INTERVIEWEE: Dr. William London
INTERVIEWER: Jessica Roseberry
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PLACE: Dr. London's home in Durham, NC

LONDON INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. William London, and he was the president of the medical staff at Watts Hospital as well as the chair of Pediatrics at Watts Hospital from 1968 to 1976 and the chair of Pediatrics at Durham Regional from 1976 to 1978. And I want to thank you very much, Dr. London, for agreeing to be interviewed. It's a privilege to speak with you today.

WILLIAM LONDON: Can I make one correction?

ROSEBERRY: Of course. I apologize.

LONDON: I was not chief of the medical staff at Watts Hospital during—as you stated in there—I was chief of the medical staff from '73 to '77. And Pediatrics was longer than that.

ROSEBERRY: Okay. Great. Thank you. I apologize for that. Well, if you don't mind, I thought I would ask you a question or two about your background and how you got into Pediatrics and medicine if that's okay with you.

LONDON: I was born and raised in Pittsboro, North Carolina, thirty miles south of here. Went to the undergraduate school at the University of North Carolina and then to medical school there and then did pediatric training at the Children's Hospital in Boston for three years and then was a fellow in pediatric hematology at the same hospital for a year. And then came here into practice.

ROSEBERRY: What was interesting to you about pediatrics, if you don't mind my asking.

LONDON: You take care of young people who are basically well, who get very sick very quick and very well very quick. And you don't have as much self-inflicted chronic illness as you have in dealing with adults. They don't—of course, addiction is now a problem but was not so much a problem when I was there. But I didn't like dealing with self-inflicted illness like alcoholism and obesity and a lot of other things that old people do.

ROSEBERRY: Well, how did you come to Watts Hospital?

LONDON: My uncle practiced pediatrics in Durham from 1930 until he died in 1976, and I went into practice with him. He was an excellent physician, and it was a good opportunity for me.

ROSEBERRY: So that was not a private practice?

LONDON: Oh, yes. It was a private practice.

ROSEBERRY: (*speaking at same time*) It was a private practice. Okay.

LONDON: And we were in—I was in private practice from 1961 until Duke bought our practice in—let's see. Nineteen ninety-nine minus five years is what? Nineteen ninety-four. And the last five years I worked for the Duke Health System. But before that, we were all in private practice. Started out with three physicians and ended up with eight.

ROSEBERRY: Well, tell me about the relationship with Watts. Tell me a little bit more about that.

LONDON: Well, Watts was—Watts was—there were two hospitals in Durham when I came—three. Duke, Watts, and Lincoln. And pediatric services existed at all three

hospitals. In that day and time, I had admitting privileges at all three hospitals. Duke welcomed practitioners to practice at Duke Hospital. Not all practitioners; they welcomed pediatric practitioners. Only a few of us used Duke. The rest of us used Watts almost exclusively. We had a very good pediatric service at Watts. As pediatrics evolved, it became more and more tertiary medicine. And with tertiary medical care, you required much more equipment, much more specialized training. And for instance, now there are no inpatient child services at Durham Regional Hospital. All of that is appropriately done at Duke. We—when I started, we could do anything Duke could do, but as the specialty evolved, it became—there were only a very few subspecialists when I started. Now there are subspecialists in everything. I was a member of the hemotology-oncology service at Duke and put patients there and worked in the clinic there a day a week. And thoroughly enjoyed my association. Lincoln was—Lincoln had a very small pediatric service. I was chief of the pediatric service at Lincoln Hospital for several years. And with the merger of Lincoln and Watts Hospital, those patients came to Watts Hospital. Lincoln did not have the facilities to provide anything like tertiary care. And Dr. William Cleland, who was the only pediatrician at Lincoln Hospital, was an integral part of the Watts Hospital staff when he came there.

ROSEBERRY: Was there competition for patients among—?

LONDON: Oh, there's always competition for patients. Everything is competition in the United States. But it was friendly competition. When I started out, Watts Hospital had a pediatric training program, and we had interns and residents in pediatrics—

ROSEBERRY: I'm going to—I just—that'll pick up the noise. I'm sorry.

LONDON: —and we didn't have the caliber of trainees that Duke had. And then eventually we relinquished our training program, and Duke sent its pediatric residents to Watts Hospital and then to Durham Regional Hospital, which was a great boon to patient care in both hospitals.

ROSEBERRY: Thank you. Well, tell me about your presidency of the medical staff.

LONDON: I don't know what to say. There's not much to tell.

