INTERVIEWEE: Philip Pearce
INTERVIEWER: Jessica Roseberry
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PLACE: Dr. Pearce's home in Durham, North Carolina

PEARCE INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. Philip Pearce, and he is a partner in the Durham Women's Clinic. Today is May 25, 2007, and we're here in his home in Durham, North Carolina. And I want to thank you, Dr. Pearce, for agreeing to be interviewed today. It's a real pleasure.

PHILIP PEARCE: I'm happy to.

ROSEBERRY: We're going to be talking primarily about your business partner, now deceased, Dr. Eleanor Easley.

PEARCE: And, to be fair, I'm a retired partner also. I've been retired for two and a half years, but Dr. Easley and I went back as partners, back to July of 1967.

ROSEBERRY: Well, if you don't mind my just starting with asking when you were born, if that's all right.

PEARCE: Yeah. April 10, 1936.

ROSEBERRY: And your interest in medicine—how did that begin for you?

PEARCE: As a boy, I grew up in the rural Southeast, in the Carolinas and Virginia. And when I was a little boy in Virginia, my dad was a pastor of a church. And one of the leading members of the congregation was the family doctor, and I always admired him and actually would visit in his home—which, his office was in his home—and that

always inspired me. I wanted to be like Dr. Dew, which was his name. And so I guess my interest just followed naturally from that point on.

ROSEBERRY: Where did you attend medical school?

PEARCE: Duke.

ROSEBERRY: At Duke?

PEARCE: Yeah. And I did my internship and my residency there. And between internship and residency, I was in the Air Force for three years, and I did ob-gyn in the Air Force and I came back and finished my residency at Duke. So I finished my residency in June of 1967, and began practice with Dr. Easley the following month, July of 1967, at the old Watts Hospital, which was a predecessor of Durham Regional Hospital here in Durham, of course.

ROSEBERRY: And why ob-gyn for you?

PEARCE: Got into it in sort of a funny way. In med school it was the course I liked the least. I guess I just felt uncomfortable with it. But when I got in the military, I was stationed at a Strategic Air Command base called a SAC base in Stephenville, Newfoundland. The hospital commander at the time that I got there said that they needed another doctor in ob-gyn, because the chief of ob-gyn needed another assistant because his assistant—there were just the two of them—the assistant was leaving to rotate back to the States. And so there were three new general medical officers, of which I was one. He called us into his office one day and says that Dr. Meagher needs someone to replace Dr. Irvin. So who wants to do it? And none of us wanted to do it, so we all just looked at the floor. So he says, “Well, gentleman, think about it and come back tomorrow and let me know who's going to do it.” So the next day we came back, and we were all still

looking at the floor, so he says, "Pearce, you're it. (*laughter*) So I started doing ob-gyn, and, oddly enough, I really came to love it, because it embraced a lot of the things that I liked in medicine. I love the rapport with the patients. I'd had a surgical internship at Duke, and so I was sort of leaning towards something with some surgery involved with it. And it also has a lot of general medicine, when you're doing obstetrics and gynecology. So it allowed me to be the old family doctor that I admired and wanted to emulate. It allowed me to pursue some of the surgical interest that I had, and the special rapport you got with the patient was, I guess, the core matter for me.

ROSEBERRY: Now, were you familiar with Dr. Easley when you were in medical school? Had you heard of her?

PEARCE: No, I did not actually meet her until I was in my residency, and I came back to the residency in January of 1964. And in the summer of '64—in July—Dr. [Roy] Parker, who was the chairman of Ob-Gyn, started a rotation with the Watts Hospital, with the residents going over there. They would send one resident over at a time to take care of the deliveries, which were the staff deliveries, and to assist the doctors with their surgery, and to run their ob-gyn clinic, and to get surgery set up for your own patients through the clinic. I had a four-month rotation, and Dr. Easley was the chairman of the Ob-Gyn Department at Watts Hospital at that time. So we worked together a lot, because we were organizing what was to follow, since I was the first one there. And since I enjoy organizing things, she liked it that I took an interest. And she really was a very bright person and a very hardworking person and, as I said, a person whom I admired enough so that I subsequently went into practice with her.

ROSEBERRY: Now, I understand that she had co-founded the first physician partnership in the state of North Carolina.

PEARCE: That's right. That's right. Because back at that time, many doctors felt that women would not accept a partnership, and that they would only want to see one doctor—and, of course, if he were ill or away, they could accept somebody stepping in—but they wanted to see one doctor. Well, when the doctors were called away to the Second World War, she stayed behind, not being subject to the draft, and she wondered if women would want to see her, because women were not very poplar in medicine at that time. So it is my understanding that Dr. Robert Ross—or people called him Daddy, Dr. Daddy Ross—was one of those that was called away, and he was a professor at Duke at the time, and later, after the war, he went to UNC [University of North Carolina], and he became head of their ob-gyn department over there. But anyway, for a period of months she occupied his office, and saw patients in his office. Then she got her own office, which was in an old house near what was then McPherson Hospital. And after that, she got an office that she and Dr. [Richard] Pearse (*pronounced like* purse) subsequently went into that was on Chapel Hill Street. But it was very small, and they outgrew that. They had another partner at the end of the war, after Dr. Pearse joined her and became the first partnership. Then Dr. Podger joined them some years later and they became three, and then Dr. Stokes and others later, and I was one of those later ones.

ROSEBERRY: Well, what was she like? What was Dr. Easley like?

PEARCE: She was very hard working. She had the reputation in residency of feeling like, as a woman, she had to prove herself. So the guys said that she would work them until their tongues were hanging out, and she was still working and they would go to bed

(*laughter*) and go to sleep. But she was also very bright. She graduated Phi Beta Kappa from Idaho—University of Idaho, I think—college. It's in her bibliography. But there's no question about her intellect and her willingness to work. And she grew up in a family where people were expected to work, as did I, growing up as a child. You didn't just have the summer off to play or go to camp or things like that. You worked. So we all worked. And that being a part of my background; I could identify with the way that she also came up.

ROSEBERRY: So it sounds like the two of you probably worked fairly well together.

PEARCE: Oh, very well. Very well, indeed.

ROSEBERRY: Now, you mentioned that she had to maybe—her reputation was that she had to prove herself as a woman. Do you think that she actually probably did have to prove herself as a woman?

PEARCE: I think in many ways she did, because there was a bias against women in medicine then, you know. Women were supposed to be nurses and not physicians, and so there were only a very small number of women in medicine at that time. She was not the first woman to graduate from Duke Medical School, because when Duke Medical School opened, they accepted students that rotated in from other colleges, that may have been just two-year colleges. And so I think there was some woman—I don't know her name—that may have graduated from Duke ahead of her. But she was the first woman to start at Duke and go all the way through the four years of medical school at Duke, so she was the first full four-year graduate female in medicine at Duke.

ROSEBERRY: So was she still having to prove herself when you joined the practice, or was it—?

PEARCE: Well, I think by then she had really proved herself. She had a wonderful reputation, and the practice that she and Dr. Pearse had built together. They had a wonderful practice and a wonderful reputation, and that was something of which I wanted to be a part, so that was another thing that attracted me to stay in Durham. We loved the area, we thought it was a good place to raise our family, we liked the church that we were attending, and it was a relatively easy drive from where our own parents lived three or four hours away, so it was good for us in those respects as well.

ROSEBERRY: So what about Duke? They also had a department of ob-gyn. That could have been another option.

