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INTERVIEWEE: Walker Blair

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TOPIC: How medicine in North Carolina changed after World War II as a result of new technology, federal health programs, insurance, and desegregation. This interview covers Dr. Blair's early life and medical education at UNC at Chapel Hill and the University of Pennsylvania; his subsequent training at Penn's University Hospital during the Korean War; his assignment to the Naval Hospital at San Diego, CA; his early practice in Burlington beginning in 1953; his experiences with new technology, pharmaceuticals, and the increasing regulation of medicine; the interference of third parties on the doctor-patient relationship; the transition from private proprietary hospitals to public hospitals and the growth of Health Management Organizations (HMOs); medicine as a "cottage industry" and the impact of "socialized medicine" and programs such as Medicare; the difficulty of attracting general practice physicians to underserved areas, and the impact of graduated fee schedules; transition from segregated Alamance County Hospital to new, desegregated Alamance General; and differences in levels of federal control between the Hill-Burton hospital construction program and Medicare.

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[Begin Tape 1, Side A]

Intro announcement.

WALKER BLAIR: I was born July 15, 1924 in Pittsboro, North Carolina, a small town in Chatham County. I was raised adjacent to the town, but we had a 600 acre farm. Primarily we ran it as a dairy farm, but also had 4 or 5 tenant families raising cotton, which was not all that good, but you couldn't raise tobacco in Chatham County because of the land. I graduated from Pittsboro High School, which was located 3 blocks from my home. It was a grammar school and high school all in one building. I received a very good education in the public schools at that time. There were only about 40 students in each class, divided into two sections. There was no problem as far as who was boss—The principal was

boss, and the teachers were boss because all they had to do was mention the principal, and that straightened us out.

I went to the University of North Carolina in 1941. I was maybe a little bit behind the students who came from prep schools my first year, but since they were ahead and tended not to work quite as diligently, by the end of the first year, I had caught up with them, and really thought my basic education in public schools was very good. The war started, and consequently I was only allowed three years of undergraduate work. I had mostly science, and relatively little time to take as much history and so forth as I would have liked. Went to school twelve months a year from the time I started until I graduated from medical school.

I started medical school in 1944, and finished the two years at the Medical School at the University of North Carolina eighteen months later. At that time, we only had a two-year medical school, and all students transferred. I was seventh in a class of approximately 45. I transferred to the University of Pennsylvania and stayed there six years. Two years my junior and senior years in medical school. I made AOA, which is the equivalent of Phi Beta Kappa in medical school. I stayed at the University Hospital for an additional four years, one year internship and three years in internal medicine.

The Korean War was going on at the time, and since I had not served except in D-12 during the war, while I was in med school, it was my turn. I was attached to the First Marine Corps Evacuation Hospital, stationed in San Diego, California. I thought I was going overseas within a week of when I arrived there, and stayed there on additional duty for the two years I was in the Navy. That was my first introduction to the inefficiency of the armed forces.

We were scheduled to go over and back up the First Marine Corps Division, the Marines being attached the Navy and the Naval Hospital attached to the Marines. But the Army said once we set foot on Korean soil, it would be under Army command, and the Navy said, we'll have none of that. We'll just keep these boys and 400 corpsmen in Southern California, since we can't command them after they land. We actually worked the entire time we were there, so it was not a waste. Half of us were assigned to the Naval Hospital at San Diego, and half of us were assigned to the Naval Hospital at Camp Pendleton, the Marine base about 40 miles north of San Diego.

I was at the Naval Hospital in San Diego the first part, and then they switched us to be fair. I had the last part of my training at Camp Pendleton. Both of these hospitals were busy taking care of boys who came to go to boot camp with the Navy at San Diego and the Marines at Camp Pendleton. The orthopedist and the dental group who took care of facial injuries were particularly busy, not from war casualties, but the casualties of Highway 101, which was the only real road going up from San Diego to Los Angeles. These boys were young, going overseas, and so from five in the afternoon until one the next morning, they kept that three-lane highway with two-lane bridges busy, and the ambulances busy bringing them in.