ROSEBERRY: (*laughing*) Okay.

LONDON: You ran things called the medical board meetings. And during the time that I was there, there was a great deal of activity going on with the planning of the Durham Regional Hospital. I cannot remember the name of the committee nor the committee that was formed that undertook the planning of the hospital. People that I remember that were on that were that were Dr. Eugene Stead who was chairman of the Department of Medicine at Duke and just an outstanding person. There was a—I was on it. And I can't remember the other people on that committee. There were several administrators, there was a person that was hired to facilitate the planning, from the Durham County Hospital Corporation I assume. And Tom Howerton, who was the head administrator, was on it. But I cannot remember the other people: it's been a long time ago. Surely that's in the minutes of the hospital somewhere.

ROSEBERRY: Well, what was the reason for the need to integrate the two hospitals and create another?

LONDON: Well, integration occurred before the Durham Regional Hospital was—that occurred about 1965, somewhere in that region. It was—the facilities at Lincoln were not what they should be. There were many physicians on the staff at Watts Hospital who

worked at Lincoln Hospital. And the ability to provide appropriate care was not the same at both institutions. Durham Regional Hospital [Watts Hospital?] was full. It had open wards with beds in the halls. It was just vastly overcrowded. It needed to be expanded. (*coughs*) There was an attempt to pass the bond issue to expand both Watts and Lincoln Hospitals. And it was soundly defeated. The blacks were against it. The Ku Klux Klan was against it. I don't remember anybody but the staff at Watts Hospital that was for the thing. But it was—

ROSEBERRY: Were you for it?

LONDON: Oh, sure. It would have been a good thing. I mean, having two separate hospitals I thought was not good. But yeah, I think the medical staff was in favor of expanding the hospital. It needed to be expanded. And at that point in time—now, I can't remember all of the politics of that. But the Durham County Hospital Corporation was formed. And building a new hospital was a response to not having—not being able to expand the existing hospital. If my memory of events is correct. The—as far as integration of Watts Hospital was concerned, there were—the bylaws of Watts Hospital had to be changed. You had to be a member of the Durham-Orange Medical Society to be a member on the medical staff at Watts Hospital. The Durham-Orange Medical Society did not accept blacks. I don't remember whether the medical society changed first or the hospital changed first, but that requirement was rescinded and then people on the medical staff at Lincoln Hospital made application to the—I remember the first ones were Charlie [Charles] Watts, Bill [William] Cleland, Bob [Robert] Dawson, Don [Donald] Moore, and I can't remember—there were two others that I cannot remember. And my memory is that that was a seamless—that they moved in and there was

absolutely no difficulty with that. The difficulty was not the medical staff, it was other forces in the community that wanted separate but equal—but it wasn't equal. They were not comparable, the facilities at Lincoln. They didn't have the services that Watts Hospital had or that a modern hospital needed to have. And they needed to be integrated. There was a great deal of pride in the black community about Lincoln Hospital, and thank goodness the Lincoln Community Health Center was formed to give them a facility in their neighborhood. But it was—I remember distinctly at a medical board meeting, there were two complaints when the first black patients were admitted. One was that Bob Dawson said that somebody served his patient dinner and didn't bother to find out that she was blind (*laughs*). And she didn't get her dinner and complained to him. (*laughing*) And the other patient, somebody saw somebody in the bed next to him that had turned black and thought the patient died and called an alarm to the nurses. And they were the only two instances that I remember when the hospital integrated. It was—and there were a lot of people who said, I won't go to a place where a black is. And that just didn't happen.

ROSEBERRY: So there was no loss of business, it sounds like.

LONDON: Oh, no. I don't know this, but I assume that with increase of physicians admitted there, it was increased business. But Watts Hospital was a very different place. There were private rooms. Not like now when hospitals have virtually nothing but private or semiprivate rooms. In those days there were open wards with twenty people in them, with only a curtain separating them. And one bed here and one bed there. And the only separation was male and female. And there would be beds down the corridors of the hospital, there would be a white person in one bed and a black person in the next. And

that needed to be improved. Because it was not good for infectious disease reasons and privacy reasons, but that was what hospitals were like years ago.

ROSEBERRY: Well, what kind of equipment were you using back then?

