INTERVIEWEE: Dr. E. Harvey Estes
INTERVIEWER: Jessica Roseberry
DATE: April 28, 2004
PLACE: Duke University Medical Center Archives

ESTES INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry. We're here in the [Duke University] Medical Center Archives. I'm here with Dr. E. Harvey Estes, Professor Emeritus of the Department of Community and Family Medicine. Today is April 28, 2004. And we've decided to restrict this interview until January 1, 2014. Thank you, Dr. Estes, for agreeing to be interviewed today. I appreciate that.

DR. E. HARVEY ESTES: You're welcome.

ROSEBERRY: If you don't mind, if we could start with maybe a little bit of background and how you came to Duke and what originally was your role at Duke.

ESTES: Okay. I came to Duke in the fall of 1952, really following my mentor from Emory who had recently come to Duke to be the first chief of Medicine at the Durham Veteran's Administration Hospital. This was Dr. James Warren, who was one of the original group who came to Emory from Boston in the 1940s to be on the staff of the Department of Medicine there under Dr. Eugene Stead. So I guess you could say that Gene Stead brought me to Duke, because he brought Dr. Warren, and Dr. Warren brought me. I was a student under Dr. Stead at Emory back in the forties. Dr. Stead decided to leave Emory in the fall of 1946 and move to Duke. I had already signed on to be an intern on Dr. Stead's service at Grady Hospital in Atlanta. So when he departed, he left the department in the hands of Dr. Paul Beeson, who was his second in command. And Paul Beeson still had a strong department. I stayed there, finished my residency

and a year of fellowship in the Department of Medicine. Had just started my fellowship with Dr. Warren in the Department of Physiology there when the Korean War broke out. And I was a member of the Navy Reserve and was called to active duty. So I went in the Navy in the fall of 1950 and was assigned to Bethesda Naval Hospital and eventually to the School of Aviation Medicine in Pensacola. Served two years. And when I emerged from the Navy in the fall of '52, everybody in the Department of Medicine at Emory had departed because Dr. Paul Beeson had been appointed as chief of the Department of Medicine at Yale. So he had taken the rest of the department that I knew with him. So there was no one left at Emory that I knew. So I contacted Dr. Warren, and we agreed that I would come to Duke and finish out my uncompleted fellowship year, and then at the same time finish my residency requirements. So I came to Durham instead of back to Atlanta. I came here fully intending to stay for a year or so and go back to Atlanta and go into practice. But (*laughs*) here I am (*laughter*), still here. Well, it was an interesting time. Dr. Warren was chief of the Medical Service at the VA Hospital. The VA Hospital was brand new; some of the floors had not even opened. And the Department of Medicine was just forming. So I stepped in at the end of my fellowship time as the first head of the Cardiology Division at the VA Hospital.

ROSEBERRY: Is that why you chose to stay at Duke, because of that opportunity?

ESTES: Yes. I had, while still at Emory, I had worked with a man who was an outstanding teacher and an outstanding person. This was Dr. Robert Grant (later became the first director of the National Heart Institute at NIH, Bethesda, MD. Now deceased). Dr. Grant was someone whom Gene Stead had recruited to Atlanta. Dr. Grant and I had worked together for a year, me as a fellow under him. And together we had written a book on the interpretation of the electrocardiogram.

ROSEBERRY: (*softly*) I see.

ESTES: I had gone to Bethesda as a cardiologist and had then gone to Pensacola where I taught electrocardiography to flight surgeons. So I'd had a good deal of cardiology experience by then. And so I stepped in as the first cardiologist at the Durham VA. This was before there were boards and qualifications for cardiology. You just sort of did it. I stayed there for a couple of years, then went back across the street to Duke to join the Medical Private Diagnostic Clinic as a cardiologist, working under Dr. Ed Orgain. So I became a cardiologist, was in charge of reading electrocardiograms, seeing patients, and had patients in the hospital and so forth. And remained here until I think it was 1966. (*sound of heavy traffic outside*) No—time flies. Fifty-six, at which point I came back to the VA, this time as chief of the medical service, and remained there for about five or six years. So then I went back to the Private Diagnostic Clinic and was there until 1966, at which point Duke formed the new Department of Community Health Sciences.

ROSEBERRY: Now, up until this time did you have any formed opinions about generalists versus specialists; as you were in cardiology, did you have any—?

ESTES: Opinions, yes. I think, looking back, there are two influences that came to bear on me. Number one, I grew up in a small rural community in Georgia that had, oh, 250 people. Still has 250 people. (*laughs*) Very rural community. And though I lived in this little town, I really lived on a farm, because you could look out my window and see the farm that my father was part owner in—and within a stone's throw of farms and barns and animals and everything else. But the important part was that this town had a solo general practitioner who was really the most important guy in town. Now, in looking back, he didn't do very much in the way of care. I mean, he would sew up lacerations and things of that sort. But his chief function was getting you to the right person. But he was an extremely important individual in town, and everybody knew him,

