure that everything was correct. All the schedules were coordinated, and there were no glitches.

ROSEBERRY: What schedules was she—?

ESTES: House staff schedules. Who worked where, who worked with whom, vacation times, and anything else that affected the operation of the residency. Grace was the person who planned it, knew it, or could flip it out of her pocket in a flash and give you the correct answer. She was also a hard-working clinician. She saw patients, made rounds, and taught. Her specialty was arthritis. She was a well-regarded faculty member, taught regularly on rounds and so forth, but her chief role was that of the lady who made everything fit together, and made it all work. She was Dr. Stead's right arm, as the planner of the schedules in the residency. She was chief resident the year before I got here. I didn't know her in that role. I only knew her in her faculty role.

There is one other thing I remember about her—Dr. Stead believed that the psychosomatic aspect of medicine was the most neglected part of medical teaching. Most physicians would be surprised to hear it, because they always thought of him as a sort of clinician-scientist. But he believed very strongly that a doctor, in order to be empathetic, had to understand the patient's perspective. A good doctor-patient relationship was a major responsibility of the doctor, and he could not let his personal life, personal opinions, or anything else get in the way of that communication between patient and doctor. Two of his early residents at Duke started him thinking about how he could make that area of medical teaching better in his department. One was Dr. Bernard Holland, who became professor and chairman of the Department of Psychiatry at Emory. As an early house officer and later chief resident under Dr. Stead, he was interested in psychosomatic aspects of medical care. Dr. Sam Martin was the other. He later left Duke to become the chairman of the Department of Medicine at the then-new medical school at the University of Florida. These two people, I think, sort of focused Dr. Stead's interest in

psychosomatic medicine. When I arrived here in 1952, he had already instituted what to me was an absolutely unique feature of his department. I am sure others have also described it. It was a weekly psychoanalytic session with Dr. Bingham Dai, a very good classical psychoanalyst. Once a week, every chief resident at Duke had one year of weekly analytic sessions with Bingham Dai. This was not done with an objective of improved care of patients. Instead, it was to improve the understanding of one's self. Eventually every person on his faculty had gone through this experience, except one. Guess who? Grace Kerby. Grace Kerby turned it down. She didn't want to do that, and she didn't. She's the only exception.

ROSEBERRY: So she got away with that?

ESTES: She got away with it. I don't know if she was better or worse for it. I suspect worse, because Grace was a very reserved, very private individual who didn't have many close friends. And she lived her work, and work was her life. So I think she was probably a very isolated and probably a not very happy—if that's the right word—person. The person who probably could have used the experience to improve her life more than anyone else is the only one who ever turned it down.

ROSEBERRY: Was she well respected?

ESTES: Very well respected, as a person and a clinician, though not in a personal, friendly kind of way. I mean, she was always reserved, always took care of the business at hand, and was never socially interactive outside of the ward, the clinics and teaching. But yes, she was a very essential person. She retired early, and died early. She didn't appear unhealthy, and I was surprised at the early retirement and death. I remember her quite well, and respected her, and liked her, as everyone did. She was not a warm person,

but was a very helpful person, always could be counted on for what she was supposed to do.

ROSEBERRY: Do you remember any interactions you may have had with her that stand out?

ESTES: When I came to Duke, I spent about six months finishing my residency, and she was in charge of my life for that period of time. (*laughs*) But I remember interacting with her in caring for patients, teaching sessions, schedules, and things of that sort. She was always very warm and friendly in her interactions with me, and I had nothing but positive feelings about her. As an individual, I felt that she was much more reserved than was required. She could have used a few social evenings with the house staff, with perhaps a few drinks under her belt, (*laughs*) and a little more camaraderie! But that wasn't there.

ROSEBERRY: Do you think that maybe held her back in any way from the work that she—?

ESTES: No, not really. That was—I think it would have helped her, but her work got done. That was first! (*laughs*)

ROSEBERRY: Well, you mentioned she was Dr. Stead's right hand, and I've heard that Bess Cebe—am I saying that name correctly?

ESTES: Each had their own roles. Bess was certainly his right arm and shoulder, but Grace was the person who managed a very picky and contentious part of the job of running a medical service. Everything has to be arranged! Someone must manage that very complex interaction of fifteen to twenty people in such a way that it fits. Everybody has a start date, everybody has a finish date, everybody has a vacation time. It must be

arranged. You can't leave anything uncovered. But Grace would work all that detail out in the days when there were no computers! It would be a lot easier now, (*laughs*) but it was all done on the back of an envelope and was in written form in her pocket. After it was published, it did not change! Compulsive and rigid! (*laughs*) She didn't like to change things, because it meant going back through all of that stuff. But anything that would require detail and precision, she handled beautifully. Both Bess and Gene Stead would assign that kind of work to Grace, and she did it with perfection! So she was a very unusual person.

ROSEBERRY: Tell me a little bit about Bess. What do you remember about her?

ESTES: As warm as Grace was cold! (*laughs*) Bess took a personal interest in everyone. She knew everyone, she knew what their problems were and would try to help you read Dr. Stead in your favor! (*laughs*) "Today's not a good day! Come back tomorrow, it'll be better." (*laughs*) That sort of thing. She did that for everybody, not just me, though I felt a personal warmth and affection for her. She was a very warm and caring housemother as far as the department was concerned. Always smiling, always wanting to know how things are. She would always listen, and always trying to do her best to take care of what it was that was needed to make your life easier. For me, this helpfulness and friendship extended beyond the time that I left her department. She retired when Gene Stead retired, but her tenure overlapped part of the time that I was head of my own department. Bess took it upon herself to help choose staff for me and my new department—"I think this person is better than that person, and this is why"—and I always took her advice.

At a certain point when I was chief of Medicine at the VA [Durham Veteran's Administration Hospital], I remember that we had an employee who was working for me in a quite responsible position who had a psychotic break. She left her family, she had a break with—she became suspicious, moody, and unpredictable at work. One day she dumped all of the departmental files in a large garbage can, called for the housekeeping department to come get it, and walked out! Not only that, but she declared—to all who would listen—that she was being imposed upon, and that she was resigning because of just cause, aimed at me, (*laughs*) her boss! And she was going to sue everyone—Duke, me, everyone. Fortunately the housekeeping service recognized that something was wrong, and they took the garbage downstairs and hid it. They knew that something was wrong.