LONDON: Well, as far as pediatrics is concerned—the only thing that I could address—I mean, we had the same incubator kind of things for newborns and prematures that anybody else had. One of the advances was in respiratory care of the premature and newborn, and we did not have the facilities nor the training nor the personnel to do what Duke, for instance, could do. And neither did Lincoln. And now—this is all so changed, with—now there are level-one nurseries, level-two nurseries, level-three nurseries. Level three is the tertiary care now. And you need pediatric surgeons, you need all of the subspecialties. And that's just not something that a community hospital in my estimation shouldn't try to duplicate. Pediatric care is largely now preventive medicine and child-rearing kind of—trying to help children develop into their full potential. And preventive medicine and vaccines in particular have just eradicated many of the diseases that were rampant years ago. Polio no longer exists, as one example. Measles does not exist—I mean, the wards were full of people with measles. And the things that are now mistakes of nature: children that are born with various defects, cardiac defects, lots of things; and the hospitalized pediatric patient now requires very specialized care. My subspecialty training was in hematology and oncology. When I started out, if you had a child with leukemia, they could expect to live six to eighteen months. Now almost ninety percent of them can expect to be cured. These are *huge, huge* improvements. And for instance Duke has a very excellent program in cord blood cell bone marrow transplants. And these things just have made a tremendous difference, and there's no way that there should

be two programs with that kind of foolishness—I mean, not foolishness, with that kind of level of expertise in a community. I'm rambling.

ROSEBERRY: It's great, thank you. Well, I wanted to ask just as a matter of explanation, the medical staff and you being president, what was the structure like? I mean, what was that setup?

LONDON: There was—the governing body of the medical staff was something called the medical board. It was composed of the officers of the medical staff who were president, vice president, secretary, treasurer. And I don't remember if there was a secretary *and* a treasurer, but I just don't remember that. And the chairman of all the medical staff divisions: chairman of Surgery, chairman of Medicine, chairman of Obstetrics, Pediatrics, Urology, Orthopedics, Anesthesiology, laboratory services. I'm sure I've forgotten some. But it was composed of the chief of service of all the various departments within the hospital plus the officers of the medical staff. And it was really—anything that was brought up was approved by that body. And there were times when that body had to go to the entire medical staff: when you had an election of an officer, it was not done by medical board but by the entire medical staff. But the—it was the executive committee—and there was an executive committee of the medical board, but the executive committee could act but then required approval of the medical board. You did not have to go to the medical staff to get every action of the medical board approved. But things like elections were done by the entire medical staff. But it was a working executive committee for the staff. And the hospital administrator would have been a member of that. And I can't remember how many administrators there were; it seemed to me as we progressed there were more and more, but probably won't anybody like that.

ROSEBERRY: Well, what things needed to be done by this group or by you to prepare for the new hospital?

LONDON: Oh, well, it was endless hours of meetings to—I mean, the surgical service—I mean, I obviously cannot speak for what they did, but they would have met and discussed what they wanted in the operating room and what the physical of things would be. The obstetrical staff would have discussed the delivery room suite and however that was arranged. The medical staff, the internal medicine department would have done the same thing with their floor. And then so in terms of departments, radiology—I think a hospital is built now around a Roentgen ray tube: it's such an important part of medicine now, the imaging things that they do. But that would have been done by department by department. And then the compromising when there were—I mean, I don't know this. I know when the pediatric floor was built, we were assigned many more beds, because we were given a wing of the hosp—a floor. The hospital was built as a sort of a cross—

ROSEBERRY: That's the new hospital; I'm sorry.

LONDON: The new hospital. But there was a floor on each of the three legs of the cross. And we were given one leg. We didn't need nearly that space. But that was—at that time the thinking was that that was the way things should be divided. And then we got much more space than we needed nor could utilize. But we told them at the time that we didn't need all that space, but we got it anyway.

ROSEBERRY: Do you remember what kinds of things you asked for? You said the departments—

LONDON: (*sighs*) Well, when it came to things like the newborn and intensive care nurseries, we would have asked for a lot of equipment. In terms of the floor itself, that

was largely just a matter of the number of beds we got and the arrangement of the beds, and that was much—I don't remember having significant input into that. That was done much more by the architects and hospital planners.

ROSEBERRY: So tell me about that move over to the new building.

LONDON: Well, it happened—I can't remember. I remember riding over with the newborns. We put them in bassinets and they were put in ambulances and driven over there. It wasn't—no one with elective surgery, for instance, or elective medical conditions had been admitted for a period of time. So that the move itself was no big deal. It just went off as smoothly as could be. We drove over there, and that was it. Now, I don't remember all of the logistics of what the various departments had to go through to get things like equipment over there, but it must have been people worked on that for a long time. But I was not involved in that kind of structural operation. Only thing I remember is going over there with the babies, and that was nothing.