and everybody utilized his care in finding what they needed. This is a true story, that he maintained an office in the middle of the little town, but people knew where he lived, and they knew which room was his. And if you wanted him—many people didn't have telephones then, and they would go tap on his window. (*Roseberry laughs*) And he would come outside and hear what the problem was and take care of it at night. So anyway, he was a powerful influence. So I knew what it was to be in a small town. The second influence was the fact that I had gotten involved at a very early stage as a member of the local medical society. I also became involved with the state medical society and became active in both organizations and became the secretary-treasurer of the state organization at about that period of time. Eventually I became president of that organization, but this was before—I mean, I was secretary for many years. So I was involved in state medical politics, I guess you'd say, and knew from that experience that there were places in the state that were having a terrible time finding doctors. So I was involved, and people knew I was involved. So I think those two things made me a little susceptible to taking on a new task when this job came along. But at any rate, one day in 1966, I was going about my normal business, and Dr. Stead called me and said, "We're forming this new department, and we'd like you to consider taking over as its chief." And with his urging I elected to do it. I think in retrospect that this was a much more complex enterprise than I thought at that time. I thought I was just taking over a department that somebody had thought up. But in reality this thing was several years in forming. The recommendation for a new department came from a faculty committee headed by Dr. Roy Parker. It had a number of other chairmen on the committee, but I was not a part of it, had nothing to do with it, didn't know it was functioning until the end. But in retrospect and in the light of some developments that I came to know about later, I think that that department was formed in that fashion for very tangible reasons that were never expressed, but

which I think were there.

ROSEBERRY: What were some of those reasons?

ESTES: The mid-1960s were significant in many ways. But there was a large activity in the state to get family medicine reactivated because towns all over the state were experiencing a shortage of doctors. And general practitioners of that time would get together at meetings and talk about their plight. One of the reasons that they envisioned as the cause of their problem was the fact that there was no organized training for a general practice. One of the ideas was that we ought to have a new specialty of family practice or family medicine. That ferment was very strong in this state because there was an individual in the state who was the head of the American Academy of General Practitioners. He was a very powerful man politically, not only in the state but also nationally. He was agitating around the state for existing medical schools to take on this challenge and form new departments of family practice and to counteract the trend towards specialization by doing this.

ROSEBERRY: What was his name?

ESTES: Dr. Amos Johnson, who practiced in Garland, G-a-r-l-a-n-d, North Carolina. A remarkable man. His name will come up many times, because he also had the prototype, self-trained physician's assistant (*laughs*) that Dr. Stead has mentioned many times in his description of the early days of the PA program. Well, Amos Johnson sent all of his patients to Duke and had lots of connections here at Duke. One of them was Dr. William DeMaria, who was a pediatrician. Bill DeMaria was a general pediatrician, took care of the kids of most of the faculty here. But he got together with Dr. Johnson and talked about having a Department of Family Practice at Duke. Bill DeMaria recruited Dr. David Smith, who was a well-known and revered internist and tuberculosis specialist at Duke. He had recruited Dave Smith on his side, and so

they were making a lot of moves to get someone interested in starting a Department of Family Practice. He even had a scheme for getting space. He said, "Well—." This was the time of racial integration as well, and every bathroom at Duke was really four bathrooms: white and black male and white and black female. He put together a paper saying that if we took every—if we took all the black bathrooms that had been freed up by integration, then we'll have enough space at Duke to have a Department of Family Practice. Well, that movement was taking some force or was acquiring some force politically within the state. And the departments here were not only not enamored of that idea, they were actively in opposition to it. And in retrospect, I think the election to form a Department of Community Health Sciences was the answer to that movement, and it was a negative answer.

ROSEBERRY: An appeasing answer?

ESTES: An appeasing answer, because it was a way of getting at the problem without actually forming a Department of Family Practice. And there were department chairs here who actively expressed their vehement opposition to the idea of training generalists. Dr. Sabiston, head of Surgery, has said this in my presence, that he could not stomach (*laughs*) the training of generalist physicians. That Duke was at the cutting edge. And to go back and train generalists was to go back to 1920s medicine. He felt this very strongly. But others shared that opinion. The Department of Medicine under Dr. Wyngaarden shared that opinion. And I think I was chosen for this job because I was a traditionalist. I had grown up under Dr. Stead as a cardiologist, and I had worked in a laboratory, and I understood writing papers, I understood academics, and I understood the system here at Duke. So my choice was as a person who would agree with that prevailing notion rather than go out and do something wild. (*laughs*)

ROSEBERRY: Stir things up.

ESTES: Yeah. So anyway, I took over this department. The general idea was that we would form a department that would use disciplines such as sociology and economics and computers and management in order to solve the problems of rural North Carolina without actually creating a generalist.

ROSEBERRY: How was that possible?