But Bess was my best friend during that episode in which where everything was really pretty hairy. This lady was going to accuse us of everything, all sorts of harassment, sexual stuff. She left her family, her home, and moved to Florida—you know, a real psychiatric break. Gene Stead, as he always did, designated Bess to handle this problem, and she did. It all worked out and the threats were resolved. (*laughs*) I'll never forget that episode. There was tremendous support from everybody. The chief of staff of the hospital recognized what was going on. We retrieved the barrel from the basement and put the departmental records back together again and trained a new staff assistant. But Bess handled all of that for me, on the Duke side of the street, including the contacts with legal people, and that sort of stuff. I always felt very close to Bess! (*laughs*) And you couldn't ask her anything she couldn't answer. She knew Dr. Stead better than he knew himself. She arranged everything. When I was chief of Medicine at

the VA, Gene Stead and I each had our own house staff. It was the same house staff, but when they were at the VA they were paid by the VA and administered by the VA, and at Duke, the same. And we would have joint functions for the house staff during the year. Bess was always the person who did all the cross-coordinating and so forth in addition to handling all the financial details. Gene Stead managed almost nothing in the financial area. He knew the broad outlines, but Bess did it. In this area she functioned as independently as Grace Kerby in house staff affairs. She knew all the grants and accounts, how much money was left in each account. Could we transfer money from one account to another? She knew and did it all very smoothly, with no problems.

ROSEBERRY: Now, did she play kind of an unusual role for an administrative assistant?

ESTES: Oh, yes. He gave her far more autonomy than the administrative heads of other departments. She was the department's administrator and helped everyone. Those were simpler times, and I don't think that could work today. But she did it then, and she did it with great skill.

She was a very warm and caring individual that people just naturally trusted and liked, and she quickly became every house officer's best friend. She knew them all, she knew their kids, she knew their wives—and just took care of them. She had her own family, but the department was her extended family. She had a key role.

ROSEBERRY: Were there other women that during that time, that you think of as—?

ESTES: None that I can recall. There was very few women faculty, very few women residents—mainly a man's world.

ROSEBERRY: And this is kind of in the 1960s?

ESTES: Yeah. I can't recall any others—or, not offhand, unless you've got some on your list?

ROSEBERRY: No, I don't. I do think of Susan Dees and Mary Bernheim, in other departments.

ESTES: Oh, yes. Oh, yes, they were there. They were in other departments, but I knew them, and knew of the key role they played. Susan Dees has always been respected and revered in her field. And the same for Dr. Bernheim. She and her husband were a husband-and-wife team, and they were all very well respected, but I had no personal, day-by-day contact with them as I did with these other two in my department, the Department of Medicine.

ROSEBERRY: Well, I guess then let's move to Community and Family Medicine. We were talking a little bit about Eva Salber before we turned the tape on.

ESTES: Yeah. She came in the early '70s, I guess. At that time there was a fairly large contingent of South African faculty members in the School of Public Health in Chapel Hill. The School of Public Health also had a steady stream of visitors from South Africa who came and spent time—sometimes a week, sometimes six months, sometimes a year in Chapel Hill. Some returned to South Africa, but there were others who emigrated to the U.S. This was a very stressful era in South Africa, and most of their physicians left South Africa in protest against the apartheid policies of the government and came here. Eva Salber and her husband Harry Phillips were part of that group, but instead of coming directly to Chapel Hill, they went to another nidus of emigrants, which was Boston.

Eva and Harry joined the Harvard School of Public Health. Later, she became the director of a large community health clinic at Bracken Field, a poor area of Boston.

Harry had his position as a faculty member but became unhappy and accepted a position in Chapel Hill. Eva was forced to break her relationships in Boston leave her position at Harvard and come here and find a new position. She looked around Chapel Hill, and there was nothing that fit, so she came to our department at Duke. She was interested in running a community health center, and at the moment Lincoln Hospital was beginning to put together their community health center. She joined with Dr. Charles Watts, and they wrote the grants that made the Lincoln [Community] Health Center possible. When the funding was approved, Eva was asked to take the position as the director, which she turned down—I think with some help from her family. She had become so totally involved with her job in Boston that she spent all her time at work and little with family. I think they talked her out of taking that job. That's when Dr. Evelyn Schmidt was appointed as the director of the Lincoln Community Health Center. So Eva came back to see me and asked if there was anything else available. We were at that time beginning to plan a clinic in rural northern Durham County. Lincoln Community Health Center was right here in the middle of Durham, taking care of East Durham and South Durham and the citizens in the center of town. There was nothing north at all. The community hospital was still the old Watts Hospital, located where the [North Carolina] School of Science and Math[emetics] is now. Our first efforts were to look at the northern area that didn't have any health care, and draw up a plan to meet the area's needs. We mapped northern Durham County, identified the homes in this area, and went about visiting each one to see where they got their medical care.

We were in the very early stages of that. We had hired a person to head this effort, who had begun very slowly and not very expertly. When Eva came back and said, "Look,

I'm ready to do something else," I said, "Okay, here's a position that you might be interested in." She was not only interested but very interested, and she immediately took over and began to enlarge and complete the survey of these homes in northern Durham County. She recruited Connie Service, who joined her in the project. (*telephone rings*) Excuse me.

ROSEBERRY: Um-hmm. (*pause in recording*)

ESTES: Anyway, Eva took over the project. She visited all of these homes, many in person. Eva knew how to go about the task, in contrast to her predecessor. She and the other people in her group knew a whole lot about community surveys and what to do and what not to do. The original objective, which she continued, was to do the survey, find out what they needed, and then to design a health service unit to answer their needs. It was pretty obvious that we could not afford to build a conventional health care clinic or center out there, so what was the next best thing? And maybe not the next best thing, but maybe even the best thing. Her concept was that community health workers could become the first line of primary health care for people in the community. This was a very rural section, out in Rougemont, Bahama, and northern Durham County. There was no health care at all out there. Many people lived by themselves in houses far away from any clinics or doctors, such as in the Watts area, the Duke area, or the downtown Lincoln area. We did put together, for a brief period, a small clinic out in the Rougemont area. But we soon found that that wasn't viable, and Lincoln took it over and then eventually folded it back into the main clinic.