PEARCE: Yeah, Dr. Parker offered me a chance to stay there, and he wanted me to head up a division of the practice of medicine in obstetrics, particularly with the orientation towards being the primary medical doctor for women. I guess at that time I'd had enough of organizing different things, and I felt that I wanted to go on into practice at that time, and I really saw myself more being in private practice. I felt that being at Duke, to be in the hierarchy system, I would always sort of feel like I was under someone's thumb, and that did not appeal to me as much, so that was another reason that I made that decision.

ROSEBERRY: Well, how did that partnership work?

PEARCE: Oh, extremely well. We shared night call, in which most of the night call was taken up with obstetrical problems—deliveries, or miscarriages, or those sorts of emergencies. You'd have an occasional gyn emergency, but most of it was with obstetrics. And we had our own days per week in which we did surgery. We covered the hospital, usually, while we did surgery, so if there was any deliveries going on at that time, we would have to work it out around our surgery. Or if you're in the midst of

surgery and someone had a critical need in obstetrics, then one of your partners may have to rush up from the office to take care of that. But as it usually happened, that did not occur so often to be disruptive.

ROSEBERRY: So the practice was affiliated with Watts Hospital?

PEARCE: Yeah, we primarily worked out of Watts Hospital, although we were all clinical associates or clinical associate professors at Duke during this time, as well. And our primary use of Duke Hospital at that time was we did not have a tertiary level nursery. So, if we had women in labor who were going to deliver premature babies prior to the thirty-fourth week of pregnancy, then we would accompany our patients over to Duke, and we would deliver them over there. It was a rare problem that the woman would have that we were not capable of taking care of, but it was primarily because we needed to deliver them where they could get the tertiary nursery care—neonatal care, as they would call it now.

ROSEBERRY: So was there any competition between maybe, say, the Duke Department of Ob-Gyn and a private practice such as the Women's Clinic?

PEARCE: Not initially, but later times, when there was a different chairman of the department, he came to our office and was trying to go to each of the offices in town, and there were three major groups in town at that point. And he tried to get us to join the Duke system, and we did not want to do that. The other two groups did do it. And he told us if we didn't join Duke, we would be buried. He would bury us with competition. And it affected our practice, but it didn't bury us. So even though I was a Dukie, yeah, I was a Duke graduate, I was Duke trained, Duke affiliated, I was a Duke supporter, a Duke giver—it sort of made you chafe a bit at that approach. But that was hardball

business, and it was in Duke's best interest to do it that way, and so we had to respect what they were trying to do, but we wanted our own respect, too. So we stayed (*laughs*) separate, and we're still separate to this day.

ROSEBERRY: So it sounds like you had a—the clinic had a loyal patient following.

PEARCE: Oh, yeah, we did. We had a great deal of doctors who—women at Duke who were our patients, as well as nurses and people that belong to Duke, in some fashion, as employees. And, of course, that's one way that they could hurt us immediately, is that the Duke health plan—they could restrict them to seeing only Duke doctors. And so a lot of the women would come—for a number of years, they would come and pay out of their own pockets to see us, even though they had the medicinal coverage through Duke. But eventually, over a period of time, you know, that would wane more and more and so it did affect us. But as that waned, then we would build up in other respects, so there were blips along the way, but we survived.

ROSEBERRY: Well, Dr. Easley must have been a fairly good businesswoman to have started this practice.

PEARCE: Oh, yeah, she was. In fact, Dr. Pearse, who joined us, was a terrible businessperson. (*laughs*) So she really literally had to do it all if they were to survive. He was an eccentric—a wonderful man, a very bright man. He took excellent care of his patients. (*laughs*) But he was not a businessperson. He did not have a business bone in his body, so Dr Easley was the one who oversaw that until we got other partners in the practice who did have business interest and business training, and then eventually she was very happy to turn that over to them.

ROSEBERRY: Well, how did she keep him on track, or keep the—?

PEARCE: Well, she had arthritis in her index finger, and she would take out that hand with that arthritic (*laughs*) finger. And she'd say, "Now Richard, Mrs. So-and-so has been complaining (*laughs*) about you." Says, "Don't you do that anymore!" And he'd just say, "Yes, madam; yes, madam." And so for maybe a few weeks to a month, he would behave—and then she would have to get her finger out (*laughs*) again and point it at him, and get him corralled again. He was an interesting fellow to practice with.

ROSEBERRY: What would the complaint be, or what would—?

PEARCE: Oh—if there was a chink in your armor, he could sit here, and he could size you up in just a few minutes, talking to you. If there was a chink in your armor, he had a way of hitting that at times that would really annoy you. And some people took great offense at him doing this. He did not care for people who were greatly overweight, and he did not hide his feelings. Of course, what he would tell them was really best for them, that weight was not good for their health. But the way he came across would actually anger them, so he did not approach it very sensitively, I guess you would say. But, if a woman was in labor and he was with them, he was so good with labor support that even though—somebody he had made an enemy during the pregnancy because he would harp on her, because it was important they thought, back then, to stay on a certain diet and not gain but so many pounds, and that sort of thing—of course, those sorts of things have changed a great deal since them—but he would fuss at them and make them mad, and a lot of times so mad that they didn't want to see him. But if he was on call when they went into labor, he was so good with them that he would win them back. And so he had a very loyal following; even though he had made a lot of them mad, he would win them back because he was really so—he was so wonderful to them in labor. And of course, he

practiced hypnosis, and he conducted the classes, and he was a great showman, and he could pull this off. And he could transfer the abilities for women to go into a trance in labor, so that they could go completely through labor with not a single bit of any analgesia or anesthesia of any sort. And at the end of the delivery he would give them their baby, and they would march out with their baby and show it to their husband or to their family, and then leave it at the nursery. And so he would transfer that in his classes to us, and we would go to his classes to learn what he did. We could continue with the hypnotic techniques in labor, although none of us were as good as he was. He was extremely motivated and extremely good at it.

ROSEBERRY: So that seemed to be effective?

PEARCE: Oh, yes. Oh, yeah. And like many things that will come and go back during the Second World War, women for analgesia would use—drop ether or later trilene mask, which was much safer than ether. Then Dr. Easley, during the Second World War, learned how to do epidurals and would start to do epidurals. And the type of epidural she did then was called a caudal, which was given in right through the end of the spine. And she was very good at it, and so was Dr. Pearse, but there were technical problems that you could get into. And he had an anesthetic death in one lady in labor. And that motivated him. He just didn't want to use it anymore, and so he went to England to study under a world expert (Dr. Grantley Dick Reid) in hypnosis, and came back with that technique, and he used it. And of course, with that experience he was very motivated, and, as I said, he was a natural showman, and he was extremely good at it. And so we rode that peak, you might say, for a number of years. People would come to us. We would have women come from southern Virginia. I remember a patient came from

Wilmington up here during pregnancy and would drive all that way. And it wasn't just a two-hour drive or two-and-a-half hour drive as it is now; it was about a four-hour drive then. They would come up here. Or they would come up here and stay with family or friends as they got into their last few weeks of pregnancy and deliver here. So he was a very important attraction for our office during those years. And then the epidurals that you now know came into being. But even before that, they had other natural childbearing techniques that were used; you may have heard of the Lamaze technique. And so since that was easier on the physician—it was more patient-input oriented than the doctor's use of hypnosis. The doctors would be very weary of doing the hypnosis reinforcement, because it was very physician-labor intensive. I think they very easily gave way to the Lamaze and the other methods, because the patients would have instructors in the Lamaze method, and they would follow through with that in labor, and it was not as labor intensive for the physician. And then the epidural came, and of course with anesthesiologists taking care of that part of it, for the most part, then it made it even easier for you.