I finished my tour of duty there, and wanted to come back to North Carolina. I had three criteria: I didn't want to be too far from my family and where I was raised, I didn't want to be too far from Chapel Hill, and wanted to go where I was needed so I could make a living immediately, since I didn't have any money in the bank. I borrowed $4,000 from my father to buy medical equipment and started practicing by myself. I was busy from the day I set foot in the office. I had

a contact or two that immediately began to refer me patients, plus there was a shortage of physicians. My training was in general internal medicine. At that time, the internist was the cardiologist, the gastrointerologist, and the pulmonary man all wrapped into one. I had had a year in cardiology and a year in gastrointerology in my four years of post-graduate training. I had a very busy and satisfying practice.

KAREN KRUSE THOMAS: So you set up practice by yourself in an office. Were you connected with a hospital?

WB: No. My office was rented from the heirs of a general practitioner who had died just a year or so before I came to town. One of my contacts made arrangements for me to rent the office the day I started practice. I remained in that office until I and others built an office building across from the new hospital, about 1960.

KKT: This was in Burlington, where you spent your whole practice.

WB: Yes, it was in the middle of downtown, between the Catholic Church and the Christian Church. We sold our office space to the Catholic Church because both of them really needed the property, but the Christian Church people talked a lot and did nothing, and the Catholics said they'd take the building and offered a fair price, so we sold it to them. This was about 1960.

KKT: What year did you start practicing in Burlington?

WB: 1953. Shortly after I started practicing, I realized that practicing by yourself and being on call 24 hours a day, seven days a week, 52 weeks a year was sort of tough. I started to search for a partner, and while I was visiting my wife's family in Atlanta at Christmas time, after I'd been here two and a half years, a good friend of mine, John Howard, who was only four or five years older

than me, had become chief of surgery at Emory. I went out with John, and asked him if he knew anyone I might contact, and he immediately said there was a physician who was just finishing his residency named Jim Lee, and wanted to practice in a relatively small town. It turned out, as time passed, that he really wanted to stay there in academic medicine, but his wife wanted to go to a small town, so that was the end of that. Jim was an excellent physician, and an excellent partner.

KKT: He started with you in what year?

WB: He came July 1, 1956. He subsequently left and went back into academic medicine at Emory, about four or five years later. By that time, a friend of mine that I'd known at the University of Pennsylvania, a few years younger than myself, had finished his residency. He went to Wake Forest for undergraduate, and the University of Pennsylvania all four years to med school, and the University of Michigan for his four years of internship and residency. I re-met him at the wedding of a mutual friend in the late 1950s, when we were both in the wedding of Ellis Fuller, who was practicing in Louisville, Kentucky. The day after Jim left, on the 30th of June, Paul Williams came to practice with me on July 1. Paul is one of the best physicians I've ever known. I guess I feel that way because we practiced the same way and thought the same way. We practiced together for 30-some years, and I never remember having a disagreement with him about the way we took care of patients, or who was on call, or finances or anything else. I'm not sure, but I believe he was first in his class at University of Pennsylvania. He brought with him a lot of knowledge and know-how, but more importantly, applied it.

KKT: You say you thought and practiced the same way. Could you describe your philosophy of practice, or how you went about things?

WB: That's hard to describe. Both of us had a clean desk at the end of the day, as opposed to some physicians I've known, where you walk into their office, and the desk looked like a pyramid, with some off on the floor. When I asked him how he ever found anything, he said he had the world's only perfect filing system, everything was labeled miscellaneous. Paul and I were quite different, we tended to run things in an orderly fashion. That's not to say that that's the only way to practice medicine, but it's nice to practice with someone who approaches things much the same way. When they work up a patient, interview and examine them, and write the history, it's something that you can read and really have your hand on the situation from the beginning. If he was on the schedule for a certain time or day of the week, you could put your money on it, he'd be there. But more than that, the patients thought the world of him, because he was not only well-versed in medicine, but he cared for the individual, and liked people, which is something I'm not as certain we're teaching in school today as we were indoctrinated in at that time.

The University of Pennsylvania always prided itself, as well as being a great research institution, on putting out physicians who cared a great deal about the patients. I had three pictures in my office, one of my father, one of Dean Berryhill, who was the Dean of the Medical School at the University of North Carolina at Chapel Hill, and one of Dr. Francis Wood, who was Chief of Medicine at the University of Pennsylvania. I said that my father taught me integrity, Dr. Berryhill taught me to work night and day, and Dr. Wood taught me to love the patient and not just love the science.