ESTES: Well, the PA program was a part of it, too, because Gene Stead had started the PA program some years before that, a couple of years before that. And we were now turning out our first class of PAs. As soon as I accepted this job, Gene Stead was at that moment planning his retirement at the end of 1966. He had announced when he came that he was going to retire in twenty years, and he came in '46, and he retired in '66. Well, he came to me and said, "Now, look, I've got this PA program in the Department of Medicine—" and I had been a part of it from the start, because I'd been one of the original teachers. So I was familiar with it, familiar with all the people involved with it. And Gene Stead said, "My successor, Dr. Wyngaarden is not interested in the PA program. It doesn't fit his mission. It doesn't fit his future. It does fit yours, because it's a solution to rural communities. And so I'd like to transfer, before I retire, to your department (*sound of heavy traffic outside*) and give you the responsibility, the duty of taking care of it, because I'm going to be away." Well, we quickly agreed that this is a logical fit with my new department, and it was not with Medicine. So at that moment I took over the new PA program, and our department has had it ever since. And along with it a lot of challenges about how to regulate and how to get it established and how to spread it over the country. By the way, I just heard yesterday that there are more PA programs in the country now than there are medical schools.

ROSEBERRY: Wow! That's quite a statement.

ESTES: So it's quite a thing after thirty years. But anyway, Duke and Bowman Gray were the only two places that had PA Programs at that point. So it was a brand-new fledgling kind of thing. But, okay, the department was formed with a notion that we were going to solve these problems without training family doctors. But it soon became fairly apparent that the lack of generalists was a major impediment to getting medical care. You can't have PAs out there if there are no supervising physicians anywhere.

ROSEBERRY: So the PAs were doing the work, and the generalists were missing?

ESTES: Well, for example, there are some very heartwarming stories from the times when we actually plugged PAs into a number of these practices, and it worked.

ROSEBERRY: Okay.

ESTES: And I can remember one two-man general practice in Plymouth, North Carolina, way down east, near the coast. Two older doctors, one of them was in his late seventies and the other was in his early seventies. Had tried for many years to get a partner and could not. One of our first PA graduates went there and literally saved the practice, because the older of the two doctors had a quite serious heart attack as soon as our PA got there. So pretty soon it was one doctor and one PA, and they carried that clinic for another ten or twenty years. But it's situations like that in which, if there had not been a doctor there, the PA could not have come. So it quickly became apparent that we needed some generalist physicians, too. And we actually made some early inquiries here at Duke about starting a family practice program and learned that it would not fly. We actually tried a couple of times to do it at Duke. But nobody was in favor of having a program here. Let me step back just one bit, because the mechanisms we were going to use to solve the problems were first of all to use computers. And to—we brought aboard a group of people who would be called medical information specialists now, but which were then

computerniks (*Roseberry chuckles*) who were playing with small computers and bigger computers. We were interested in self-administered medical histories, medical examination forms that could be mark sensed—computer interpreted—so by just making a checkmark on a page, these things could go in and be combined with the medical history form and print a history and physical without the doctor or his secretary being involved. We worked on these things and actually did them, and they were successful. We had responsibility for student health here at Duke, and we did some papers and studies of self-administered decision trees in caring for sore throats, for example. The decision as to whether you need a culture and antibiotics, for example, could be made with fairly simple rules. And if the patient filled out a questionnaire, which we could then feed into the computer immediately, the decision, the correct decision could be made by the computer as to whether they needed treatment with antibiotics. Actually the computer was better than doctors, because doctors are often influenced by how sick the patient looks and talks. So they make decisions not on the basis of rationality but on the basis of sympathy. (*laughter*) So the computer actually did better than doctors. But it's not a popular answer. (*laughter*) Particularly in medical schools.

ROSEBERRY: (*speaking at same time*) It gets rid of doctors. (*laughter*)

ESTES: But at any rate, this is the kind of thing we were doing. We were trying to use research, computers, and PAs were part of the plan, and also management was a part of the plan. Putting together a system that used computers and PAs and sympathetic doctors in a system was one of the questions to be asked. And this led to one of the early crises in the new department, because one of our plans was to start a new clinic across town. It was not to be at Duke Hospital. It was to be at the community hospital, which was at that time Watts Hospital. And we were to organize it in a different way so that it would use these things that we were experimenting with. We chose

three young men who had finished our training program here at Duke. We rented a building, and we actually caused the building to be built by Mrs. Frances (Hill) Fox (trained as a physician and once a faculty member at Duke. Daughter of John Sprunt Hill, founder of Central Carolina Bank and many other Durham enterprises) who owned Croasdaile Dairy at that time and had the means to do it. So she built a building on Hillandale Road that was to house our new clinic. The clinic was to start operating, when we got word that there was major opposition within the medical school to our new clinic. The opposition centered around the fact that we were going to form—and I'll quote here, "a Lahey Clinic in our backyard to be a major competitor—"

ROSEBERRY: I see.

ESTES: "—from within our home, the mother church." (*laughs*)

ROSEBERRY: Oh, no.

ESTES: And so there was major opposition with the existing departments and in the existing PDC structure at Duke. Dr. Anlyan was the new dean at that moment, and these complaints came to him, not to me. He had supported us and continued to support us. But he felt that this needed to be resolved. And there was an early extraordinary meeting that was called. It was called at the Medical Private Diagnostic Clinic meeting room at ten o'clock on Sunday morning. All of the Private Diagnostic Clinic people who had expressed opposition to this were supposed to be there. And this issue was to be argued out. I was, of course, summoned to be at the meeting and defend it.

ROSEBERRY: May I turn our tape just a moment?

ESTES: Yes.

(*tape 1, side one ends; side 2 begins*)

ROSEBERRY: We had stopped at kind of an important moment. You were in the middle of a

meeting?