ROSEBERRY: Well, you mentioned that it was in the shape of a cross, and what did it look like other than that?

LONDON: You mean at Durham Regional?

ROSEBERRY: Yes, Sir.

LONDON: Go look. (*laughter*) It's just the same. It's like it is now.

ROSEBERRY: So very similar to—?

LONDON: Yeah, it's the same general structure. Now, there's lots gone on that I don't know about in terms of changes in services and arrangement of the hospital. But I'm not competent to discuss that.

ROSEBERRY: Okay, sure.

LONDON: When I retired, I retired.

ROSEBERRY: (*chuckles*) I understand. Well, so now we're at the new hospital, and I wonder just what the logistics were of—

LONDON: I don't remember any trouble at all. It ran smoothly. The medical staff stuff, I can't remember when we moved. Was it in the fall? I don't remember that, but I was involved with—I mean, I had been there much longer than I should have been. People kept asking me to be president because they didn't want to stop while the move was going on. And I was—as soon as this was over, my term was over as president of the medical staff. I stayed chairman of Pediatrics for a year or two. But I was not intimately involved in the medical staff part of the hospital after that. I stayed chairman of the credentials committee for what seemed like to me forever, but (*laughs*) I quit that, too.

ROSEBERRY: Well, tell me about—obviously there were staff changes at the—

LONDON: There weren't.

ROSEBERRY: New staff. New staff.

LONDON: The whole staff moved over to the hospital.

ROSEBERRY: Okay. That's because you integrated before.

LONDON: (*speaking at same time*) The nurses that were in charge at Watts were at Durham Regional. And there of course may be new people that were on the staff. But the same people in pediatrics that ran—the important things were the premature nursery, the newborn nursery, and the ward nursery, and they were the same people. They just moved from one building to another. Took the equipment with them; we had some new equipment. But it was the same people.

ROSEBERRY: Well, tell me about some people who were noteworthy or maybe who stand out in your mind, people who maybe should be mentioned.

LONDON: Well, in terms of the planning of the hospital, Eugene Stead said things that the rest of us were too timid to say. And I think he's one of the more impressive people that I've ever seen. And his remarks were listened to by all in the planning stages of the hospital. Tom Howerton worked very hard and was instrumental in getting all these various groups of people together. I know there was political turmoil with the integration of Watts and Lincoln, but I really wasn't involved in that at all. I know when the medical staff came together, there was not any trouble. But there certainly had been trouble getting to that point in time.

ROSEBERRY: Well, tell me then about pediatrics as it continued. Tell me about some of the changes that you saw.

LONDON: Well, as pediatrics progressed at Durham Regional Hospital, it became obvious to us that we needed more expertise in the care of sick, premature, and newborn. What we had done—and so a division of neonatology was set up. And we had neonatologists that came from Duke. And eventually hired our own I think, but by that time I was getting old and was not intimately involved in this. But the provision of neonatal services was essential to the care of the newborn and premature in a modern-day hospital. And that was developed towards the end of my practice career. It occurred maybe in the last five years that I was in practice. We had tried to do that ourselves and needed help, and got it, thank goodness.

ROSEBERRY: Well tell me again about—we had talked some about the community hospital and then maybe a move towards tertiary care and maybe Duke's—

LONDON: Well, Durham Regional does some tertiary care. They certainly do tertiary heart care very well. In terms of pediatrics, which is the only thing I ought to discuss, in order to provide decent medical care, you've got to have numbers, you have to have a population base. If—for instance, we talked about leukemia. There might be one leukemic patient in Durham County in a year. You need a place that's getting referred those things from all over in order to have the nucleus of people and the experience in dealing with the disorder to provide good care. And that's what referral hospitals are all about. Now, as you—I'm speaking only about pediatrics—the number of cases that need that sort of thing from a small community are not many. And so you need something that's grouping people together from all over to have the volume of patient care, to have the volume and experience to provide that care. But this doesn't have anything to do with Durham Regional Hospital.

ROSEBERRY: Well, I know that you were also involved in statewide pediatric activities as well. Do you mind sharing a little bit about that as well?

LONDON: Well, I'll give you the numbers. (*sound of papers shuffling*) I can't remember anything anymore.

ROSEBERRY: (*laughing*) Okay, great.