KKT: Can you give any examples of how, in your medical training, they instilled that kind of medical ethics, to really love the patients?

WB: By example. You can't lecture this for anyone. But if you made rounds or were around Dr. Francis Wood, and saw the way he treated patients, and the patients adored him—it's by example, you can't give a lecture on how to like people. It's sort of like the second lieutenant in the army—the one they respect is the one who says, follow me, do as I do. I don't send you over the top first.

KKT: I just want to go back and follow up on a few things. You said that a lot of doctors had a lot of paperwork...

WB: We didn't have all that much paperwork at that time.

KKT: Did y'all have a secretary then?

WB: When I started out, really, the doctor did all the write-ups locally by hand, your history and physicals. There was no provision made for you to have a copy, so the way I solved it was that on the day I discharged a patient, I'd take the history, physical and progress notes out of the chart, have them photostat in my office, and take the originals back to the hospital when I went back that evening. I never kept or lost any. Such a practice would be frowned on today about taking records out. At that time, when I wrote an interpretation on an EKG, for the first number of years I practiced, I just made the interpretation part of my progress notes. After a few years, the inspectors got into it, and said, that's not right, you have to write this on a special form. That just became an added burden to bear, with someone telling you how to do things and thought nothing of adding an extra step that made for inefficiency. I complained about it, but there was

nothing I could do. That example is mild compared to what you have to go through today regarding records and so forth.

KKT: Who was it that required you to make a separate EKG report?

WB: Every three years, as I recall, you had people who came by to inspect the hospital. Most of the these were retired physicians or those who got tired of practicing medicine and decided they could best spend their time how to tell other folks how to practice medicine. Some of them, and this is not true of all of them, were obviously people who had gotten into trouble with alcohol. I was not impressed with the quality of these people, but they were backed up by the Joint Commission, and what they said was law. If you didn't do exactly the way they did, they would take the privilege of the hospital even being open away from you. And did this with threats.

KKT: Did they work for the state of North Carolina?

WB: No, no, you'll have to look this up. The Joint Commission—it's still in operation—was made up of three organizations, I think the American College of Physicians was one, and maybe the College of Surgeons. I'm not at all sure of the mechanics of this, but there were several organizations that jointly inspected hospitals to make sure that they stayed up to snuff. I'm not sure how much good they've done over the years, to tell the honest truth. They've given a number of hospitals a hard time, including the hospital at the University of Pennsylvania, where I trained. I expect they ran into people up there like Isadore Ravden [?], who knew how to practice medicine, and taught folks how to practice medicine. He probably bowed up to them a little bit more, and people like him, because they had broader shoulders than some of us, but I don't think it ever did a great deal of good. As time has gone by, you not only have the Joint Commission

inspecting you, but if you have a nursing home, you have about three different organizations inspecting you, some sponsored by the state of North Carolina. So you're inspected to death. You spend much of your time getting the notes in order, so that you can pass muster. A lot of it comes down to whether the t's are crossed and the i's are dotted, and not really the care that you are giving people. This is sad but it's true. Of course, like any bureaucracy, they just build on themselves, and there's more and more of them. It's one of the causes of the inefficiencies and the high cost of medical care today.

KKT: You mentioned interpreting EKGs. Can you mention some of the technological changes in medicine, and what effect they had on your practice?

WB: The electrocardiogram, I'm not sure about this, but was probably started back in the early 1930s. Dr. Francis Wood and Dr. Charlie Wolthus [?] were the men who introduced pre-cardial electrocardiography. Up until that time, they just had three leads, and after they found out that you were missing an awful lot of heart attacks, they started doing pre-cardial leads as well. This ended up in a twelve-lead electrocardiogram. This one misses some, and hasn't changed a great deal since they introduced it back in the late 1930s. Of course, we've had other technological advances as far as diagnosing infarctions, enzyme studies and so forth, that add to the EKG and help each other out.

KKT: Can you remember when a new technology came out and you thought, this is really going to change medicine?

WB: The biggest technology after the EKG was enzymes, where you checked the blood at intervals after the man has bad chest pain, and the destruction of the heart cells releases certain enzymes into the blood stream that you pick up. If the cells die, and these enzymes are released, then you know that

you've had muscle damage. I guess they came along sometime in the '50s, because they didn't have enzyme studies when I was doing my training.