ROSEBERRY: Well, did Dr. Easley ever try the hypnosis approach?

PEARCE: Oh, yeah. As I said, he would transfer that leadership, you might say, to whichever partner was on call, and he would tell them during the hypnosis classes that they would respond to Dr. Pearce or Dr. Easley or Dr. Allen or whoever was on call that particular night, that they would respond to his voice and to his touch. Because usually a way that he would get them to go into the trance is that during the classes he would tell them when he would touch them on the shoulder that they would relax—and he would go through this spiel of relaxation techniques, and they would be familiar with that and so—.

But when labor got very intense, that meant that you had to go in there and talk to them and (*laughs*) get them to simmer back down, because it was like a roller coaster, up and down, you know, as they experienced labor. And so some of them could go into a pretty deep trance, and it was very little care that you had to give, except the times that you would go in to check on their progress and that sort of thing. And some of the others it was almost handholding throughout the entire labor experience. So there were different susceptibilities to being able to attain a good hypnotic trance, or hypnoanesthesia or hypnoanalgesia, we would say. But there have been people who have had cesarean sections with just nothing but hypnosis, strange as it seems. And I've seen him do episiotomies and repair with not a single drop of any anesthetic. And a lot of times I would do that, and I would usually give them maybe a half cc of an anesthetic, so that they could feel that there was something there. But during labor and during the labor process, nature gives you some local anesthesia, so it was not as barbaric or cruel as a person might envision it to be. Because when a baby was crowning, if you felt that you needed to do an episiotomy—you could see the tissue was tearing—at that point, nerve transmission usually has stopped. And so if you did a quick episiotomy, it was a relief. It wasn't anything that they felt that was uncomfortable. And if the placenta came quickly and you were able to suture them up, then there was still some of this residual analgesia. And we did not put the stitches through the skin, it was always beneath the skin. So again, that area was not as sensitive as if you had put something through the skin. So that made it possible to use that technique and to use it pretty comfortably. So if women were uncomfortable—I will always say, “If you're uncomfortable let me know

and I can add something local," and sometimes you would and sometimes you wouldn't. So—

ROSEBERRY: Would it be all right if I shut these doors?

PEARCE: Sure.

ROSEBERRY: Okay. What was Dr. Easley like with patients?

PEARCE: She was their friend. But she could be a very stern friend. And if somebody wasn't doing what they should do for their health or for their baby, she would let them know about it. She would have people that would come out of her office crying, too, because they may have been people that had been catered to, perhaps by their family or their husband, and they weren't wiling to face up to certain problems in life, or to do things in a way that would be better for them—and so she would lay it on the line. But also she had a lot of women who'd come to her for counseling. And she was extremely sympathetic to them, as I think most of us in ob-gyn—we tend to see the woman's point of view more than the man's point of view. And I have a great deal of admiration for women and women in labor. I think they, for the most part, have been very brave people. And we help them when they're not brave. (*laughs*)

ROSEBERRY: So what were some of the things that women might need to be doing that she would kind of scold them—?

PEARCE: Well, if they were actually not taking care of themselves. If they were, I don't know, smoking during pregnancy or obviously eating things that they shouldn't have and their weight would go up ten pounds in a week, and she would feel that they would be subject to developing complications of pregnancy like toxemia—that is, high blood pressure—retention of fluids. And there are disorders that will sort of have a domino

effect, and they will go downhill and have loss of consciousness or seizures, and if it's severe enough, they can kill themselves and kill their babies. So she was very much in tune to doing what was felt to be the best of medical care, and if she wasn't getting the patient cooperation she thought she should be getting, then she would tell them.

ROSEBERRY: Well, it sounds like she was a very frank—

PEARCE: Oh, yeah. There's no doubt about where you stood with her. No doubt at all. She would not beat around the bush. She would face things head on. Because she felt that if you didn't do that, then you would not—you'd be a part of the problem, and you would not be helping solve the problem. Just like being a good parent. You do things at times that may be hard for you and hard for your children, but you realize if you don't, if you pamper a child and let them have anything that they want and do anything that they want, this does not train them to be a very good adult, so you have to have some modicum of discipline. And the same thing applies to your care of people. We all need discipline as we go through life. I need it. (*laughs*)

ROSEBERRY: Are there other areas in which her frankness showed itself?

PEARCE: Well, she would lobby legislators at times. She said at one time Daddy Ross would take her to introduce her to legislators that he knew that she might not have known. And she would approach them like—it was a very sensitive time, as far as the abortion issue was, back in the sixties. And she had seen many women sick and some women die as a result of having abortions by nontrained people—from women who felt that their situation was desperate, because there was a much different mindset about being pregnant and unwed then than there is now. And so to have a child out of wedlock or to be pregnant and unmarried was then a great cultural and family embarrassment,

much more so than it is certainly today. Consequently she approached the legislators to try to get them to liberalize the legislation, so that women could elect legally to choose to end a pregnancy in the early part of pregnancy, if they felt that this was the best for them and their situation. There are many groups that adamantly oppose that, and there are many groups that adamantly support that, but she felt that women should have at least the right to choose. She says that she may have come over so strong that she thought some of the legislators thought that she felt that every pregnancy should be aborted, which, of course, was the opposite of what she was trying to achieve, but to allow women that choice.

ROSEBERRY: Did she perform abortions?

PEARCE: I'm sure that she did at some point. I'm sure that she did. Because most people in ob-gyn did at that time. So that was something that was not a part of your practice that you liked to do but something that you would do, because you knew the patients and you knew their situation, you knew, a lot of times, the parents or the grandparents that you had taken care of as well as the young person who was pregnant.

ROSEBERRY: So did you have to get kind of a special request from a physician that this was necessary?

PEARCE: Well, years ago, initially, it required the signature of two physicians, and usually they recommended one of them be a psychiatrist—so a young woman who, for her reason, sought an abortion would see you, and then she'd see another physician and a psychiatrist, and they would give written affidavits saying that they recommended she be allowed to have an abortion, and then you could legally do one. Eventually, after the law

was changed again, then a woman could come in and request an abortion, and if you agreed that that was suitable, then that would occur.

ROSEBERRY: I know that she was also a pretty strong advocate on other women's health issues as well.