Her idea was that we should identify people who are natural problem solvers in the community, train them to be adequate first-line health workers that can give advice to

people in the community, and enable them to do their job. She put together a network of professionals who could support them, answer their questions, and get those that need a higher level of care to the services they need. If these community health workers, or community lay advisors—which she called them—needed more information, more advice as to what to do for a given individual, this was provided. The idea was to create a new relatively inexpensive level of health care between the profession health care giver and the people who needed it. This was her idea, which she proceeded to develop. It became the Community Health Advisor program. She trained a group of twenty or so health advisors in a formal evening training program that met once a week. They learned to take blood pressures; to do first aid; and learned about hypertension, strokes and a wide variety of things from sexual advice to young teenagers to caring for an elderly person with Alzheimer's. They learned how to recognize many common problems. A lot of these people continue to serve in this role. They were unpaid. Many of them worked through their churches. I think it was a quite successful program.

And she wrote a couple of books—a book on interviews of people in her old Boston Clinic and one book on the program itself, which she wrote with Connie Service. She wrote another book on her interviews with old people living alone out in the country; what they felt about things, how they lived, and what they thought were important points in their lives, and what they missed, and what they had, and what they didn't have. It included a lot of anecdotal and personal things about these people, which she came to know on a very warm and intimate basis. She knew them! She would go out and visit them many times. She arranged with Dr. Duncan Heron, a Duke faculty member who was an amateur photographer, to go out and take pictures of some of these people in their

homes. He involved another distinguished photographer, who made a series of portraits of these people in their homes and work settings, in their kitchens, washing dishes or whatever. It became almost another career for her: how to interpret what old people in rural environments need and want. She wrote several papers and books on what she had learned.

She was a remarkable lady. She had come from an apartheid atmosphere with which she violently disagreed. I remember talking with her about her early experiences in the South after coming here from Boston. She hired a lady to be her maid, a black lady, of course, and she [Eva] insisted that she [Eva] call her Mrs. So-and-So. This black lady was not accustomed to that, insisted that she call her Mary, or whatever her name was. And Eva insisted back, "Okay, if I call you Mary, you call me Eva." (*laughs*) She also insisted that she sit at her table and have lunch with her. She didn't treat her as a servant, she treated her as an equal. The lady was astounded and shocked at her behavior. (*laughs*) It was the same with her hired man—he was always Mr. So-and-So.

I remember another story that she told me. This man that worked for her was well known in Chapel Hill, and she later met another man with a similar occupation, and asked him, "Do you know Charlie?" The response was, "No, I don't know Charlie." And she later asked Charlie if he knew Bill. "I don't know Bill." They didn't know each other. She thought that was strange. At some point later, the two of them came together in the same place, and they greeted each other as old friends. Eva commented to them, "Well, I thought you two didn't know each other?" "Well, I don't know him as Mr. So-and-So. He's T.J., and he's Joe!" (*laughs*) They did know each other, but never called each other by their last names. So she had a very different relationship with the black

people with whom she worked. Her interviewers, most of whom were black, were her friends. They became her social equals. She wiped out all ethnic or hierarchical lines; they were all mixed together as colleagues. She invited them to her home as friends and guests. Some of them were not comfortable with to that, and it was a bit awkward at the beginning. She believed in that, and she did it.

Her relationship with medical students was somewhat the same. She frequently pointed out that Duke was not a friendly place for people with her interests and background. They were all interested in biochemistry, genes, and mechanisms of disease. She was out there finding out what people wanted, instead of what they needed! (*laughs*) She had an uncanny knack for picking up medical students who had a spark of her interests within them. She would get them involved by inviting them to participate in her teaching sessions in North Durham, and take courses that she taught. She was very serious about her teaching. She spent a lot of time preparing, lots of time getting together her materials. She was quite successful in getting those people who she identified to spend time with her, and she in turn would steer them to take this course instead of that course. She also steered them to outside resources: "This person in Chapel Hill will help you with that." She knew the faculty there quite well.

As a result we had a whole stream of people from Duke who went to UNC for their MPH [Master of Public Health] degree. They were steered in that direction by Eva Salber. Some of them went on to work in public health and others didn't. They went into practice and carried with them what she taught them in their hearts and heads instead of in their careers. A remarkable lady! She was very warm, and caring about people and

would absolutely do anything for anybody! She would take the coat off her back, the shoes off her feet, to give to those who needed them.

She managed her own affairs and activities. Very few Duke faculty members got to know her very well, but the medical students did! She was not very well known among the faculty because she was doing things that were totally different from what they did. She did it very effectively. Both Eva and her husband Harry are now dead, but their kids both are cut from the same cloth. Her daughter is a health administrator. She was with Kaiser [Permanente]; I don't know whether she still is or not. Her son is a quite famous in sociologic research. For many years he studied why people die at a particular time. People tend to not die in the days before their birthday. They will live until their birthday occurs and then die! (*laughs*) Like Eva, both of her children are interested in research on people. Eva was much more the research person than Harry, her husband. Harry was more a teacher than a researcher, but did both. They both did both. They were both my good friends, and I miss them both.

ROSEBERRY: It almost sounds like she was a one-woman show?

ESTES: She was, but she put together her own little research team. Connie Service was one of the group. Connie began as an administrative assistant, and Eva encouraged her to go ahead and get an advanced degree, which she did. And she was always pushing people to do that. She told her staff: "If you want to do something, you can do it." The fact that you're a forty-year-old woman with no education doesn't matter. Go back, pick up what you need, and keep going. She was very encouraging, would push women, particularly, forward. They all admired her, and for good reason!

ROSEBERRY: Did she do the same with some of the members of the community as well?