KKT: How about pharmaceuticals? What kinds of drugs were introduced?

WB: In 1940, when penicillin was so hard to produce and there was so little of it, we gave such small doses, but it cured a lot of people. We used it against pneumococcus and strep, and in the early days, staph even. It was extremely good, but over the years, more and more bugs have become resistant to it, and now, you couldn't measure 25,000 units, which was the dose we started with. Doses now are in the millions of units.

One of the great problems with pharmaceuticals was, in the 1950s, a drug that had been on the market for a while, like penicillin, became much cheaper. Today, and I retired five years ago, every two months, the price of all drugs goes up. These are not drugs that require cutting down trees in Malaysia, as you had to do when you were first treating people with quinine, but these things are manufactured in a plant. I find it extremely difficult to understand why the cost of drugs has continued to go up, even drugs that have been around a long time, when they are produced the way you produce chemicals. This was certainly not true in the early days of my practice, when drugs that had been around went down in price. Penicillin is still cheap as dirt, but there are so many drugs that continue to go up and up. Even making allowance for the fact that we have to allow drug companies to make a good profit in order to continue research, I think the drug industry has taken down the road to increased costs, just like the HMO people today. Medicine is being run more and more by masters of business administration and not doctors. It's taking us down the road where such an amount of money goes to the insurance companies as profit and Wall Street and

the people who run these companies. And advertising, which I find extremely distasteful. But that's newspapers and radio and TV, and when you fight that combination along with fighting the trial lawyers, you get little other than a bloody head.

KKT: Was there any resistance among physicians at the time, when these drugs were increasing in cost?

WB: During the last ten or fifteen years of my practice, and I don't have any figures to give you on this, it seemed like the price of drugs just kept going up, and I couldn't justify it in my own mind. It certainly made it very hard on a lot of patients to take medication.

KKT: But had drug companies seen a lot of resistance from physicians...

WB: How could the physicians do anything? All you do is give the prescription to the patient. If anybody's going to resist, it's got to be the patient. Doctors can't resist.

KKT: What you've just brought up about all these things that caused increased costs, when did you first start seeing patients who were carrying health insurance?

WB: Not nearly as many people had health insurance. In the early days of my practice, one of the beauties was that I didn't have to worry about insurance. The surgeons did, since surgical care was insured to a certain degree, but during the early years, I never had to fill out insurance forms. When I started practicing medicine, my charge for an office visit was four dollars. And I made a living. Even with that, I was able to take care of people who weren't able to pay even the four dollars. Today, and I'm not talking about surgical fees, but medical fees, primarily with pediatricians, general practitioners and internists—taking care of anyone

over 65, or with pediatricians, with these multi-thousands of people who are on Medicaid, anyone you see as far as office visits, you're taking care of for absolutely nothing. The government affords you just enough to pay your overhead, so you really give your services. In that situation, there's nothing left to take care of anybody just on pure charity, which is a sad commentary.

KKT: So before, there was enough of a cushion from the paying patients.

WB: That's exactly right. But the paying patients didn't have to pay as much, even correcting for inflation. We're not talking about what the government pays you for medical care, we're talking about the paying patient who's under 65 and over 20. Another reason why the cost of care goes up so much, if the patient doesn't have to pay anything, or practically nothing, for their care, they demand care when they don't need it. If they had to pay for it themselves, they wouldn't demand the care. On the other hand, if a physician sees a patient, and somebody else is paying the bill, they don't have the same constraint about keeping prices low. The patient doesn't give a damn if the bill is five or five hundred dollars, as long as somebody else is paying it. That's just an inherent flaw in the approach we've gotten into.

KKT: When you started practicing in the '50s, for someone who was poor in North Carolina, where would they usually go for medical care?

WB: My practice has always been in the Piedmont, where you had roughly 20% blacks and 80% whites. You've got poor whites and poor blacks, of course, but I don't think you had the same inability to pay that you would find at that time in eastern North Carolina or in Appalachia. I was never faced with a situation where I was seeing a great volume of patients who couldn't pay. I think that was

true of this area compared to the east and Appalachia. Both have improved since that time, obviously.

KKT: So you'd only have a handful of patients who couldn't afford to pay the regular prices.