PEARCE: Well, she also approached the legislators when the bill was presented to allow physician's associates and other people that were not physicians to practice medicine. She was a pioneer in this state being the first—we were the first practice in this state to have a trained and certified nurse midwife work for our group or work with and for our group. The first one was Nancy Carreras, who was trained in Scotland. She emigrated to Canada. She met her husband who was there who was there in training, and he had emigrated from Spain—and they married. Dr. Easley met her at a ob-gyn convention in Chicago, and in conversation with her found out that they were moving to this area, where Pedro is a psychiatrist, and he was accepting a job here with the state government in Butner. Dr. Easley offered her a place in our practice to work with patients and also to teach classes, because Dr. Easley was very motivated and had started classes even when we were back on Chapel Hill Street for women to attend during pregnancy. Some of the people wanted to have these at Duke, and so she tried to combine the classes and have them at Duke. But the women wouldn't go to a big tertiary institution with the problems with parking and going in, you know, and that sort of thing. And so she had them back in her office. When we built the office on Green Street, which they built a few years before I joined them, we had a large basement that was designed to have a large amount of classroom space, so that we could conduct the childbirth classes there, and Dr. Pearse could conduct his classes there, and when Lamaze was in vogue, then they had the

Lamaze classes there. We had dietitians that would come in. We had psychologists and psychiatrists who would come in, and would teach classes on the emotional changes of pregnancy and postpartum depression and things of that sort. So we tried to give them an educational experience—and this is before all of the books were out about what to do when pregnant or—. You can maybe remember the name of some of those books better than I can. The classes were very well attended. So she promoted education of women as well as promoting healthcare givers in medicine. Following Nancy's arrival here, a few years later we became associated with, the Yale University School of Nurse Midwifery. We had one of their young women to come down and spend—I think Vicki spent about six months with us, went back, and then subsequently, other young women from their program came down, and a lot of times we would have one or two of those nurse midwifery students coming through our practice. Eventually we started a nurse midwifery practice within our practice, so that when patients came to our practice, they were told about the nurse midwives, and if they had not come primarily to see the nurse midwives, then they would have the option, nonetheless, to elect to have the nurse midwives for their prenatal care and deliveries if they chose. They would usually see the doctors for a visit or two during the pregnancy, and we would supervise what the nurse midwives were doing—we were signing off on their charts. They would bring patient problems to our practice's weekly conferences. We met every Thursday at 7 a.m. for this conference. And when a patient was in active labor that was being looked after by the nurse midwives, one of the doctors was always in the hospital, so if there was a complication, there's no question that the nurse midwife had backup immediately. If you had somebody with hemorrhaging or fetal distress and you needed to do an emergency

cesarean section then we were there, there was no delay. So women could come with that knowledge that they would not have to be shifted in from their home somewhere outside the hospital in order to have good care and still had the nurse midwife look after them in a personal way that they wanted to have.

ROSEBERRY: Now, were these issues things that were kind of—were they kind of ahead of the curve—of the trends that were happening in ob-gyn at the time, or were they on par with—?

PEARCE: Very much so ahead of the trend. In fact, Dr. Easley took pride in doing that. Like I said, during the Second World War she learned how to do caudals—most people did not do caudals. Back when the natural childbirth trend hit the country, Dr. Pearse was already up and running with the hypnosis part of that. We were always quite permissive in patient choices, so that as long as we didn't feel the patients were making choices that didn't make sense medically—that were bad for them—then if they wanted to have a technique of delivery, whether it was in water or whatever, then we sought to try to please what they felt most comfortable with, as long as we felt it was consistent with good medical care.

ROSEBERRY: And that was not necessarily what other practices were doing?

PEARCE: That were doing this—no. In fact, the labor-delivery-recovery rooms that are so common now were not at all present then. So when Dr. Pearse would have somebody labor and deliver and walk out of the room—labor and delivery room—with their baby, they were sort of the early genesis of this sort of movement. And so the earlier discharges—which were prompted as much by insurance issues as anything else—you had to try to figure out how to get them out of the hospital. So the less you could

interfere with the childbirth process by giving medications that would make them feel bad perhaps for days, then these methods tended to prevail, so they would labor and deliver in a room, and they would go home within twenty-four hours. Soon lots of hospitals developed labor and delivery rooms with postpartum care in the same room or suite. And I don't know of any other place in this state that was doing it at that time. I know I went to a place in California and looked at a place there. Dr. Easley, I think, went to a place in either Arizona or Nevada that was doing that. There were a few other places doing that, but not in this area and certainly Duke wasn't doing it, so we did it. In fact we had those rooms for a number of years before Duke eventually started doing that. So in that way we were ahead of the curve, yeah.

ROSEBERRY: Were there any other ahead-of-the-curve kinds of—?

PEARCE: Well, we—well, we allowed the father to stay with the mother during—and, in fact, encouraged him to stay with the mother—during labor and delivery. We used not to allow them to do that with cesarean section, but by about the time that Durham Regional was built in 1976, by then we had started allowing the husband, if he chose, to follow his wife into the operative delivery room. Because to us, it didn't make sense. He was trained, he'd gone through Lamaze or other methods of childbirth training. They wanted to have their child in the most natural way possible, and yet they'd encountered an obstetrical complication that took that choice away from them, and it seemed to be counterproductive to separate the husband from the wife at that time. And so we found out that we could get him to stay at his wife's head where he could pay attention to her, and she to him, and we could put up drapes so that he would not have to see anything that he didn't necessarily want to see, but we didn't keep him sitting down. If he wanted to get

up and see the baby being delivered by cesarean section, then he could do it. And I don't recall us having a husband faint in the delivery room under that circumstances. I did have a husband who was a friend of mine—who was a Duke surgeon—that his wife was having a very nice, normal delivery, and he felt faint and had (*laughs*) to get up and leave the delivery room, even though he was an experienced surgeon. (*laughs*) He was very embarrassed about it. I had and experience with a state legislator one time in which I was doing an amniocentesis in the darkness of the ultrasound room, and the nurse saw him sort of sinking towards the floor, and she grabbed him. And I heard this commotion over there and I said, “What's happening?” And she says, “Well so-and-so just fainted.” (*laughs*) So the women never gave me any trouble, but the husband sometimes couldn't measure up to the “bar”. (*laughs*) But most of the men did quite well. Their wives appreciated them being very supportive, and I think this was wonderful that they had that relationship. In fact, it felt good to me, because I was with my wife when all three of our babies were delivered, and back at that time it was not—at Duke is where our first two were delivered—it was not customary that even the residents or interns or students went in with their wife during labor and delivery, but I asked, and they let me do it. When I was in the military doing my ob-gyn service after that, I would encounter patients who did not speak English. Their husbands had married them while on foreign duty and they were from different cultures and languages. They may have been German or French or Israeli or African or Far East or Middle East. They would get in labor and get very excited and, you know, I mean our communication (*laughs*) wasn't very good. But if the husband was there, it was pretty darned good. So I found out that that was very helpful to me to have the husbands there. And so having the husbands in the delivery room never,

never ever bothered me. I just—. As far as me doing or not doing something because the husband is there, it just never occurred to me they were there.

ROSEBERRY: Was there any education beforehand? I mean, obviously, Lamaze.

PEARCE: Well, yeah, we had classes involving the husbands and the wives, sure. And the husbands were invited—encouraged—to attend all the classes, except maybe breast-feeding. So if you had a breast-feeding class with women breast-feeding, you didn't want a lot of husbands around at that time, but that was probably about the only one. They attended all the other classes.

ROSEBERRY: Well, I've read a few of Dr. Easley's letters. And, again, the frankness comes out to me—that she was pretty open in talking about contraception and talking about sex and in talking about abortion, and these kinds of things were just very—. She just kind of laid it out.

PEARCE: Oh, yeah. She—as many of us did in our practice through the years—we would go to various public schools and talk to them about sex education measures. I think the schools have developed programs over the years, and I don't think they do that so much anymore. And it was an extra effort to do it, but I think it was important for that time that we did it. My daughter-in-law, who teaches in the Chapel Hill system, would occasionally have me come in and speak to her classes, but beyond that in the last five or ten years before I retired, the schools were doing it on their own, which is good, and which they should.

ROSEBERRY: But they would maybe ask you to come out beforehand.

PEARCE: Yeah, right, right. The School of Math and Science [North Carolina School of Science and Mathematics], I went there. And Dr. Easley did, too, to the various

schools and women's organizations. She was a very popular one with women's organizations, and she went to a lot of meetings that I didn't know about, you know, for years, but she had just been doing it.