LONDON: I was secretary-treasure of the North Carolina chapter of the American Academy of Pediatrics from 1966 to '69 and then chapter chairman from '69 to '74. So I was involved in pediatric politics at the state level forever. And then was involved with something called the American Board of Pediatrics which is the organization that tests pediatricians to certify their competence to provide pediatric services. And if you're certified by the American Board of Pediatrics, it means you have had *x* numbers of years

of pediatric training and then taken a certifying examination that the board creates, and I was with that organization for twenty years and secretary-treasurer of it the last year. And that was a very interesting experience. The testwriting is an art form. And what you do is you sit around the table, and let's say you write a question about so-and-so. And you'd write that question. And then that question will be given to your peers to see if the people who are supposed to know what they're doing get the right answer, and then you test that question in various settings. And this is what goes on in the national boards and all these things. And testwriting and test testing is a big business.

ROSEBERRY: That's interesting.

LONDON: Because what you want is a question that all the smart people get right and all the stupid get wrong. It doesn't work that way all the time.

ROSEBERRY: Well, tell me about pediatrics on a statewide level. What were some of the things that were being discussed, or what were some of the issues?

LONDON: Well, the first thing that politically that we dealt with was that newborns were not insured. If you were a young couple and had Blue Cross Blue Shield or any other insurance and your newborn had a medical problem, he was not—he or she was not covered by your policies. So that this left young people who were unable to afford—the people at the bottom end of the earning spectrum were faced with tremendous medical bills when there were problems. And it took us five years to—at least—intense lobbying to get newborns insured under their parents' policies. And that was a major initial effort that we did. And then subsequently coverage of the uninsured in North Carolina, a large portion of which are children, is a huge problem. And to get the state to provide adequate compensation for taking care of uninsured and Medicaid children is something that is a

continuing and will be a continuing problem. And the Pediatric Society in North Carolina has been very active in this. You—the kind of worst care on earth for a child is episodic emergency room care, which is what typically happens with the uninsured and the underinsured. And you can prevent by proper immunization, proper medical care, you can prevent a tremendous percentage of the illnesses, particularly serious illnesses. But they've got to be able to get to the doctor, and the doctor's got to be able to treat them. And a doctor's got to make a living like everybody else. And you can't have in many communities, in many areas in North Carolina, fifty percent of the childhood population will be uninsured or Medicaid type people. And you can't make a living being paid less than fifty percent of what you charge. And it's—being uninsured is a terrible problem everywhere. But the huge Hispanic population is a—I don't know, I shouldn't comment on that. But I certainly know from when I was there, I would have people come in and say, I know so-and-so who has a child that needs this. And you'd say, Bring them in, and we'll see them. But then they might need stuff, and there was no way to cover them. It's a terrible problem. But this has got nothing to do with Durham Regional Hospital. (*sound of papers being shuffled*)

ROSEBERRY: Well, I did want to ask about the Pediatric Department at Durham Regional and just kind of—first wanted to ask how many pediatricians there were in the department kind of at its beginnings. Or approximately.

LONDON: Good gracious. (*pauses*) Six, eight, twelve, eighteen, nineteen, twenty—roughly twenty-one. I can't—somewhere around there. I could go back and look that up, but I don't really remember that. Somewhere around twenty, twenty-one people.

ROSEBERRY: Okay. And did that number stay fairly consistent, or—?

LONDON: It's increased.

ROSEBERRY: Okay.

LONDON: Most of the groups that were there when the hospital integrated had four to six people. And most of them would have six to eight. But now they're not—the only the thing a pediatrician is doing at Durham Regional Hospital is newborn care. The hospitalized older child would go to Duke. But you need to talk to somebody that's doing this now. My information is at least six years old.

ROSEBERRY: Okay. So that's happened since you retired?

LONDON: Yes. Since I retired.

ROSEBERRY: Okay. Maybe then we can talk about again some of the things that you were doing as you were practicing there. We've covered a little bit about that, but—.

LONDON: I don't understand what you're asking me. (*Roseberry laughs*) I know you're asking—having a hard time asking.

ROSEBERRY: No, it's—not at all, not at all. Well, tell me about—obviously without identifying anyone—but tell me about some memorable patients that you—if there's anyone that stands out to you.

LONDON: Oh, obviously I couldn't say names, but there was a little girl who had a congenital—had a disease that she was born with. And she was retarded. And she subsequently got a horrendous type of malignancy. And she just was the sweetest, nicest person you ever met. Never complaining about anything and going through horrendous stuff. And she nor her parents never did anything but say thank you. And that kind of person makes you cry. But things like that touch anybody. Next question; I'm going to cry.