WB: I didn't have many, and one of the reasons was because when I started practice, I started on an appointment basis, but I can honestly say that throughout the 45 years that I practiced, if anybody called and they really needed to be seen that day, they were seen that day, not two or three weeks from now, as is getting to be more and more the practice, particularly in HMO set-ups. People who will keep their appointments are basically the people who go to work every day. They run their lives orderly, and if somebody made appointments and didn't come back a couple of times, I never told them not to come back, but they more or less automatically weeded themselves out. Consequently, I developed a practice of people who ran their medical lives like they did the rest of their lives. I had a practice where everybody wasn't rich, but they were responsible individuals. I think that starting out with appointments, which was sort of new in this area—most doctors, you just walked into the office and sat down, and when your turn came, you went in. I knew it took me an hour to adequately work up, examine, and take a history from a new patient. So my return office visits were set up at twenty minutes.

KKT: At this time in Burlington in the 1950s, were most doctors seeing patients of all races?

WB: From the day I opened my practice I 1953, I had one waiting room for blacks and whites. They were treated with equal respect, and they were still treated that way the day I quit practicing. But to go back to what we were just

talking about, my black patients tended to be school teachers and so forth, because they ran their lives in an orderly fashion too. That's not to say I didn't see people who were otherwise, particularly in those days, since the emergency room in the two hospitals were covered by nurses who were there all the time, but also by physicians in the community taking turns. Back in those days, I guess every twenty days, I was on emergency room call at one or the other hospitals. Of course, you saw patients there who just wandered in or didn't have anywhere else to go, as well as true emergencies. The emergency rooms have always been, and I guess always will be, where the majority of patients who come are just looking for care, not real emergencies.

KKT: You think those patients went to the emergency room because they weren't able to pay, or they couldn't find care elsewhere?

WB: Or hadn't established themselves with a physician, or if unable or unwilling to pay for their care, they'd see a different physician each time, and it wasn't like going to the same physician and never paying one physician. The emergency room becomes a publicly sponsored care situation. That's entirely different from today, where they have emergency physicians and that's all they do, is take care of emergency patients. Which is a better situation, certainly, than having the doctor in his office having to go one day out of every twenty repeatedly to the emergency room. He can't take care of his own. And the emergency room physician today is better trained in true emergencies. I was an internist, and when they brought in automobile accidents, I had nothing to do with surgery. I'd do little more than evaluate the situation and then call the surgeon, but it was up to me to be the first man there. A lot of the emergency room

physicians today can take care of minor surgery, and that's what they're trained to do.

KKT: Was this volunteer work you did in the emergency room?

WB: If you didn't do it, you were off the staff at the hospital. That's pretty strong talk. But this was set up by the doctors, it wasn't something that was shoved down your throat. Obviously, the emergency room had to be covered, and that's the only way we could cover it.

KKT: This was the hospital that you had admitting right at.

WB: I had admitting rights at both of them. There were two hospitals in town at the time. Later on in my practice, when I built adjacent to one of the hospitals, I stopped going to the other hospital. Not that there was anything wrong with it, but it was four or five miles away, and I could more efficiently work at one hospital and my office across the street, rather than making rounds at the other one twice a day. The doctors adjacent to the other hospital did the same thing. The doctors adjacent to each hospital took care of its emergency room, until we full-time physicians in the emergency room.

KKT: Did you ever do any work with pubic health clinics?

WB: Never. When I left medicine, I was almost 68 years old. Some physicians after they retired would do some volunteer work in the hospital, but my feeling was, I'd practiced as long as I'd wanted to practice, and when I walked out the door and closed it behind me, I went to other things. I didn't try to interfere with the way medicine was run in the town, or anything else. This is not to say that I didn't enjoy practicing medicine, at least until about the last five years, when the government became more and more intrusive, causing me to be more and more inefficient, and wasting more and more of my time, and frustrating me

to death with things that seemed awful stupid to me. Had it not been for the government, I think I would have had more difficulty stopping when I did, and maybe would have practiced for another four or five years, at least an office practice. It's not only me, but any number of physicians today are stopping early because of the frustration. Twenty or so years ago, the man in private practice was already beginning to feel the heat on this thing, and if you talked to the academicians at the university centers, they'd just say, "You don't know what you're talking about." Now that the government is squeezing down on the academic community, as well as the practice outside, you go back and those guys are whining more than we used to whine. When I say whine, they've got something to whine about. But there's nothing like feeling the heat yourself.