ROSEBERRY: Well, one of the letters that I read of hers was that she was writing to the partners, I think, and she said, “I'm being paid too much money.” Do you recall something like that she said—cut back a little bit—?

PEARCE: I think that—my recollection of that would be, is when she was retiring and she was seeing fewer patients, working fewer days. And so she made the time interval—in which she was seeing a patient—a longer interval for each patient. We worked under a unit system, so that it was not competitive among ourselves. That is, if you work a half a day in the office, it was worth so many units. If you did major surgery or minor surgery or that sort of thing, they were each apportioned so many units. You earned sort of—you were paid what you earned. So if you were working harder and you were doing more surgery and you developed the clientele that sought you because you were good at doing something, then you were awarded for that ingenuity or that energy. But as she got older and stopped doing deliveries and stopped doing surgery and was just seeing office patients, and even that was slowing down, she said, “You're paying me too much, because I'm only seeing a half or a third as many patients in a given period of time as you are.” She was doing it because she loved patient care, and women were seeing her because they liked that woman-to-woman interface. In the retiring years of her life, she enjoyed sharing with them things that she had learned through the years, and so she was popular in that, but again, it wasn't bringing in much money. She saw that, and I think that probably elicited her response. Back when she was practicing full time, I don't ever

remember that coming up, because she worked as hard or harder than anybody—so there was no reason for that to ever come up. But she was always a very fair person. She was the one who set up the unit system, and for our practice it worked extremely well. In fact, in many practices, that's the major reason for breakups of practices, as it comes down to the bottom line, you know, of just money. Somebody thinks they're working harder than somebody else, so they want to be paid more, yet people don't always see eye-to-eye on that. But with the system that she put in place that we had throughout the years that I was in practice, for us it worked very well. Now I don't even know what the young people are doing in the practice since I left, whether they've kept the unit system. I haven't even asked them. But it worked for us extremely well for forty years or so.

ROSEBERRY: Were there other systems that she put into place in the practice that—?

PEARCE: Not really, because computers were not used back when she was in practice. They were in their infancy, and it's only when we got younger people in our practice who were more computer-oriented or computer-literate did we computerize the business aspect of our practice. And then, just before I retired, they went to computerized medical records, but they were kind enough to tell me I didn't have to do that, and so I obviously have a computer but I—it's a part of my being— I didn't—I couldn't see myself doing that. I couldn't put the computer between me and the patient. There are people who can do that and do it very well and take very good patient care and show that they're caring people. But for me, it was something that was a brain strain, that it was going to be difficult for me, and I told them I didn't want to do it, and so they didn't make me do that. So they are happily—or unhappily—computerizing my records, because I have some records that were *that* thick [*indicates about two inches*]. But I did organize them, so that

I would have a summary sheet, so that all that they would really have to do is go back and look at my summary sheet, and they would know as much about the patient as I would. So I tried to make it so it'd be fairly easy for them to computerize the record.

ROSEBERRY: So what were some of the things that Dr. Easley maybe was very good at?

PEARCE: She was good at recordkeeping, in a way. She grew up as I did, from a background of which your parents were not wealthy. She would make notes on any scrap of paper. It could be an old envelope or something like that. But she would take her notes, and she'd put that in the record. She would not throw it out. She would not waste it. She would not dictate it. And then eventually we started dictating all of our records, but I remember the earlier years—you would look in her records, it would look almost like a Sears and Roebuck catalog that you'd torn pages out of. (*laughs*) Some of the younger partners would come in and say, Whoa, look at her records. It was really a marvel to see how she would keep her—but she kept records, I'll tell ya. She could go back—she could make sense out of them. (*laughs*) But as far as other things that she was innovative in, they had more to do, I think, with human-to-human relationships than it did business relationships. And then we've already recounted many of those things.

ROSEBERRY: Well, was there ever a time when you and she had a—when she was firm with you, or that you were disagreeing with her, or—

PEARCE: No. She was almost the age of my mother. I'm trying to remember. I do not clearly remember a difference. I do not clearly remember a difference that we had. And I don't clearly remember a difference that she had with most of the other partners. There were two instances—which I'm not at liberty to divulge—but two instances in which

partners that were with us were no longer with us, and it was because of things that she and we disagreed about them doing. And so we parted ways, and so those were times I'm sure were hard on her, because they were personally very hard on me. I mean, you'd be driving down the road, and you would get home, and you wouldn't remember doing anything, but you would be thinking about that issue, because it'd be such an emotional thing to you. But there were instances that occurred, yeah, and she could be very firm but also very fair.

ROSEBERRY: So there were, on average, five partners when you were there, or—?

PEARCE: No, usually four. Easley, Pearse, Stokes and me. Dr. Podger had left to go into gynecology. Dr. Stokes subsequently left to go into gynecology. And within a year after that, Dr. Allen joined us. So there were four again. And then another man joined us for a few years, and then left. And then two people joined us, Dr. Gunter and Dr. Beckwith, and Dr. Beckwith's husband was in the oncology fellowship at UNC, and he decided to go back to Indiana, where he was offered a very good position, and so she went back with him. We had another lady from UNC join us, and she became divorced during her first year with us, and married about the second or third year with us and moved to Boston with that husband. We had a series of other ladies join us but then leave when their husbands left or when they had children and chose not to continue to practice. And that was the summation of the people that were with us in practice during those years. But there was an average of four with us, but sometimes it'd be down to three and sometimes up to five. When I retired, there were actually six or seven—six, I guess. And then we've lost some of those, and they were ladies who moved away with their husbands. One of them had had three children and decided not to practice anymore.

That was a common theme, which I know Dr. Easley had some things to say about it. She did not agree—and she was pretty outspoken—and if a woman is going to go through all the rigors, and the years of training, and all the money that's involved in doing that, and all the investment that society puts into training doctors—of which we pay a part, but society pays a part, too—she did not feel it was the thing to do, is to go into practice and have your children—. (Of course, she never had any children.) She would refer some of them to Georgeanna Jones—Georgeanna and Howard Jones were from Johns Hopkins. They founded the ob-gyn department at the Eastern Virginia Medical School. They worked as physicians all of their lives. And so if there were young women in practice with us, she would ask them to go up and talk to them about how they managed their families, because they—the Joneses had , I think, three, if not four, children, and how they managed all the years. Both of them continued to work full time throughout their professional careers. In fact, they worked until they were in their eighties. (*laughs*)

ROSEBERRY: So she would definitely advise people in that direction?

PEARCE: Yeah; right. She said, "If you're going to commit to medicine, you need to be true to that commitment," and she felt that those women who did not do somewhat similar to what she did were not true to that commitment, and so she did not like that.

ROSEBERRY: She did have a husband?

PEARCE: Oh, yeah, her husband was a professor of psychology at Duke. In fact, she was older going to medical school, as you may remember, from reading the background information. She graduated from the University of Idaho. She got a master's in music education or music theory. She then got a degree in anatomy. Then she went to medical

school. And so by the time her husband taught her psychology, I don't know, she was probably about his age, because he was a young professor, and she was an (*laughs*) older-than-usual student, because she'd been a student so long. He eventually got a place at Duke, and she moved here, and went to medical school here. It was due to his influence and that of his peers that got her accepted in medical school and got her accepted into her internship and got her accepted into her residency. Because they didn't want women. And so Howard Easley was very instrumental, and he was—he was a cantankerous old guy, he really was. But he really stood up for his wife. He really did.