ESTES: Oh, yes. Oh, yes! She was very proud of some of the people in her original community lay advisor group, because they moved ahead to do higher-level things, such as becoming administrators at Lincoln, things of that sort. This was universal; she encouraged everybody! (*laughs*)

ROSEBERRY: Well, you mentioned she trained Becky Heron, who is a County Commissioner?

ESTES: Becky is, of course, very much into politics at this time, but when Eva came to Duke, she was a faculty wife who was interested in a wider role. At that time I think she was on the Board of Education, or something of that sort. She was doing less advanced things in politics, but her chief role was the wife of Duncan Heron, professor of geology. Becky began to work with Eva as one of the people who interviewed people as part of surveys, visiting people in their homes. It would be interesting to contact her and get her perspective on Eva. She's gone ahead to do much bigger and more responsible things since those days.

ROSEBERRY: So when Dr. Salber retired, were there people that were able to kind of take up that mantle of community outreach?

ESTES: Eva's group as been transformed or replaced by Susan Yaggy's division now. But not anybody who could really fill that niche exactly as she did. But the division continues, and Susan Yaggy is doing a great job with probably *the* outstanding division in the department, as far as the school in concerned. I don't think Susan ever interacted with Eva, because they didn't overlap. Susan came later.

ROSEBERRY: There was—that division kind of—there was a time when there was no Division of Community Medicine?

ESTES: We had several divisions, but when Eva retired, there was no one that filled that role. This was at the time I left the department as chairman, and George Parkerson took over—and the department changed quite a bit at that point. And Connie Service retired along with Eva. That whole division went out of existence and didn't get restarted again until Lloyd Mitchener came along and brought Susan Yaggy in. So I guess it went out of business for a while.

There were lots of women in the house staff, many of whom are now in practice in this area. In the Family Medicine program we had thirteen residents per year. I can remember one year in which we had eleven women out of thirteen positions, so we specialized in women as house officers—many of these were quite strong, active house officers.

One I can think of that's still very active in the medical school is Kathy Andolsek, who was certainly outstanding as a resident, and then as a faculty member, and has gone up through the ranks, and has done it all—has raised a family, has been a faculty member, and has had to adjust her schedule and manage children and schedules and husband's schedule. But she and her husband Don have done it, and done it very well. She is another person I admire tremendously. She is another very warm and caring person who gets involved with people and convinces people that she really cares about them, and she does! She was a good family doctor who took good care of her patients, was devoted to them and vice versa. Kathy's is one of another outstanding younger woman, and she typifies her group.

ROSEBERRY: Well—I'm sorry, go ahead.

ESTES: I haven't looked in the university phone book recently to see who's still around, but Susan Brown was on the faculty, and Joyce Copeland is still on the faculty. But I think Kathy deserves special attention; she's just continued to enlarge her scope of activities and influence as she's continued in the faculty.

ROSEBERRY: What do you think about—what was it about Community and Family Medicine that made it a good fit for women?

ESTES: We were looking for people who were interested in becoming caring family doctors. At that time there were more women than men that were interested in responding to our need for people of that sort. We weren't prejudiced against women in medicine, and we were glad to have them—looked for them, welcomed them. It was kind of hard when four or five would get pregnant at the same time (*laughs*), which they did! But we adapted, and everything went on. But it's different working with a group of young women instead of young men. You have to adapt to a different kind of reality! (*laughs*)

ROSEBERRY: How did you do that adapting?

ESTES: Well, I didn't have to do it, all, fortunately, because I had a division chief (*laughs*) that did that! That was William J. (Terry) Kane at that moment. Terry was very flexible and very interested in solving problems and moving on. So it worked, that's all. But one interesting thing that I recall which struck me then—and still strikes me. Most of our young women who took maternity leave to deliver and care for their new baby were delighted to come back! (*laughs*) I guess their medical work was less stressful than staying home with their new baby! (*laughs*) So this wasn't a long-term problem. They

were always glad to come back, and to arrange for child care or live-in care—or sometimes their husband would stay home with the baby. But this was almost invariably the case; they were delighted to come back to work! The quicker they could get back, the better.

ROSEBERRY: Were there policies in the department for maternity leave or paternity leave?

ESTES: I think we must have made them up as we went. There were no hard and fast policies, and we sort of made our rules as we went. And everybody's different, every family is different. I don't think we had hard and fast rules. We had rules, yes, but we—I mean, everybody got leave! (*laughs*) And everybody didn't have to come back until they were ready. But as I've just said, that wasn't a limiting factor, it was how soon they could get back! And I think that it was also true that they liked what they were doing, and they were as anxious to get finished with training as we were to see them come back. It all worked out.

ROSEBERRY: Were there other policies within the department that—I don't know, a tenure policy, the tenure clock, or anything like that? Was that departmental, or was it—?

ESTES: Our department did not pay much attention to tenure. Most of our department would have never made it through the usual tenure ranks, it required a certain number of juried publications, books, and research, and most of our people were straight clinicians. They may have written papers, but they didn't write research papers that the review committees were seeking. So our department was more relaxed about having clinical appointments rather than tenured appointments. Most of our faculty didn't think that was very important, so I guess we were unusual. We did have difficulty getting our faculty

recognized through the regular promotion ranks. "This person has written only three papers." "But this person has only been teaching; this person has been only caring for patients. This person has been taking care of huge numbers of patients." As I've already said, for most of our faculty members it didn't matter, but occasionally there were particular people for whom it mattered a great deal, and we always had trouble getting them through. Our chief problem was keeping those faculty we had, because unless they had rank, they would be lured elsewhere. We had to get them promoted in order to keep them—we wouldn't keep them. So occasionally we had to run that gamut. We did it by appealing to other department chairmen, who could understand the problems were. We maneuvered most of those crises. It may have taken two or more tries, but we achieved promotions for those few for whom it really mattered—usually division chiefs. And we did lose some, but not many. But when we did lose them, we missed them, and we saw them go to other places and immediately go up the ladder.

ROSEBERRY: Were there quite a few women on the faculty as well as in the department?

ESTES: Not at the beginning. We began to recruit our own trainees—who remained here and become clinicians. Kathy Andolsek is a good example. Kathy would occasionally drop out for a while when a new child arrived, et cetera, but she would always come back. She paid a price for that, in terms of promotions and things of that sort, but she always jumped back in and made up for the lost time. We had several people like that, who eventually decided it was not their cup of tea to remain a faculty member in the medical school and moved to community practice or went elsewhere. But not many.