KKT: Earlier, you'd mentioned the hospital inspectors who gave you a hard time about the report. Can you remember some instances of when the government began interfering?

WB: You say the government—the earlier hospital thing was not government.

KKT: Maybe I should say third parties, other than the patient and doctor.

WB: I remember when I came to town, the old hospital was Alamance General. It had about 60 beds. The newer hospital at that time was Alamance County Hospital, with about 100 beds. The old general hospital was run by one administrator, who had a secretary, and a person who sent out all the bills. These were the people who ran the hospital. That hospital administrator was not trained as a hospital administrator, but had graduated from Duke in business, I guess, and remained administrator even when that hospital was disbanded and the new Memorial Hospital was built about 1960. A grand administrator, he just ran it

right. He liked the doctors, the doctors liked him, the patients liked him, the board liked him, he just ran a tight ship, very economically.

Then, as we had more and more inspections and got into the new hospital after 1960, we had to have an assistant hospital administrator. They picked up a delightful fellow, also able, but who had retired from running hospitals in the Army. He knew all about keeping records and so forth, and a few months before we would be inspected every three years or so, he would more or less quit everything he was doing and get the records in order. He understood clearly that it didn't make that much difference how you were treating patients, as long as you had good records. So he would get the records right. We had to change things according to the rules, but it amused me how important records were, and records had become increasingly so. Part of this is medicine's own fault, and part of it is the threat we all live under as far as lawyers and suits are concerned. It's costing the American public millions and millions of dollars every year of doing unnecessary records and tests.

When I started practicing medicine, if somebody was in a little automobile accident, and said they had a headache, you didn't immediately order a skull x-ray and an x-ray of the neck. But later on, and I'm free to admit it, if a patient of mine had a wreck and came by the office, I would order everything that I thought I'd need in case I was called upon to testify in court. And this amounted to maybe four times as much as what was necessary to charge a patient, simply because I figured if the American public allowed a system like this to exist, I certainly wasn't going to put my neck on the line and have every cent I'd ever earned and saved taken away from me, and my reputation as well. This goes on today, as another reason for the increased cost of medical care.

KKT: Did you ever have malpractice insurance, and if so, when did you start?

WB: When I started practicing, I think my malpractice insurance maybe cost me $200 a year, something like that. When I quit practicing, I don't remember exactly, mine hadn't become all that high compared to others because I was in internal medicine, as opposed to surgery. When I stopped practicing, it wasn't more that $4,000 a year, in 1991. I never had a malpractice suit brought against me, or even threatened. But the poor fellow who finishes a six year residency in neurosurgery and goes to Florida to practice, his first year's insurance may cost him a hundred thousand dollars. If anybody thinks you can practice medicine and charge $15 for an office visit, and pay $100,000 a year on malpractice insurance, they don't know much math. But malpractice, when I started practicing in the '50s, this was something you just didn't hear of.

KKT: You told me earlier that you knew some people who were on the board of the Medical Care Commission...

WB: I'm not going to mention names.

KKT: You don't have to mention names, but what do you know about the Medical Care Commission?

WB: I think the Medical Care Commission in North Carolina has done a good job. I don't have any criticism. I think they've been even-handed, and in my experience, it's been run well. There's no question that the Hill-Burton Act brought hospitals to communities that would not have been able to afford them otherwise. We had a unique experience when Alamance Memorial was built in 1960. That year, until that time, it had been a one-to-one thing.

[end of tape 1, side A]

[begin tape 1, side B]

WB (continued): If you needed to raise a half million, then the government would put up a half million to go with it. When our hospital came along, just as a matter of pure luck, they had some money left over at the end of that year. As you well know, the government doesn't look kindly on keeping funds that have been put up for use in anything. So instead of saying, we've got a few extra dollars and we'll just save that, the government said, we'll just get rid of that, because we don't want to carry it into the next year like they're appropriating too much money for us. They said, if any hospital is ready to go, we'll give them two dollars for one. Ours had applied, and the new hundred-bed hospital was built for around $1,800,000. The local community raised $600,000, and the government gave us $1,200,000. So we had the hospital paid for the day it was opened. That's not to say there was money to run it with, but at least the building was debt-free, essentially. The $600,000 raised locally was not tax money, but was donated by local citizens and industry. The Duke Endowment made some donation, but not the major part.