ESTES: Yes, telling about this extraordinary meeting.

ROSEBERRY: Yes.

ESTES: I had been on a trip to New York or someplace. And on the way back from the trip—this was just before this meeting, I think Friday before the meeting—and I flew back on the plane with Evelyn Stead, Dr. Stead's wife. And I happened to sit next to her on the plane. I told her about this little problem (*laughing*) we were having. Dr. Stead was spending that year as visiting scholar, I guess you'd say, with the Commonwealth Fund in New York in order to get out of Dr. Wyngaarden's hair while he was taking over reins for the new department. She listened to my story about this meeting the next day, and she mentioned that Dr. Stead was going to be flying back from New York that night, later, maybe the next day, and she would tell him about it. And sure enough, when he returned home, he called me to find out what time and so forth. He appeared at the meeting and literally excoriated the group for doubting that this little fledgling clinic should be. His comment was that this was their own trainees who were trying to start something new and trying to do it in a new way and that it was absolutely unthinkable that they would oppose this. They should help it in any way they could. At the end of his speech there was no argument. Everybody put up their hand and voted for it. At which point they phoned Dr. Anlyan, who was in his office waiting for the result, that the decision was made to go on with the clinic. Well, in retrospect, the clinic didn't fly not because it was a bad idea, but because the people we chose were not really as committed as we thought they were. One departed to go to Montana within a—actually he never started, because he got a better offer. (*laughs*) The other—we actually started the clinic, but the other one proved not to be as committed to new things as possible, and it didn't work. But the clinic did form, and it still operated for many, many years.

But it wasn't our clinic, and it wasn't the model that we had envisioned. By the way, I just saw Dr. Davison's picture outside. There's a little insert that I ought to make about Dr. Davison. Dr. Davison was a pediatrician. One of his favorite people at Duke was Bill DeMaria. And Dr. Davison was quite openly in favor of starting a Department of Family Practice. He had retired as dean when all of this was being debated. But was still very much in evidence and still maintained his little one-room office, the first door on the left as you entered the Davison Building from the campus. So Dr. Davison still had a very benign but influential eye on the medical school and how it was going. This decision to form a department that was experimental and did not encompass family medicine was not exactly what Dr. Davison had in mind. He was very much for this.

ROSEBERRY: For family medicine?

ESTES: Yes. And Bill DeMaria and his scheme was what he wanted. So my new department was not exactly what Dr. Davison had in mind. And I remember he also had a house in the mountains where he spent most of his time. So I remember going up there and talking to him at his mountain house to try to assuage him that we really were devoted to doing what we'd said we were going to do, trying to help rural North Carolina. It was an interesting trip, and I respected Dr. Davison and what he thought, and I can see why he didn't trust me and the way we were going about it. I think he understood the political situation at Duke probably even better than I did at the moment. But back to the plan here at Duke: we felt that medical centers should operate in cooperation and in synchrony with doctors in the community. And we wanted to do this here in Durham.

ROSEBERRY: This is your department, felt this.

ESTES: We bought a trailer and put it out behind Watts Hospital and put our office, our

departmental office, a branch thereof, at Watts Hospital. This office was there and was staffed by a very skilled group of young women who were wives of house staff at Duke, whose job it was to bring Duke library, Duke research facilities, whatever they needed in the way of academic support to them at the local community hospital. So this building was within two minutes of their parking lot. You could walk from the Watts Hospital into our office, find somebody there who would listen to the problem you wanted solved and help you solve it utilizing the resources at Duke to do that. We paid for the building, and we paid for the person, for the search and everything else. Well, at that point in time the residency program at Watts Hospital was in full swing. I mean, Watts had its own independent surgical residency, medical residency, and these people were the house staff at Watts Hospital. But they were in trouble, because they could not recruit US medical graduates. They couldn't fill their ranks from graduates of our own medical schools. So they had to go overseas. Indians, Near Easterners, Filipinos, and others had to be recruited for those spots. Many times they came here without good command of the English language. So our staff at Watts Hospital began to teach English language courses for house staff that couldn't quite understand the lingo. So we got very involved with the house staff problems at Watts Hospital. The surgical residency bit the dust about this time, and the medical residency was the only one left. The chief of the medical service at the Watts Hospital, Dr. Edward Williams, and I began to talk about the possibility of replacing their residency at Watts Hospital with a new residency in family medicine. Not at Duke, but at Watts Hospital. So out of those discussions came a proposal to Duke to form the Duke-Watts Family Medicine Residency and to replace the current medical house staff at Watts Hospital with family medicine residents. We actually got approval for that after some discussion. And we started the family medicine residency. One of the requirements for a family medicine residency is that you have a clinic