ROSEBERRY: How was he cantankerous?

PEARCE: Oh, if you'd ask him a question, he would say something perfectly outrageous. And if you would just let him run over you, you know, he didn't have much respect for you. But if you would come back and give as good as you got, he was your friend. (*laughs*) He served on the board of the county commissioners here a number of terms. And there were very tumultuous years back then. You think it's tumultuous now, it was very tumultuous back then, too, back during the time of integration and integration of the political powers that be. He started out on one side of the street politically and actually wound up on the other side of the street, in a sense. But that didn't have anything to do with her.

ROSEBERRY: But you also said that he stood up for her.

PEARCE: Oh, yeah. Oh, yeah. If—like, in the legislature, he would stand up for her. It escapes me now other ways he would stand up for her. Well, of course, she was involved in an accident in which she was extremely severely injured, and her mother was with her. They were on Guess Road, going north to their house on the Eno, which is just on the

other side of the Eno. And if you've been out that road recently, you know it's like a five-lane highway out there. At that time, the bridge over the Eno was one lane. She was on the bridge, and she was met head-on by another vehicle, and so she had multiple fractures, and her mother sustained injuries. They were in the same room in Watts Hospital—and her mother died in that room. And Dr. Easley was in the room, I don't know—many weeks, if not months. And she always had trouble—had to wear special shoes, she still had somewhat of a limp. I remember seeing a big scar on her arm where she had injuries repaired. But she came back to the full practice of medicine, did surgery and everything that she'd always done. So I said, she was a very strong women—very strong person.

ROSEBERRY: Were there other—you mentioned that her husband liked to dish it out a little bit and respected people who could dish it back. Did she do that with him?

PEARCE: Yeah, well, he would say things with tongue-in-cheek, but he would say it in a way that you didn't think it was tongue-in-cheek. And that was just his personality. In fact, I had a call in to this elderly gentleman, as I told you, was in the hospital, and he and Dr. Easley and this couple were important in establishing the Eno River Association—or the forerunners of that. In fact, the Easleys gave land on the Eno that they owned, to not only Easley Elementary School, which my two older grandchildren actually attended, but also across Guess Road on the east side of it. East side is where the elementary school is. On the west side of it was where the Girls Scout camp was. They had given that land to them, and the Girl Scouts eventually conveyed that land to the Eno River Association, and now that's a part of the North Carolina State Park system. So what they have done has been of benefit to all of us in this area.

ROSEBERRY: So she owned quite a bit of land?

PEARCE: Yeah. They did that. Both of them were working, and they had no children, and so they bought land. After a while, they gave it away.

ROSEBERRY: Is that where they lived, in that area?

PEARCE: If you go just across the Eno, as I recall, the first right hand turn is Lebanon Circle, and it's like a horseshoe. If you go up the right side of the horseshoe and back towards the back of the horseshoe, their house was over on the right there, and their backyard went down to the Eno River. In fact, Dr. Easley would have us out for dinner, occasionally, and she would take great pride in telling us she went down to the Eno to get creek grass for her dinner salad. She would go down there, and she would get a certain type of leafy plant that would grow, and that would be her dinner salad.

ROSEBERRY: So would she kind of spar with—?

PEARCE: With Howard? Oh, yeah. Oh, yeah. He wouldn't run over her, no, no. In fact, as you saw in that interview with her, he came in towards the end of the interview, and the lady who's doing the interview says, "Oh, I've heard a lot about you," she said. And he would say, "Oh, my ears are burning. I'm sure you heard a lot of lies," or something like that. (*laughs*) Or, "What lies was she telling you?," or something. But then he'd immediately change, and he would say something that was quite supportive. But that's just the type of guy he was.

ROSEBERRY: Well, what would you say was her impact on medicine, or on the city of Durham?

PEARCE: Well, she encouraged young people in medicine, specifically ob-gyn, and I was certainly one of those people. There were a number of residents who came through

the Duke system that rotated through the city hospital. She enjoyed teaching them. Her teaching was primarily practical rather than classroom, although we did have conferences on a regular basis—at least weekly—and the staff, of which she was a member, would take part in the teaching of the residents. We had a journal club at one point that we participated in. But her forte was taking the residents or the students on rounds with her, and showing them how she interacted with patients, so they could learn a certain amount of not only wisdom, but decorum and respect. I think that's very important. I'm not sure they get that now.

ROSEBERRY: So you felt that she was supportive to you in your—?

PEARCE: Oh, yeah. Oh, very much so. Very much so. And so, as you learn, I think, that's what you do, and I think her respect for each individual person was so obvious by the way she interacted with them—and I tried to emulate that myself. I felt that was a very important strength that I had, i.e., my interaction with people.

ROSEBERRY: Well, what were some of the maybe weaknesses that she had or—that might not be the right word for it.

PEARCE: Well, I don't know how to describe a weakness in somebody that you admire, that you thought had none. (*laughs*) I don't know. I don't know of any particular weaknesses she had. We were different, I guess. She was not a churchgoing person and was not "religious." Religion was not at all important to her. And since I grew up in a home—my father was a minister—it was sort of part of my being. It was important to me, but our interaction was such that that was never an issue in any respect, never, ever.

ROSEBERRY: Did she ever, in her advocating, say, for abortion, did she ever encounter any resistance from churches, or from—?

PEARCE: Well, I know we had had patients that would leave our practice because they felt so strongly that abortion should not be done under any circumstances, that when they found out that we did abortions sometimes under certain circumstances, that they have left our practice, yeah. But then, on the other hand, there were people that came to the practice because they felt that that was a solution that they wanted, and they did not want to go outside the law, and they did not want to go to somebody who would not take good care of them. Eventually it became sort of a moot point, because abortion clinics sprang up and they, most of them, were good at what they did, and we no longer felt that we had to do it. We could refer them to an abortion center. And we rarely did them after that, and usually then it was somebody who you practically felt like was family, you know, they felt so close to you—they didn't want to go, and they asked you to do it. And sometimes that was hard to refuse. And the parents you know very well, and their daughter's gotten into some trouble—very hard.

ROSEBERRY: Were there other issues that may have been somewhat controversial?

PEARCE: Not so much as abortion, that's for sure. Not so much as abortion. I don't know. Maybe you can think of something that I can respond to it, but I don't think of any at the moment.

ROSEBERRY: Probably not as (*laughs*) controversial as that.

PEARCE: No. No. That's the strongest difference of opinion that people have, and I guess it's ongoing. There are people that are still trying to reverse Roe v. Wade, which I wish the country could get beyond that and let it lie. And I have strong religious feelings, but I try not to impart those to other people. I try to divorce religion from medicine—just like religion and the state should be separate, I think religion and medicine should be

separate, in that I would not ask somebody to do something that they did not feel comfortable with. And so, if people ask me to do something I was not willing to do, then I want them to respect me.

ROSEBERRY: And were there—I know one of the arguments for safe abortions is that, you know, a middle-class woman could find a way to have an illegal safe abortion, but maybe someone who is not—?

PEARCE: Well, you go to a different country, for instance. Many of them would do that if they were wealthy enough to do that, they could do that.

ROSEBERRY: But someone who couldn't afford that option—there is a danger.

PEARCE: Um-hm. Yeah.

ROSEBERRY: Was the clinic dealing with people who maybe couldn't afford those options?