KKT: What do you think was the impact of that Hill-Burton hospital? What would have happened if it hadn't been there?

WB: The greatest impact was that in towns this size, certainly in North Carolina, most of the hospitals had been privately owned. When I came to town, the 60-bed Alamance General Hospital had been built by a surgeon and a urologist with their own money. Shortly after I came, as costs were going up, they had given that hospital to the board of trustees. It had transformed from a completely privately-owned hospital into one owned by the board of trustees. Throughout small towns in North Carolina, and that's what most of them were,

except for Charlotte and Raleigh and Durham, the hospitals were owned by individuals, generally surgeons. They ruled the hospital, until they gave it to some public board of trustees. They ran it, they owned it. Doctors who came to town didn't automatically have a hospital they could put patients in. Generally speaking, they had to refer patients to the surgeons who owned the hospital, even if the patient had a heart attack, and had nothing to do with surgery.

But people who take the attitude that that was all completely bad, have to look at the other side of the coin. If these people who owned the hospitals hadn't been pioneers, and willing to build hospitals for the community, there would have been no hospitals at all. When we look back and say, that's a terrible situation, there was a little clique of doctors who owned and controlled the hospital like it was a monopoly, now that sounds just unbelievable and inexcusable. The truth of the matter is, until Hill-Burton, the federal and state governments, or anybody else, weren't going to help build a hospital in these 30,000 population towns. If you hadn't had people who were willing to get out there and take risks and work, there would be no hospital at all.

KKT: After you started admitting patients at the new Hill-Burton funded hospital after 1960, did you see any differences in how that hospital was run because it was federally funded?

WB: The old hospital was run by the same board of trustees that came into the new one, so there was no difference whatsoever.

KKT: Did they close down the old ones?

WB: Yes. The original laboratory for blood testing and so forth was bought by Dr. Powell—he wasn't an MD. He started what is now Biomedical, and just combined with a west coast concern, and I believe it is now one of the largest

testing laboratories in the United States. The headquarters are here in Burlington. They have recently gotten into trouble about overcharging, but they are not alone. Every company like them is being sued by the government for the same reason, and most of the hospitals. To give you an idea of how much money we're talking about, Biomed has just agreed to pay the government $185 million. And some of the largest teaching hospitals.

KKT: And they're being sued for what?

WB: You would do a blood test, and what's called a panel, which can be either 3 or 4, or 21. The blood sugar would be one thing, and the BUN testing kidney function would be another, blood calcium level, and so forth. The cost of running that panel is the about the same whether you run it for one test or for 20. It's all automated now. Biomed and all the hospitals—it's still going on in the hospitals, more than even these testing labs—will break the panel down, and instead of charging the government for panel twelve, will charge individually for each one of the tests. When you add them all up, you've got ten times the charge you had for just running the panel itself. All of them insist that the government said that was all right, and I don't doubt it, knowing the mentality of the way the government runs things. Now they're going back and saying, over the past ten years, you've done this so many times, and we feel you owe us $185 million. The company says, we did what you told us we could do. But the government says, that's not so, we never did tell you to do that, you pay us $185 million or we'll have a trial. When they think about a jury trial, they figure they'd better give them $185 million instead of the $500 million the jury might decide. I understand the University of Pennsylvania hospital has already been hit with this. They're making a list of the companies, but with the hospitals, they're playing it a little bit

political, and saying, if you settle with us, we won't put it in the newspaper. Same old story.

But this company, that's able to pay $185 million and still keep going, was started in the old hospital by Dr. Powell. He had already started selling biological supplies to schools and universities. That company's still going, and imports bones from India to sell the skeletons. At one time, in order to test for infectious mononucleosis, you had to have sheep cells, of all things. Did he buy sheep cells? No, he bought a sheep farm and started raising his own sheep. He's an amazing man, no question about it. He hasn't been dead too many years.

KKT: I've been reading a lot of old North Carolina Medical Journals, and one of the things the editors seem most concerned about it socialized medicine. Of course, throughout the past several decades, there have been a lot of proposals to have some kind of universal health insurance. Do you remember at the time how you felt about those plans?