building and that the clinic look like a normal doctor's office and that residents be trained to take care of their own patients in their own teaching clinic. We rented a building on Broad Street not too far from Watts Hospital, an old house that had been once a general practitioner's office, that of Dr. Waldo Boone (was a very popular and beloved GP in Durham) , who was an older general practitioner in Durham. We bought his office when he retired from practice and started our family practice clinic building there. We hired a physician from Smithfield, North Carolina, to come here and take over the direction of the clinic as director of the practice, which he did, and did it well. But he could never forget his patients. In fact, he would go back to Smithfield every weekend and see his patients. (*laughs*) He really had two jobs: one here and one there. And after a period of about a year, it was pretty obvious that he would never dig his heels in here. His heart was back in Smithfield. So he went back there, took over his old practice. He wasn't having any luck replacing himself, either, (*laughter*) in Smithfield. So he went back and took over his old practice, leaving us without a chief. We contacted the chair of the new department at the University of Rochester in Rochester, New York, which was one of the first family medicine programs that actually started, and talked to him about our problem. He recommended a young man named William Kane, who went by the name of "Terry" after a comic strip of that time. (*laughs*) He said, "Now, if you get this man, he's very young, he's very inexperienced, and he's just been in practice about two years. But if you get him, you will have, I think, the best man in the country." So we called Dr. Terry Kane, induced him to come here as our new chief, and never regretted it, never looked back. Because Terry was exactly what we needed: a young, charismatic family doctor trained in the new system who knew how to do it. Very much identified with the new residents who were fighting all kinds of battles. Very much understood the intellectual battles that were being waged between traditional academic medicine and this

new upstart breed of people. So Terry came and brought with him a man named David Hunter (he later founded Hunter and associates, a nationally recognized hospital "rescue" firm, taking over operation of financially distressed hospitals and putting them back in "the black"), who was his business manager trained as a hospital administrator. And together Dave and Terry got us the money for a new building, which we built and occupied on the campus of the new Durham General Hospital. Watts Hospital had phased out in this interim, and we moved to the new Durham General in a brand-new building, better than anything we've ever had since. (*laughter*) It was designed for exactly what we were going to do. We quickly became one of the most popular programs in the country, and we always got our choice of residents. They were good residents, and many of them are still here, including the current chair of our department. (*laughs*) So anyway, the Family Medicine Program came to be, though we were formed originally in order to prevent that. (*Roseberry laughs*) Now, okay, that leads to the next phase, and that's how family medicine came to be a sort of thorn in the side of Duke, and this led to an attempt to remove it and a very serious attempt. That's an interesting story, which begins with one patient. Our clinic at Durham General was a clinic that signed on with some of the new HMOs in the area. And we quickly began to recruit a group of very loyal patients who came there and saw their family doctor. Our doctors, including the faculty, were not allowed to use Duke Hospital. But they were on the staff of Durham General. So when we saw a patient at our new clinic and this patient needed to be admitted to the hospital, they were admitted to Durham General rather than Duke Medical Center. Among our patients were quite a number of Duke faculty who could not find a primary doctor at Duke. So one of these patients came in our clinic one day with pneumonia and was hospitalized by our faculty member who was his doctor. He needed to come into the hospital and did come into the hospital under the care of our faculty member. It happened that this patient

was a Duke faculty member who had been the patient of Dr. David Paulson, who was chief of the Urology Service at the time. And Dr. Paulson had done a prostatectomy on him. While this patient was in the hospital, our faculty member-slash-his physician said, "Would you like someone to check your prostate while you're here?" "Yes, that would be very convenient." So he called in a man who had just entered practice at Durham General who had been up until that point a faculty member under Dr. Paulson here at Duke. So he asked this man to see him. He did, and everything was fine. He gave the patient that information, and it was over and done with. But the next time this urologist saw Dr. Paulson at a cocktail party, he said, "By the way, I saw your patient, Dr. So-and-so, at Durham General, and he's doing great." "What do you mean you've seen my patient?" "Yes, he was a patient at Durham General, and I was asked to see him, and I did. He's doing fine." Dr. Paulson was incensed at this because his patient had been seen by a competitor across town. (*laughter*) So he went back to his chief, Dr. Sabiston, and said, "Do you know what's going on? Our Duke Family Medicine faculty are calling on Durham physicians that are our competitors to see our Duke patients. This is not right, and we ought to protest it."

ROSEBERRY: Dr. Sabiston already had expressed some mistrust.

ESTES: He had already expressed his opinion that this was a bad thing. But HMOs were here, and HMOs were dictating that patients be followed by their primary physician. So life was a little different than it had been. Okay. This feeling was expressed in the meeting of department chairs, and other departments were brought into the picture, because this same thing was happening in Medicine and other services. So behind the scenes and unknown to me, department chairs were getting together, talking about this, and they talked about it to the point that they came to see Dr. Anlyan and said this had to stop. We can't tolerate Duke being diluted this way or being competed with this way because this is becoming a significant financial loss.

ROSEBERRY: So not just your department but in other ways as well.

ESTES: Right.

ROSEBERRY: I see.