PEARCE: Well, they—it wasn't very easy to get abortions, and you had to go to places that were doing this, of course, under—beneath the law or outside the law. And so I don't know how easy it was, even for affluent people, to get them safely done, unless they were willing to go away. But I know as a resident, I remember seeing women come in sick, and occasionally they would die of abortion complications. I remember seeing women who had had such infections that you would try to go in to try to clean infected material from the uterus, and it would be just like the uterus was wet tissue paper, and you would actually have to remove the uterus, because there was nothing viable there that you could retain. They would have given up their right or their choice to have children in the future, because they had had an abortion and had a complication. So she dealt with it, I'm sure, maybe more than I did, because she was older than I was, and—I was a resident at

the time; this was in the early sixties. Then Roe v. Wade came about, I'm trying to remember, I'm guessing ’64, or mid- or late sixties. May have been later than that. Because I think when I went into practice in ’67, the state had changed the law to some degree, but that's when you had to get all the consultations I was telling you about to do an abortion. And then they changed the law again, and they liberalized it again, and that must have been in the seventies.

ROSEBERRY: And did the clinic deal with underserved populations in general, or—?

PEARCE: We did through the hospital clinic that we would serve in, you know, without charge. We would go there. Usually the patients that came to our office would be self-pay, insurance or that sort of thing. And so if they came and had no funds, then we would tell them that we were a private clinic and we could only stay open if people paid us, you know, because we didn't get money from the government. And if they had no funds, then we could refer them to a city clinic was funded by the government, that would take care of them. So they did. It's not that they didn't have an option; they did have an option.

ROSEBERRY: I understand that Dr. Easley worked some at Lincoln as well?

PEARCE: Um-hm. Yeah. Yeah. Right. We all did.

ROSEBERRY: You all did?

PEARCE: Yeah. We all did. Yeah, part of my training and residency, we would rotate through Lincoln, and we would do deliveries and surgery over there. And the Salvation Army had a home here, and we would go to the Salvation Army Home and would have OB clinics there. We would go up to Warrenton and we would have OB clinics there, and we would bring back patients with us who were having complications. I remember I

saw one woman who was starting to go into premature labor, and I had a station wagon. I had two medical students with me, and I had two patients in there. And one of them went into hard labor on the way from Warrenton back to Duke. And I mean, she was having the baby, and so I was looking for a place to pull off the road to help take care of her, and the first place I came to was a church parking lot, so I pulled around behind that, and she had the baby and got things taken care of. At that time, we had no equipment in the car at all to take care of her, because we didn't anticipate that happening. And after that, we got a crash kit, or an OB kit, that we took in the car with us. But—so we continued on, and there were people that saw us back there. And in those days, you saw this carload of these three white men and two black women, and something funny was going on, and I had one guy tailgate my car for about ten miles—and I was doing like 80 or 85 miles an hour on a two-lane road coming down the Wake Forest Highway. This guy was trying to see what I did. And after about ten miles, he peeled off. (*laughs*) Strange—but interesting—times. (*laughs*)

ROSEBERRY: What is the Salvation Army House?

PEARCE: The Salvation Army had a residence home for unwed mothers, and they would stay there until they had their babies. And so they would go there from, different parts of the state. We'd have girls here that would go to Charlotte to the Florence Crittenton Home, or to Salvation Army Home, or hospitals in other places. So if they were having a baby out of wedlock, then this is the way the system worked.

ROSEBERRY: So they would be sent there to live?

PEARCE: Um-hm, yeah. And so a lot of times, if the family wanted to say, Well Suzy, Sally, Mary, whoever, was going away to school this year, she went away to school.

Well, they did. They did continuing education with these kids, but they went away to have their babies.

ROSEBERRY: Well, it sounds like times have changed a lot.

PEARCE: Yeah, you no longer have those. They don't need them anymore. I don't think the Florence Crittenton Home in Charlotte is open, and I'm pretty sure the Salvation Army Home here has closed.

ROSEBERRY: What have been some of the other changes in the field? You mentioned that anesthesia—

PEARCE: Of course, there's been a great revolution in things you would do. The care of premature babies has allowed more and more of these babies to survive, and a higher and higher percentage of them to have a reasonable quality of life. Changes in surgery involving equipment, laparoscopy, doing less invasive type of surgery, more advanced surgery in gynecology—from the standpoint of repair of the disorders that were brought about as a result of women bearing children, that is prolapse of the uterus, the bladder, the rectum, incontinence problems. There's been a great deal of change in the surgery for those through the years. So that we're doing things that are more and more effective and much less invasive. So those are the major sorts of things that have been done. We're treating things with lasers—we've been doing that for ten or fifteen years now, I guess. Treating things as an outpatient that you used to treat as an inpatient. Minor surgery used to be an inpatient overnight stay, and then it got to be a few-hour stay, and now the type of anesthesia you use you wake up and go home as quickly as thirty minutes later. Those have been big changes in that you have surgical centers, and this reduces the load on the hospitals. But at the same time, it complicates the care of patients in the hospitals. The

patients who are there are hospitalized for usually more serious things, and they are there for shorter periods of time, and so the intensity level of the patient that you're caring for in the hospital tends to be at a higher level. Because before, you had a lot of them who are having very intensive care, but then a lot of them that were getting minimal care; pretty much they could take care of themselves. Now the trade-off is that the people who were taking care of themselves, they're not there. And if there are patients there, they are still all the patients that require a lot of care. So it's a fair bit more demanding on the nursing—as well as the staff in general—to look after them, because the patients that are there need more care, because they're either sicker from the medical disease, or they're closer to the time that they've had major surgery. So that's changed things. Maybe that's why women went into being doctors rather than nurses. (*laughs*) Maybe it's easier, I don't know. (*laughs*) But you see a little more males going into nursing now, which is good. I think you need physically strong people who are nurses. And we've had a lot of physically strong people that are nurses before, and thank goodness a lot of them still enjoy doing that. But we need a lot more nurses than we're training now—across the country, not just here, but across the country.

ROSEBERRY: Do you feel that maybe Dr. Easley's patients could relate to her because she was female—in some way? Does that give an advantage to someone in ob-gyn, or is that—?

PEARCE: Well, yeah, because it's a specialty in which you are relating to a patient in a way that's a more sensitive area, when you're not usually listening to their heart or looking into their eyes or that sort of thing. I mean, you're doing a breast exam and a pelvic exam, and for most people that's a very personal sort of thing that's—as opposed to

just opening your mouth or having somebody look in your nose or ears, it's a different feeling that you have. And I've felt, through the years, that I tried to make people feel at ease, because I'm handicapped in that I'm male—and I'm sure Dr. Easley felt that she needed to relate to women in this way, because she had to present herself as a doctor. So she was a woman, but she had to present herself as a doctor. They would see me as a doctor, but also as a man. And so we had to come at it from different viewpoints, but try to achieve the same purpose. And—but she obviously did a marvelous job on it.

ROSEBERRY: So in the earlier years they seemed to respect her even as a woman as well?

PEARCE: Well, when she first went into practice, she was wondering if she would have—many patients who would want to see her as a doctor, you know, because she was a woman. But then, during the Second World War, she said they didn't have any choice, if they wanted to see a doctor—any doctor—then a lot of times, it had to be her. She was certainly good enough that she presented the face of women in medicine so that they not only saw her as a female doctor, but as a very good doctor who was female. They could naturally relate to her very easily. So once she got that reputation, she was like gangbusters, you know, I mean—super.

ROSEBERRY: Did she talk about those early years, kind of in being a pioneer? Did she ever—

PEARCE: Only in a limited way. She never was one to pat herself on the back. She was just the opposite. She was very humble, great humility. And that's one thing I admired about her. She made you feel comfortable. You couldn't help but like her. She made you feel comfortable.