ROSEBERRY: I know there was a woman on the—Dorothy Naumann, I've seen her name come up?

ESTES: Oh, yeah, Dorothy. I'd forgotten Dorothy. Dorothy was the head of student health. Dorothy was here in that role before the Department of Community and Family Medicine was created. I don't recall when Dorothy first came to Duke. When the department was formed, we inherited student health as part of our new functions. And Dorothy was the chief of the service at the time, and she had been there for a number of years. She was a spinster lady who lived at the King's Daughters Home down on Watts Street, where she lived with a group of her old friends

In a way, she was similar to Grace Kerby. Her work was her life and vice versa. I think she had a much more varied group of friends and social life than Grace did. Dorothy was a Pennsylvanian, from a Pennsylvania Dutch family, with close ties to her family. And she was a family doctor by training, and she did a very good job as the head of student health. This was not a very glamorous job. Those students who came for in care usually had an ordinary self-limited illness. But you always had to be alert for those who were seriously sick. But she handled the job very well. She put together an organized service that included a clinic over on the West Campus. At one point, she had six or eight beds in Duke Hospital that were used by students who needed to be hospitalized or observed for a period of time. If they were really sick, then they went on the existing wards at Duke. On the East Campus she had another clinic and an infirmary. At the beginning, East Campus was for women only, so only women were in the infirmary. Men went to the beds at Duke Hospital. Men used the West Campus clinic, and women used the East Campus clinic.

Dorothy ran all of that before and after I took over, and ran it until she retired. Yes, I remember Dorothy very well. I didn't interact with Dorothy, because she was accustomed to running her own well-established show. We did try to change a few things, and eventually merged it with the Family Medicine Clinic in the Pickens building. Student health and family medicine were merged, and residents would care for students as well as other patients. She was not really sure about this at the beginning, because she believed that her students deserved more seniority than the resident physicians. But in point of fact, it worked very well. The residents respected the students, liked to see them, took care of them well. Dorothy came to see the family medicine residents and faculty as colleagues rather than challenges. She adapted very well to some changes that we suggested along the line. Dorothy retired, and continued to live with her old friends in Durham after that until her death several years ago. I would see her every few months. We had a very warm relationship, and I respected her a lot. She did her job well.

ROSEBERRY: Now, you had mentioned that—going back to the point about the residents, and then maybe they didn't necessarily come on to the faculty of the department but often chose to go into practice in the community?

ESTES: Yes.

ROSEBERRY: I was just wondering if you had any insight into why that might have been?

ESTES: Well, this was part of our job as a department. We were here to train doctors needed for practice out there, not to train people inside. So we stressed that every resident should start looking ahead for what they were going to do with their lives. Most of them went into practice, quite a few in the Durham area. Many of them were married

to other doctors, and had to manage double careers. Several went into practice in Hillsborough. Some went to Raleigh and Cary. Many family doctors now in this area were once our residents. And they also went elsewhere in the area. Two weeks ago I had a call from the wife of a friend and retired internist. "Do you know Dr. Walt Larimore?" "Yes, I know Walt Larimore. He was one of our residents." He went into practice in the western part of North Carolina, and then went to Florida. I've kept up with him over the years, because he's kind of medical writer. He wrote a weekly column for a group of newspapers in Florida and a monthly article for the *Florida Medical Journal*. She said, "Did you know he'd written a series of books about his medical experiences?" I'd heard that, but I had not read any of his books. She said, "You've got to get them." He'd written three books about his early years of practice in Bryson City, in the western part of the state. It's a kind of autobiographical series of three books, *Bryson City Tales.* These are popular books, not medical books. I have now read them and find them good reading. And they are quite successful, with quite a following. In addition to these three books, he has written about six others. So it is interesting to watch people who've gone on and done things. This physician has not retired, which I found interesting. My own residents are now retiring! (*laughs*) And living in Colorado! (*laughs*) So a lot of them have done some interesting things.

ROSEBERRY: That sounds kind of departure from other departments, who might—

ESTES: Oh, yes.

ROSEBERRY: The cycle would be to keep people within the department and put them on the faculty.

ESTES: Yes. Our job was to get people out, not in. We would recruit our own residents occasionally if we needed them, but that wasn't our job, so we didn't do much of that. People who have stayed have stayed for a reason. They've been interested in research or teaching and not practice.

This is one of the problems that we have as a department—maintaining stability in our own department, because Duke doesn't value them as highly as others. They don't go up the promotion ladder; they don't get rewarded. They're not viewed as eminent faculty. (*laughs*) So they tend to move on. This is a constant challenge.

I'm now at an age where I'm a consumer of medical care, not a provider of medical care! (*laughs*) My family has called on, as our own personal doctor, the Family Medicine Center. Every two years or so I have to change doctors, because my doctor moves elsewhere and I have to choose another one. Choose another one, then he goes! (*laughs*) I've learned that that's not a good thing. As you become accustomed to one, they go. My wife, the same. She still uses the Family Medicine Center for her physician, and that's worked very well. But again, it's the problem with her as well—every two years, somebody changes. So that's life.

ROSEBERRY: Were you familiar with Joyce Nichols?

ESTES: Oh, yes. She is an outstanding lady! Joyce had a very early relationship with the department. I believe that Joyce was first identified as a community health advisor, but she quickly moved beyond this to a more professional level. She applied for admission to the PA [Physician Assistant] Program, and was our first black [female] PA. I believe that she probably was also the first woman who graduated from the PA program. She joined the Lincoln Clinic staff as a PA and spent her entire professional career there.

She has now retired. I know Joyce very well, and think very warmly of her. She is a person who was living in the North Durham area when we first began to survey it in the in the early 1970s. Yes, I remember Joyce from the time she was a young wife and mother though her professional career, and all the way to retirement.

ROSEBERRY: Was she part of any of those clinics that were—?

ESTES: As I recall, she worked as one of the lay advisors at the very beginning of that program. She was identified by her neighbors as somebody that they would turn to if they needed help.