ESTES: And they demanded that Duke stop its affiliation with this Family Medicine Program and have nothing to do with it. So this feeling came to Dr. Anlyan, backed by his department chairs, except for me, and I knew nothing of it. (*laughter*) He called me in to talk to me about this, and he said, "This is so serious, I'm going to get some outside objective opinions." So he employed Lewin & Associates. Larry Lewin was well known to me and to Bill Anlyan. His office was in Washington, and he did consulting work for medical centers all over the US. And if Larry Lewin's outfit said it was so, it must be so. So he hired Lewin to come and not only survey the opinions here at Duke but also to go out in the state and look at the impact our department was having out there, whether we were doing our job, whether we had a job to do, whether there was a genuine need out there. So Lewin & Company spent about six months with two or three people going around the state gathering information and putting all this together in the form of a report, which they delivered in I guess April or May of 1985. Lewin's conclusions were quite clear: You've either got to admit that this department is part of you and begin to cooperate with it, or you've got to extrude it and wash your hands of it. But there is a real need. And you've got to realize that you are training your own competition, and they're going to go out and compete with you, and this department is your only countervailing force to this, because this department is training the generalists that are going out there who are seeing large volumes of patients and who are referring large volumes of patients. And if they are trained at Duke and they are favorable to Duke and they see Duke not as an enemy but as a friend, they will send their patients here. So there were both sides of this issue. After this presentation, all of them except me

went to a meeting to decide what they were going to do.

ROSEBERRY: Did you have any awareness that this was going on?

ESTES: Oh, I knew it was going on. I did at this point.

ROSEBERRY: Okay.

ESTES: And they came back and said, "We've concluded that we need to get rid of family medicine." And so Dr. Anlyan came in, and I think with some reluctance, told me that the other departments had voted that the Family Medicine Department would cease to exist.

ROSEBERRY: Was this because they didn't—was it still the feeling of generalists?

ESTES: Yes.

ROSEBERRY: They didn't want to integrate the generalists into their system?

ESTES: Right. That it was a step backwards. Anyway, I got the news that my Division of Family Medicine had to phase out of business. They would allow the current residents who were there to finish out their training, and at that point it would no longer exist. The rest of my department could remain, and I would remain until my retirement, which was then—I was then sixty years of age, and so my retirement was looming five years' hence. So I could stay as a professor and chairman until that point. But then I had to go. I had thought of this, of course, and elected to resign as chair but to stay as a member of the faculty and to fight it. This wasn't hard to do because the Academy of Family Physicians in the state was actively cooperating with my new Division of Family Practice. They quickly contacted all the family doctors in the state and others, and it became widely known. So people began to write and say, If you do this, I'm never going to send another patient there. So the weight of evidence was that not only was the department needed, but it was supported, and that there would be a price to pay if this were done. So Dr. Anlyan back-pedaled. And in June it was decided that it would be accepted as member of Duke

University, and the decision was reversed. So the department stayed, but I was no longer the chair. And George Parkerson, who had been a faculty member for many years before that decision was made, took over as the chairperson.

ROSEBERRY: Why not reinstate you as chair? Or had it already been done?

ESTES: This had already been done, and that was the price I paid. Well, that was fine. George took over and did a good job. But the program did shrink in size. It had been thirteen residents a year and went back to eight. So the election was to bring it back to Duke and to put it in the Pickens Building and to give up the building at Durham General, which was far better than Pickens as a place for our headquarters. So we paid a price, too. But the program is still there and still doing well, and I think the department has done well. But that's when I stepped down and became a geriatrician at that point. (*laughter*)

ROSEBERRY: Within a division of your—

ESTES: Within a division of my old department. But it's been a fascinating sort of struggle, I guess you'd say, from start to finish with the entrenched academics who really had no understanding of this. But it's kind of interesting to look back at the department and the fact that it was out there fighting some battles that the whole medical center is now fighting. (*laughs*) Because part of training a family doctor at that point was training him to be cognizant of how much things cost, because he was at the front line, and he had—or she. And by the way, this is another thing. Our department attracted young women. One year we had thirteen new residents, and eleven were women. (*laughs*) So we trained a lot of young women. The problem—

ROSEBERRY: Could that also have been part of maybe why it wasn't as acceptable?

ESTES: I doubt it. Because they were taking more women as well.

ROSEBERRY: Okay.

ESTES: But we were ahead of the curve in accepting young women. And I guess they viewed—many of them viewed their role as a more nurturing family doctor rather than a hard-nosed specialist who was treating patients and sending them back to the generalist physician. But the role of economics, the fact that you had to think about organization. You had to think about how you fit into the community. Now the medical center as a whole has to do that. We trained our young physicians how to be a business manager of the office, how to hire and how to fire, how to look at a financial statement. Now Dr. Snyderman and his successor are having to do this from the standpoint of the medical center as a whole. How it fits into the state, how it fits into the country. And it's not just how many papers you write and how many grants you get. It's an economic entity that's important to the state and to the community. Our old department—or my old department—is heavily involved with delivering medical care in the community, and I hope will continue to be. I think it's doing a good job, and it's what we were supposed to do.