ROSEBERRY: Was she funny?

PEARCE: She had a sense of humor. She could appreciate humor, but she was not a great kidder, no. No, she was more serious. When she said something, she meant it. She wasn't kidding. (*laughs*) But she could appreciate a sense of humor.

ROSEBERRY: Well, you had talked to a friend of yours and had written some information about her?

PEARCE: Well, I'm sorry to say I lost the eulogy—my part of the eulogy that I gave for her when she died, and I'm embarrassed. I'm such a compulsive keeper of things, you know, I mean, I'm a collector of everything, and I could find the eulogy that I'd written for Dr. Pearse, and I was sure that I had put them together, but I didn't—and I don't know what happened to that eulogy. It was at Duke Chapel. Dr. Albert Nelius was the minister at that time who also read a eulogy. I would imagine things of that sort that went on at Duke Chapel may be recorded at Duke in some way, because I'm pretty sure I gave my copy of the eulogy to Dr. Easley's niece at Duke—but I don't have mine anymore, I'm sorry to say.

ROSEBERRY: I'm sorry. Before we had started, you had mentioned that maybe you had written something based on a conversation that you had had with a colleague?

PEARCE: Yeah, well, I went back and talked to the people who are living, who had been in practice with her. In fact, I talked to a man this morning that was in practice with us, and he has moved away, and in fact is essentially dying of rare cancer at this point. But it was in talking to former partners that they reminded me about the donation of the land for Easley Elementary School, and I remembered about the Girl Scout part that they did not remember—so that I had called the Girl Scouts, and there was a lady who called me back

when you first got here, that was following up on the conversation of what I had looked up for her, and she confirmed to me that on September 24, 1969, the Easleys conveyed a tract of land on the Eno River at Guess Road and Open Air Camp Road to the Girl Scouts. And December 28,1993, this was in turn was conveyed to the Association for Preservation of the Eno River Valley, Incorporated, and that has now been made a part of the North Carolina State Park system. And I told you about her visits to the legislature, and her efforts to teach not only our patients, but schoolchildren about matters of interest in the area of ob-gyn. On an interesting aside, Dr. Easley, I found out, talked all the time while she was driving. I'm trying to remember—I don't think I ever went anywhere where she was driving me, but Mrs. Carerras—that I talked to earlier this week—said that when she would go to Raleigh to go the legislature, she'd be talking so much that she would get lost, and even one time drove down a one-way street the wrong way and was stopped by police. And Nancy says, "Even though Dr. Easley was not an attractive woman, she had a smile that would melt butter and could be extremely charming when she needed to be." And she would also speak to legislators in a way that would enable her to work the system, so to speak, and get legislation passed that was favorable to her point of view. So you know, they could respect her intellect and her influence with women and women's groups that she would speak to. And so they certainly respected her, and I think she was a large part of the driving force for liberalizing the law as we now see it in this state.

ROSEBERRY: So what issues was she able to influence?

PEARCE: Well, the abortion issues, and the physician's associate issues, yeah. Those were the issues that she addressed. And the spin-off from the physician's associates were

nurse practitioners and nurse midwives. Before this, nurse midwives in the state were not people that had training, they were what we used to call the granny nurse midwife system—women who had stayed with women in labor and knew how to support them, but they were not trained. If they were preeclamptic or had trouble bleeding or any complications of pregnancy, they didn't one, know how to handle it and two, they usually didn't recognize it. But they were certainly good support for women who chose to deliver outside the medical system, and for women who, at that time in the age before Medicaid, did not have any choice. They did not have anyplace that they could go, by and large. They could go to a large, public hospital like North Carolina Memorial or even Duke, who had charity built into their system. But a lot of them who would live, say, as far away as Warrenton, they may not have any choice. A lot of times they wouldn't have transportation to get in. So, the laws that she helped pass helped these women, these indigent women.

ROSEBERRY: What was Mrs. Carreras' training?

PEARCE: She was the nurse midwife. She was the first nurse midwife we had here. She was the lady that was trained in Scotland that I told you about who was married to the psychiatrist at Butler.

ROSEBERRY: So she had training?

PEARCE: She was a well-qualified, university-trained Scottish nurse midwife when she emigrated to Canada. So she had had that training before Dr. Easley met her. And she would sit with—like, if we were in surgery, she would come up and sit with our patients in labor. She did not go to get—it was before the law was passed and she did not get an official nurse midwifery license in this state, but she functioned in that way under our

license. She would sit with the patients in labor and she'd hold our classes, but she did not do deliveries. So actually, if we had to, we would scrub out of an operation for ten minutes to help do the delivery while the partner was coming up from the office three blocks away. But that may have happened two or three times in twenty years, you know what I mean, so it's—you usually can work— (*laughs*) it's stressful, but you can usually work around those problems.

ROSEBERRY: And the physician's associates would go out into the—?

PEARCE: Well, physician's associates usually would work in the offices to help the physician. So they could help the physician give a better quality of care, and could see more patients than if he was just trying to bang, bang, bang, bang run through seventy patients a day himself. With a physician's associate, maybe a physician's associate could see thirty and he would see forty a day, then that's still a lot of patients, but certainly in some areas which you were underserved, with physicians particularly, this was really a godsend—so that they could give a higher quality of care and see the patients that they had to see.

ROSEBERRY: Well, what have I not asked you today that I should have asked you, or what have we not talked about?

PEARCE: I don't know. I tried to anticipate it, and that's why I did the research to sort of sharpen up my memory about these issues that I talked to you about. And I don't know. The last fellow I contacted, the fellow that retired in Charlotte, I asked him if he had anything to add he says, “Nope.” He couldn't think of a single thing. And the others that would add maybe a suggestion, or say, “Well, why don't you look here?” Or, you know, that was the way that I approached it. One of them, Dr. Stokes, was here when Dr.

Easley had her accident, or he was here shortly thereafter, because as Dr. Easley and Dr. Pearse and Dr. Podger had already left for Duke gynecology, and Dr. Easley had her accident, it was down to one person—and Dr. Pearse had a ruptured disk operated on, so Dr. Stokes was being trained at the Boston Miami and Harvard program. And he got them to release him for one month to come down here, and he really worked their practice while Dr. Easley and Dr. Pearse were out with those medical problems. And so a few months, later he finished his residency and came down and stayed.

ROSEBERRY: Well, Dr. Pearse is P-e-a-r-s-e.

PEARCE: Yeah, and I'm P-e-a-r-c-e. He was born the same year as my father. We were both tall and slender, and he had gray hair, and—. So he looked like he could have been my father, but we were not at all related. And in fact, people would assume that I was his son, and there are more people that are named Pearce than Pearse, so people would come in and they would call him Dr. Pearce and he would say, "Pearse, dammit, madam, Pearse." (*laughs*)

ROSEBERRY: He sounds like quite a cantankerous—

PEARCE: Oh, yeah, that's what I say; he was eccentric. (*laughs*) And he was quite a character, but he would say that. I've heard him say it. (*laughts*) He would set them straight. But it was an interesting life. I enjoyed my years with both of them. They were both very special people.

ROSEBERRY: Well, thank you, Dr. Pearce, I appreciate it.

PEARCE: You're welcome.

ROSEBERRY: It's been delightful talking with you.

PEARCE: Well, thank you. I've enjoyed it. I enjoyed it.

(*end of interview*)