ROSEBERRY: So she had some leadership—?

ESTES: Yes, that's why she was identified. And that proved to be exactly right. She was a staunch, remarkable lady who didn't need much encouragement. She pulled herself up by her bootstraps, and had a very eminent career for herself from very humble beginnings. So she certainly should be recognized. I'm sorry I didn't recall her earlier. I wasn't thinking of PA graduates. I was thinking of faculty. And thank you for reminding me. She's a great lady.

ROSEBERRY: What about PAs? I know that that started—medical corpsman were the initial group.

ESTES: Yes.

ROSEBERRY: Were there—it's kind of become a more female-dominated—?

ESTES: Much more female than male, now. At the beginning, were mostly corpsman, and all of them were men, of course. So most of our early PAs were men. One of the early candidates, a woman, was a technician who dropped out of the program because she disliked patient care. Because of this, Dr. Stead introduced a rule very early in the

program that applicants must have experience in direct patient care, before joining the PA program. This lady had been a lab tech—she had handled analysis of blood, but she had not been caring for people on a one-to-one basis. When she learned what it was like to be a caregiver, she dropped out. Dr. Stead thought that this was an awful waste of talent and time, and so he insisted that people know how they reacted to patients before they become a part of the program. It's a good rule, and it's been there ever since. Very few of the early students were women—Joyce Nichols broke the mold, and she did extremely well, as you know. And it wasn't long before more and more women were accepted—to the point where we are now having trouble finding men! (*laughs*) And I'm not against that at all: I think that's great that the women are doing very well!

ROSEBERRY: You mentioned Evelyn Schmidt, and I know that she's maybe not Duke faculty or on Duke staff so much, but I know that she's had a real impact on Durham. I wonder if you can talk some about her?

ESTES: Well, Evie is a Duke graduate, of course. She had her pediatric training elsewhere and came back to Durham to take over as the head of Lincoln Community Health Center. Evie is about four-feet-six and must weigh all of a hundred pounds soaking wet, but she is a human dynamo. And she can't be stopped! She has more energy than ten people. And she has done a fabulous job with that clinic. It would not have survived without her. She has been its heart and soul. I think she's exactly what they needed. If Eva Salber had taken that job, she would not have done as well. Eva was not as forceful a person as Evie. I mean, Evie, with all of her small stature, will get in the face of anybody and argue her point. That was not Eva's style. I think Evie Schmidt has been exactly what they needed. I worry about how Lincoln will fare after Evie passes the

baton to someone else. She has been such an integral part of that place; she has made it go; she has not taken no for an answer, and has pushed and pushed and pushed, more than anybody else would have had the tolerance for. She is a real heroine, and I think Durham owes her a huge debt for what she's done, at her own personal sacrifice, at Lincoln, without any major recognition for what she's done. She's a real heroine, and that's her life work. She lives it night and day, and pushes for it, and fights for it, scraps for it. She's a fighter!

ROSEBERRY: In what ways has she kind of had to fight for—?

ESTES: The money to make it operate! She's had to fight at the city level, at the county level, at the state level, at the federal level. Every level you can think of, she's had to fight for time and space and money and personnel. It's not an easy job. And she represents, for the clinic and what it's doing and the huge demand that's out there. She just speaks for it very eloquently and demands the resources to make that clinic go. And she is outspoken about the need for universal health coverage for everyone. And she believes it with her last ounce of strength, and will talk to you about it any time you want to listen. And she's been talking that way for thirty, forty years now. The system has not changed, but she is still fighting for that. Her fight for money will ultimately result in the passage of legislation for universal health care. She has been beating her head against that wall for a long, long time. She and many others have predicted it for the last forty years: "It's going to be here a decade from now!" (*laughs*) But Evie is literally a fighter, for everything. And she pours all her effort into Lincoln. It's not for herself, it's for the people she takes care of. Someone needs to write a biography of Evie Schmidt. She'll

never do it herself! Somebody else is going to have to do that, because she'd never take the time.

ROSEBERRY: Has she been—has the department, your department, worked with her?

ESTES: Worked with her, always. We had residents going through her clinic all the time. Our mission is the same, of course. And never any disagreements. She was always a member of the Department of Pediatrics at Duke, rather than our department, because she is a pediatrician, and she sort of naturally related to that department. So her appointment has been through Pediatrics, not through Community and Family Medicine, though I think in many ways our department was more aligned to her than Pediatrics—not that Pediatrics was ever unkind to her at all. She had no direct departmental relationship with me or my department; but we were always colleagues, compatible colleagues, and worked together.

ROSEBERRY: Has funding ever been an issue for the department of Community and Family Medicine?

ESTES: Always! Every department, eventually, has to generate its own income. The Duke financial system is kind of an enigma within an enigma. The medical school, the department, and the hospital all work together, and the budgets are interrelated. The teaching function provides some funds from university endowments and other resources, and it flows through the dean. But every department has to make its own way clinically. In our department, we were on the low end of the payment scale. We did not do any procedures that produced a lot of income. We're delivering services that are the lower end of the payment spectrum. Family doctors all over the country make lower incomes than other specialties. And Duke extracts from all who works within its system a certain

amount to pay overhead, such as for the [Sarah P.] Duke Garden[s], the parking garages, building maintenance, and general administration of the clinics. The assessments are very hard to understand and justify, and they become every departmental chairman's millstone that they must deal with. At the end, our department generally doesn't make a lot of money, so we always have to scrounge for medical funds.

Very early in the history of the department, we recognized that, and we put together a division that was designed to make money. This was the Diet and Fitness Center. And I noticed in the Durham newspaper this week that our old Diet and Fitness Center building that we bought for roughly one million dollars thirty or so years ago, has been sold by Duke to the city for 2.6 million dollars! We bought it, put the diet and fitness program there, and over the years it's paid off its mortgage. Duke Medical Center took it over from our department a few years ago. That money will not go to the department—it will go to the medical center. We had to go out and buy our own building to house that program.

It has made money over the years, and we have depended on that to do some additional things. That was our structural component that we designed to earn money so that we could spend it elsewhere in the department. Yes, there's been a problem with money since the beginning.