(*tape 1, side 2 ends; tape 2 begins*)

ESTES: —how the department is now very much a part of the warp and woof of taking care of people in Durham, Durham city, Durham County, and we're involved with Lincoln. Lincoln has—we didn't start Lincoln, and we didn't have very much to do with it. This was very much Charlie Watts, a local black surgeon who did that in cooperation with the School of Public Health at Chapel Hill. But it's interesting that our department started satellite clinics. We had a satellite clinic in Rougemont, which was later brought into the Lincoln system. And we had a satellite clinic in a church in the Dearborn Street section of Durham, which was later sort of merged back into Lincoln because it was too close to Lincoln to justify a building, a new building, and that sort of thing. So we did things that were later made part of Lincoln. And I'm glad we're still doing that because we're still working with Lincoln and putting residents there

and cooperating with them on projects and so forth that are very much a part of Durham and its care for the underserved. So I think we're doing that, and I'm proud of it. And I think we are Duke's wing that does interface with the community. I don't think we are as tuned, if you will, to the state as we could be. But you can only do so much. At one time we were fairly closely attuned to the Academy of Family Physicians in the state, and I think we still are, but perhaps not quite to the extent that we were when Terry Kane was here. Of course, Terry was a quite powerful figure, not only within but without. But that was Terry, not me. (*laughs*) But Terry is still here, by the way, and is still teaching a course here at Duke. He's retired. He's been a very active figure in HMOs, trying to run them right, and I think gave up. (*laughter*) But he knows a lot. Also Dr. [Samuel] Warburton. Dr. Warburton became medical director of Aetna in Philadelphia, but still lives here in Durham and still is active at Duke, and has come back after retirement from Aetna. And has a part-time teaching role at Duke right now. So these people that were very active in the Family Medicine Program are coming back to try to help the department even now. So I think they view it as a worthwhile endeavor.

ROSEBERRY: Has the mission of the department changed since its beginning?

ESTES: I don't think so. I think the mission is still to work with people and how they get medical care and how medical care is organized. It's the link between people and the medical establishment that is our mission. It's a very complicated mission. It's one that I don't think we—I don't mean this is a slur, but because of its complexity, it's very difficult. And you cannot from one place influence something that touches so many lives with so much money when you realize that of every dollar we spend, about fifteen cents goes into health care. Now, that’s a lot of money. Every dollar you and I spend, fifteen cents is spent in the medical care system. Very little of it goes to the front end. Most of its goes to attempts to save lives at the very end of life.

ROSEBERRY: You mean chronologically in life?

ESTES: We don't spend a great deal on primary care and prevention. But we spend a lot when people have a stroke or a heart attack or need a pacemaker or get the cancer treated.

ROSEBERRY: Reactive.

ESTES: Reactive. And we are not as effective as I wish we were in prevention, taking care of things before they start, putting off the heart attack for fifteen years further before it occurs. We'd like to see that pushed away and less spent out there and more spent up here. We'd all lead better lives from it. And to an extent, this is the role of every physician, including the specialties at Duke. And I don't think we're as effective as we could be or should be. But it's a complex role, and we are just a little piece in it. We also had another division back there. We had five divisions. A computer division, which today would be called the informatics division. We had family medicine. We had an occupational medicine division, which is still functioning and still quite important; but we worked with industries and occupational groups to help them with the problems of medical care in their workforce and preventing illness in that workforce, making their products safer. We had a division that was formed with support of the rest of the department in mind, and this was a division that took care of obese people. We formed a division that was strictly to take care of morbidly obese people, trying to train them, educate them to manage themselves. And we did that. This became the Duke Diet and Fitness Center, and we bought an old YMCA building, which I guess the department still owns. It's down on Duke Street near town. We brought people in for a month or two months, a live-in experience, and it was expensive. And we attracted people who had money and the ability to do this. But they lived across the street in an apartment complex, and came across the street every day, and they ate all their meals there. We had an Olympic-sized swimming pool.

ROSEBERRY: Is this in competition with the rice diet?

ESTES: Yes. It competed with the rice diet, and it competed for the same patients. But we took them—we had a teaching kitchen, we taught them how to prepare food. We had teaching trips to the grocery store, which we had a faculty person, usually a dietician that would take the obese person and take them shopping, bring them back and prepare a meal which everybody ate. (*laughs*) And it had a mirror overhead so you could see how the food was prepared. We had lectures every day on medical topics of importance to the group. We did it well. They gained a lot of educational insight as to why they were obese. We had a clinical psychologist on the faculty who taught them why they ate and to look for why they succumbed. And I think we did a good job. It's still there, by the way, and still works. And it makes money. The money that it makes feeds the rest of the department. So we knew why it was there. But we still did a good job for the patient and still do. Very skilled people run it, and these people are very sick people, and they need a lot of attention and a lot of care, and they got it. We had two physicians that took care of them, examined them each and every one, and took care of their medical problems. Referred them to people at Duke to take care of major problems. It's an excellent program. Well, this is what we did. We covered a lot of ground. Still covers a lot of ground.

ROSEBERRY: Sounds like it's a very proactive program. Outreach.

ESTES: This is what it's supposed to be and, I think, has been. I understand and continue to understand, the way Duke functions, and I admire and respect what other departments do. But I think our role is different. I think the thing we've had to fight is the fact that our department was viewed as inferior to, and in some way not equal to, what Duke was doing. And I think it's equally important to what they do. So my opinion hasn't changed on that. I think it's an equal department that needs equal emphasis, but sometimes it doesn't get that. (*laughter*)

ROSEBERRY: Is that even still?