ROSEBERRY: Well, you mentioned that in 1994, Duke bought your practice, is that right?

LONDON: Yes.

ROSEBERRY: Tell me about that.

LONDON: I really don't know what to say. They—I think that Duke was very concerned that they were not going to have patients enough to fill their beds as a hospital. Therefore they bought primary care practices. They bought internists in Durham, pediatricians, family physicians, family physicians in Hillsboro to Henderson, North Carolina and in between. And I never thought this was a wise move for the university. They could have accomplished the same thing with us by signing a contract. But they wanted to own the practices. The fallacy on Duke's part was that the thing that determines where a practitioner hospitalizes a patient is where that patient's insurance says they should go. Because obviously hospitalization is expensive, and at that time Blue Cross and Blue Shield said that any patient insured by us must go to University of North Carolina in Chapel Hill or to Durham Regional Hospital. We were specifically, by contract, excluded from sending a patient to Duke. And we were fussed at because we were not sending all our patients to Duke, but it wasn't anything we had any control over. And I don't really think hospitals ought to be in the private practice of medicine business, but that's not the way things were going. And Duke still owns the practice. I can't comment anything about what's going on, because I don't go. But I know that everything—all the patients go to Duke, all the inpatients go to Duke now because Durham Regional is closed. But in terms of newborns, that's where the mother wants to go, obviously.

ROSEBERRY: Well, I wanted to get at somehow a little bit more at the daily life at Durham Regional, and I'm not sure exactly how to phrase that question and get at it. Or maybe about changes over time—. Is there anything that I should be asking in that regard?

LONDON: Well, in terms of pediatrics, it became—as medical care of children evolves, fewer and fewer and fewer children are hospitalized. As new anti-disease drugs become available, if you have pneumonia now, it would be a great rarity to have that patient admitted to the hospital. Most of the time the physician can, by proper administration of antibiotics, can avoid hospitalization. So the number of children hospitalized *everywhere,* not just Durham Regional Hospital, has gone way down. And the complexity of the patient who does have to go to the hospital has gone way up, so that in years gone past we would have had one patient with meningitis. This time of year we would have had one or two with Rocky Mountain spotted fever. I am—probably in the last ten years of my practice, we never hospitalized anybody with Rocky Mountain spotted fever because we—as you recognized, you put them on antibiotics and they got well. And they didn't need to be hospitalized. So in terms of pediatrics, the necessity for hospital care has gone way down. And thank the lord for the new drugs. Asthma: we would have always had somebody in the hospital with asthma. Now there are five or six new drugs that are absolutely superb in the management of asthma. Where you get into trouble with this disease is the patient who doesn't recognize he's sick and doesn't come in and initiate therapy until it is beyond the point where therapy helps. So appropriate early medical care can prevent *enormous* numbers of hospitalizations. Now you hospitalize—the need for surgery I wouldn't comment on. I mean, it has not decreased

like this. But the medical conditions for which there are therapies—you know, there are medical conditions where you don't have therapy and where therapy requires enormous amounts of equipment. Those people are still hospitalized.

ROSEBERRY: Thank you. Well, I wanted to ask when you retired. What year was that?

LONDON: Nineteen ninety-nine.

ROSEBERRY: Ninety ninety-nine. So that was—

LONDON: I was—in July. I turned seventy in November, and I thought Duke didn't like people that worked past seventy; at least that was what I was told. So I retired.

ROSEBERRY: And Duke had just—

LONDON: I'd had a five-year contract with Duke.

ROSEBERRY: With Duke, that's right. Well, maybe I could ask about that contract with Duke as well.

LONDON: They paid me to work for them, and I worked for them.

ROSEBERRY: Okay. Well, what questions have I not asked that I should have asked today?

LONDON: Oh, I've talked much too much.

ROSEBERRY: Oh, you've been wonderful. It's been great. I appreciate it.

LONDON: And there's some other people you should talk to. Specifically about—Dr. Jack Hughes was involved in—

ROSEBERRY: Dr. Jack Hughes.

LONDON: —in early things at Watts. And he's been involved in medical—he was president of North Carolina Medical Society for a time, and he certainly was intimately

involved with the workings of Watts and Durham Regional Hospital. And he's certainly someone worth talking to. They're not many of us left.

ROSEBERRY: Well, thank you very much, Sir. I appreciate it.

LONDON: You're more than welcome.