Lloyd [Michener], as chairman has been more successful in getting grant money than his two predecessors, because he's put into place several service programs down in the community of Durham. He is running several clinics there that have federal and foundation support. He's been very successful at that. Eva Salber had some similar support, but Lloyd has been more successful than anybody prior to him. I think that the

department is doing fairly well—Lloyd says it is, and I trust he is. But I'm glad I don't have to do it. I always hated that part of my job. We got along, but we didn't have enough—never did, never will, I guess. Nobody ever does, including the university's overhead. They never have enough.

ROSEBERRY: I wonder if you can talk a little bit about Mary [Duke Biddle Trent] Semans?

ESTES: She is a friend and a benefactor of the department. Mary was someone who we called on from time to time when we had special projects that deserved support. Mary was always sympathetic. First of all, she understood the need, and second of all, she had the capacity to do something about it. Eva Salber's work is a good case in point. Eva was—wanted to do some writing, but needed support for that. She needed salary for a clerical person to do her typing and editing. We put Eva in touch with Mary Semans, who supported her for this effort. We called on her for support of several similar projects which were not traditional laboratory research but nevertheless needed time and effort and support. And Mary has been always supportive.

At one point my department had the responsibility for the division of medical history. It's still an active division, but now in the department. It is in the medical library, I guess. It was once an academic division responsible for courses in medical history. We had faculty positions in medical history. Mary was very much a part of that division, because Mary's first husband was Josiah Trent, who donated the Trent collection to the medical library. Mary was interested in medical history, and Jim Semans, her second husband, also supported this interest. Mary and Jim were supportive of the division of medical history and also provided the salary support to the medical

historians on the faculty—and we had several. The one I remember best was Gert Brieger, who went to Johns Hopkins where he is still the head of the medical history division. He is a friend, and a very good person for whom I have great respect.

I've gotten to Mary Semans in a different way since my retirement, and in a wider context. I view her as a friend with whom I talk from time to time about medical care. She is a person that everybody at Duke knows, yet she understands that medical care is hard to find. Mary can call on anyone at Duke for care, and they'll do anything in the world for her. But she says, "People call me—friends of mine—all the time, from Durham. These are affluent people, people who could afford anything. And they say that there's nobody here that I can call on to take care of me as a person. If I have a kidney stone, I know who I can go to. If I have a broken bone, I know who I can go to. But I need somebody who I can see once every six months just to tell me what to do, and there's nobody like that."

She reminds me that, "You used to do it." "Yep, I did." "You used to see people in the home." "Yeah, I did that, too." She says, "I know you did. I've talked to people who you visited in the home. Nobody does that anymore." And she's right: nobody does. Those who take care of her medical needs are always available on call, but she says, "I don't want people on call; I want somebody who I can call on the phone if I get sick on Saturday afternoon, and say, 'I'm sick, what do you think I ought to do? Should I wait 'til Monday? Should I see you today?' I need that! Why doesn't somebody do that?" "Mary, I don't know! (*laughs*) I can't help you!"

Yes, I know Mary very well, and I have great respect and admiration for her. She's a lady of great charm and wisdom. She knows a lot about a lot of things. She

knows a lot about medical care, a lot about the Duke Endowment, a lot about medical history. I just think she's a great lady. But she's like most others—money or not, she needs help, and help in a way that nobody gives anymore.

My wife suddenly became ill recently, in early December. We were on our way out of town, and she began to have terrible back pain, so bad that we turned around at Burlington and came back to the Duke emergency room. She was admitted with a quite serious illness. She had total blockage of one kidney and gram-negative septicemia, and she was sick as a dog! And it was a urologic problem, of course, and the urologist somehow seemed reluctant to—and he wouldn't admit her to the urological service, though she had a urologic problem. Well, why? He told her that she did not need to be on his service and, "We're going to put you on general medicine and let them take care of you. If they need us, we are on call." That was kind of strange. But she was admitted to on the medicine service, and I really think that she probably got exactly what she needed, better than the other way. But at the time, it looked a bit strange. It turns out the man on call for urology was really not a practicing urologist. He was a researcher who was also a urologist. He'd gone through the residency, met all the requirements, done all the surgical training, et cetera. In a pinch, he could, I am sure, do anything up to a nephrectomy. But his job was to do epidemiological research on prostate cancer. He's very famous. He writes fifteen, twenty papers a year on the epidemiology of prostate cancer—why people get it, what things correlate with it, and what things don't. But he does all his research on computer, and if you go to Google or anybody else and put his name in, you'll get reams of papers, every year! But you put him in a clinical situation where he's got to take care of an eighty-year-old lady with acute renal problems, he's not

comfortable taking care of her. And yet, he's the attending on Urology. The other contact person on Urology was the urologic resident, who proved to be a very competent young man, who could have handled the problem all right. This story provides a clue as to what's going on in our own institution. He faced a urologic problem, which was shunted to another department, because he didn't want the responsibility of taking care of a sick person who might need him in the middle of the night or might require a decision that he didn't really feel comfortable making.

Life is different than it was thirty years ago, when every urologist took care of everything, every urologist thought it was their personal responsibility to come in at two o'clock in the morning whenever needed. The same for every other service. Everybody who took care of you at Duke was somebody who would actively, every day, every week, every night—take care of sick people. They were comfortable doing that and took pride in their conviction that they did it better than anybody else. That's no longer the case. I think this change in behavior probably includes our own department, because all departments, in their recorded instructions to patients who phone in, tell them, If you're really sick, go over to the emergency room. (*laughs*) It was not that way in the past. I think this is what Mary's talking about. Yes, I know Mary very well, and it started me on a train of thought that I really didn't need to get into.

ROSEBERRY: What would you say was her impact on Duke, as a whole?