ESTES: I suspect it still is. But it's interesting that—it's bigger than training doctors to go out and be family doctors, because I still think that the economic aspects of medical care don't receive as much attention as it should get. I think you could say the same for our department now. But there's not a soul running departments who's ever had to meet a payroll on Friday afternoon. They don't understand what it means to have money in the bank to pay your employees, which is what every business faces. And medical care is 15 percent of everything they pay out. Now, making that 14 percent instead of 15 is a big deal. But ordering tests, being careful with the use of medical care, ordering tests wisely, demanding proof that something works before you buy it is part of what we've been about. And I wish it were more so in every department. But again, that's a big job.

ROSEBERRY: Your emphasis on that has been because perhaps someone would go out and start their own general practice?

ESTES: Yes. And they understand, because they see them at home, and they make house calls, and they know who they work for in a small town. And they know the impact of medical care and medical care expenses. And they know what it's like to take care of people who don't have any insurance. They do a lot of this on the cuff. I think that's part of what we've been about. And I think it's good for a doctor to know some of that.

ROSEBERRY: Well, Sir, is there anything that I should have asked you and didn't? Or anything that you'd like to add to this?

ESTES: Well, we haven't mentioned the PA Division, which is the fifth division.

ROSEBERRY: Yes. Okay.

ESTES: The PA Division has been a part of our department from scratch, almost. Now, Gene

Stead started it, but it's been ours since. And we brought aboard someone who is now dead, Robert Howard. Bob Howard was the medical director—or was the director—of the PA Division for many years, and he had the job of trying to get it recognized and regulated properly and to set up a system in which they could practice out there. We in the early days got a ruling from the attorney general in the state that PAs could work under a doctor and could be, in effect, an extension of that doctor's license to practice. But this is a very slim authority on which to operate. Many PAs were going out in other states, and we had to worry then about how they were going to be regulated. So we had the job of forming or really creating laws that allowed them to practice. And we formulated an early model practice act, which was debated by legal scholars in conferences that we sponsored. We were one of the first two or three states to pass a model practice act that let PAs practice. This has been the model for practice acts in other states and for—not in a negative way but in an unintended way, it's been a model for nurse practitioner incorporation into practice which some nursing groups have not agreed with. But we also had the responsibility of accrediting PA programs. We were *the* first. And when three or four or five or ten more came along, we then had to be about the business of making sure that a given program was worthy of the name, their products were worthy of the name *physician assistant*, and to be very jealous of that. Very soon after our start there was a program that started in Atlanta with strictly financial purposes to train, quote, "physician assistants." They would bring them in for four or six weeks and given them a piece of paper that said, I'm a physician assistant. Well, now that name is protected. You can't use it. And we had to get that established, so that you couldn't call yourself a physician assistant unless you met some credentials. So we had an accreditation process. We had an accreditation of a physician assistant program. They had to work with AMA and with the College of Surgeons and the College of Physicians and the Academy of Family

Physicians to get a group formed to accredit PA programs. And that we, I think, can be very proud of. We've got a system now for all of that which is in place as a part of the work of our old PA division. It's still there, but that's been done. But I think we've been at the forefront of educating PAs, and we've learned a lot. I wrote a paper back there, over twenty years ago now, that said medical education has a lot to learn from PA education, which trains someone to go out and practice in two years, as opposed to the medical practitioner who has four years of college, four years of medical school; three, sometimes four years of medical training. So twelve years versus two. (*Roseberry laughs*) It's much more cost effective to train a PA than it is an MD. And they are more and more shoulder-to-shoulder with the physicians doing exactly the same type of work. We can learn a lot. Medical school does not have to be as lengthy as it is. It doesn't have to be as complex as it is. It doesn't have to teach everything an MD learns. And we can learn that from the PA program. And we can learn that it's important to look at what the community needs because the PA succeeded and continues to succeed because it meets a need, chiefly a financial need. Train a PA. The PA makes half as much as a doctor. So you can pay two PAs for what it costs to pay one doctor. And they can each see as many patients as one doctor. That's the chief thing that makes them popular. (*laughter*) We educate, we have done some experimentation. We've done some things that later have been incorporated into the medical school that started as part of the PA program. The PA program ten years before the medical school used trained patients, actors as patients. We trained ten years of PA students with paid models for learning how to do a pelvic exam. PAs did that ten years before the medical school did. And we got it in the medical school because the medical students began to realize that the PAs knew more about a pelvic exam than they did. Why? Well, we've been trained. How did you get trained? Well, we've been trained by paid models who provide a perspective that you don't get (*laughing*) any

other way. Well, the medical school does it now. The PA program can be the model for medical education in a very quick way. Because we can measure it five years out instead of fifteen years out. And we invite medical schools to take a look. (*laughs*) It's worth knowing that this occurs. Well, anyway, it's been a good run.

ROSEBERRY: Great. It sounds exciting. It sounds exciting, that PA Program.

ESTES: Well, that's more than you wanted to know.

ROSEBERRY: Oh, that was wonderful. Well, I appreciate it. Is there anything further?

ESTES: No. I can't think of anything.

ROSEBERRY: Well, thank you very much, Sir, for your taking your time this morning.

ESTES: Thank you. This was all worth somebody knowing about someday.

ROSEBERRY: Yes.

(*end of interview*)