ESTES: Humanizing, certainly. Benevolent, certainly. Continuity, certainly. Here is somebody who remembers Dr. [Frederick] Hanes, the second Department of Medicine chair, as her mother's personal doctor; who will talk to you about Dr. Hanes, about what he meant to their family. Her mother had a depressive episode, and Dr. Hanes was her

doctor. And she says Dr. Hanes gave her mother her life back. And he was a neurologist, but he didn't mind taking care of depression—or whatever you had. She knows the continuity of history of Duke. She knew Dave [Wilburt] Davison like a grandfather and called on him often as a child and as a young woman and as a young mother for care for herself and her children. She has, and continues to have and impact on all of those areas. As the head of the Duke Endowment, she was responsible for providing money for projects all over the state. She provided support to Bill Anlyan when he had trouble here and there, giving him the support he needed from the endowment, which was critical. She's been there, like a rock, all of this time, doing things for people. And her help to me has been minor, probably, compared to Bill Anlyan's. He could tell you a lot about the things that Mary's done for him. But she was always there, always willing to help, always willing to talk about the problem, and put a perspective on it that nobody else has. She could step in with money if it was necessary—but that wasn't often necessary or even needed or wanted, but always helpful. And she's a resource that I think we are just super lucky to have. I don't know any other institution that has anybody like her. She's unique! But I'm glad we've got her! (*laughs*)

ROSEBERRY: I also wanted to ask about—I know that there have been wives of department chairs, and wives of faculty members, over the years, who've gotten involved in the Nearly New Shoppe, or have done—

ESTES: Oh, yeah.

ROSEBERRY: I wonder if you can talk about that as well?

ESTES: Well, the first I remember was Ethel Wyngaarden. I think the idea for the Nearly New Shoppe originally came from Ethel who involved Ort [Ortrude] Busse and

the wives of all department chairmen. They started it in an old grocery store on Erwin Road, which was somewhere between the traffic light at Anderson and the railroad underpass. In the old grocery store building, they started a used clothing store to make money for medical school scholarships. And they ran it with volunteer help, entirely. Ethel, Ort, and many others spent days each week making the thing run, and run it did! It made money into a scholarship fund. Every year it was a little more, and most medical faculty wives helped. Eventually they had to look for additional space, and they moved the shop to a new building on Douglas Street, just off Erwin Road. It was built with their funds on Duke-owned land. It continued to grow, and they have now moved to a newer and larger shop, on the ground floor of the Hock Plaza, on Pratt Street. My wife has worked there for thirty years, I guess. That's where she is right now! (*laughs*)

The Nearly New Shoppe is a great success. It is an incredibly busy place. Not many people know about it. You have to know about it to know it's there. It is a combination of a business with a serious purpose and a social club, because all the faculty wives who work there get to know each other very well, interact with each other, and have enjoyable social events once or twice a year. But it also gives a great deal of money to the medical school. It's an orphan in many ways, because I don't think the university or the medical school hierarchy gives it the attention it deserves. If it were run right, it could probably make three times as much money as it does. What person in their right mind would put a place of that sort in the back of an office building that you can't see, not on a bus line—and expect to survive? But it survives in spite of that. And expect it to operate with all volunteers? But it now employs several people. It deserves a proper building of its own with adequate parking. You can't park where it is now. You can't

bring in contributed items easily. There's no place to store things. I'm very familiar with it, and I think it could do so much more if it were treated better. I don't mean it's treated badly, but it has not received appropriate attention and support. My wife is always fussing about the fact that PA students are not supported by Nearly New funds. It supports medical students, always has. For the past five years, it's supported nursing students. But the medical center administrators in charge will not discuss adding PA students to those getting support. I have deliberately not inquired, because I don't want to get involved! (*laughs*) But I have advised the PA program to apply in behalf of their students. They have, and they've spoken to everyone, and they said they've met with a stone wall—"No, you can't. It's not allowed." Well, why isn't it? You support medical students, you support nurses. PAs are part of the same family. Why not?

Anyway, Ethel Wyngaarden started it and enlisted many of the faculty wives. They became involved in a very real way, in that they contributed their time. Most spent at least a half-day a week least working in the Nearly New Shoppe.

With time, things have changed. Wives of department chairs are no longer housewives with control over their time. They are now lawyers, physicians, and business executives. They are as busy as their husbands—if not more so at times. They cannot afford the time to be away at the Nearly New Shoppe. The Nearly New Shoppe has lost, I think, the flywheel that made it go, which was the interested commitment of faculty wives. To replace that lost talent they've hired additional people, who are good people, but it's not the same. The chair of most departments probably don't know it exists—or if he does, does not worry about its welfare. But it *is* important to them, because it has given them over the years a great deal of money. They don't even know it! It's going to

get worse, (*laughs*) because women are going to be the majority of the faculty. Someday it will depend entirely on employed staff and things will need to be done in a different way. It will need more realistic space and more realistic allocation of talent. But it's a unique institution, and one that still brings in a huge amount of money. And the faculty knows it because it's a place that you can leave things, not because it provides funds for their students. (*laughs*) But they know it because you can leave discarded clothes when you clean out things each fall, or to buy new things. It's a unique place, and I wish it were treated better, particularly in their space. They ought to put it at Lakewood, right by that huge unoccupied parking area. Duke has a surplus store over there, and to an extent they are competitive with one another. (*laughs*) But it is attached to the university and not the medical center. If the medical center had a building right behind it, it would be an ideal place. Put a big sign up—Medical Center Nearly New Shoppe! It would work. I've suggested it, but nobody (*laughs*) has even acknowledged it!

ROSEBERRY: Well, are there other women in the medical center that you can think of?

ESTES: I can't think of any more, Jessica. I think you've dug up a few I didn't remember! (*laughter*) But I'm glad you did, because they all deserve comment. Well, I think it's a great project.

ROSEBERRY: I've enjoyed it.

ESTES: What's going to come out of it?

ROSEBERRY: Well, as I mentioned, we're going to make some transcripts of these interviews, and do an online exhibit. And I'm hoping to do some writing.

ESTES: Pictures?

ROSEBERRY: Yeah.

ESTES: Good, good.

ROSEBERRY: And highlight the individual women that have been important.

ESTES: I'm glad you're doing it.

ROSEBERRY: I really appreciate your input.

ESTES: You're welcome.

ROSEBERRY: It's been very valuable. Thank you, Sir.

ESTES: You're more than welcome.

(*end of interview*)