WB: The same way I feel today. Back in the beginning, one of the favorite phrases they had was that medicine today is a cottage industry. I remember seeing that in the newspaper until I was sick to death of it. The current phrase is about taking care of the children. That will last another year or two, but it has a nice ring to it. We've always needed to take care of the children, but it's popular now. The people who were interested in socialized medicine were browbeating the doctors. At that time, my office visit was around seven or eight dollars. You couldn't enter a hospital emergency room in New York City—we're not talking about getting any service, just to walk in the door was probably at least three or four times that. They were looking down their noses at the man who was running his own little cottage practice. Yet I was paying for my building, my nurse, my

secretary, my part of the lab fees, and making a living, but for much less than one-third of what you had to pay to just walk into a big place. I thought to myself, that's the dumbest thing I ever heard, giving me a hard time when I'm delivering a service so much cheaper and more efficiently, and I suspect, better.

Then that sort of calmed down. They began to realize that so much of the money in medicine wasn't so much going to the physicians, but to affording hospital care. We're not talking about the hospital getting rich, because Lord knows they weren't. They always had their back against the wall. Most hospitals by this time were public hospitals. We hadn't reached the time when the big HMOs came in and owned their own hospitals. Then we've come to a place where HMOs are the thing. Ten years ago, if you read the lay press, the newspaper or TV, the praise for the concept of the HMO could not have been higher. If you had said something against an HMO then, people would have looked at you like you were some fool that didn't know anything. I was on the board of trustees of the hospital at that time, representing the doctors. I remember saying one day, you don't understand what the HMO is. It's based on one central idea, that the less service we deliver, the more money we make. Today, people are beginning to get less of that service, and it's very heartening to me to pick up a newspaper, and I think you see more articles criticizing HMOs than praising them. Because they're seeing what it is—nothing but a business.

Back when I started practicing medicine, what you might loosely refer to as the administration of medicine—insurance companies, doctors, hospitals, all of it—was about eight percent of the total money being spent on medical care, including the drugs, doctors, nursing homes and so forth. Today, I can't give you an exact figure, but I think it's somewhere around 35%. You've got 25% of all the

things we're spending money on medicine for today, that was not being spent fifty years ago. Where is this money going? To profits of insurance companies, HMOs, Wall Street investors. The bad part is, I see no way to turn that around. If you start talking about advertising, which is where a lot of the money goes—all you've got to do is turn on your TV. If you started talking about trying to do away with the things that have contributed to that 25%, who are you going to hit? Insurance companies, advertising, newspapers, television and radio—they just skin you alive. You're talking about the trial lawyers association. Of course, Clinton is in the trial lawyers' pocket. If Congress and the Presidency would start trying to put the extra 25% back, think what you could do with the billions and billions of dollars that aren't going into medical care whatsoever. It's mind-boggling. The best thing to do with it would be to put it in the tax-payer's pocket.

The tax-payer doesn't realize that's what's going on. He looks at a man like me getting such a big bargain for Medicare like it's free.

[interruption to answer the door]

The next step was the Hillary Clinton step, which would have been one big HMO over the entire United States. It would have been federally run and operated. It would have completely taken any competition out of the practice of medicine. Whether you believe it or not, competition is why the United States is where it is, and Russia's where it is. We dodged that bullet by just that much. But in just the past four years, the evidence is beginning to accumulate that these centrally run things just don't work. You might say, the wonderful federal government won't try to make money, and it's going to be good for everybody. I would lay anybody ten to one that if we have 35% going into administration today, under a governmental system, it would be 50%. More and more would have nothing to do with medical

care. More bureaus, more investigations, more people coming around telling you what to do.

KKT: Obviously, your feelings about the federal government are based on all your experience.

WB: Absolutely!

KKT: What's made you feel that way?

WB: I'll give you an example. Back in the '60s, when the government first set Medicare fees, they based the overall fee on what everybody had been charging up to that time, and froze it at that level. The people who had been charging the least, who were, you might say, the thinking physicians: the pediatricians, internists, general practitioners. Their fees were much less that the neurosurgeon and the radiologist. Then, they started realizing that we weren't short of specialists, but the physicians who saw people when they called up and said, I'm sick. The primary care physicians. So his fee was left at the low end of the totem pole, and wasn't allowed to increase with inflation. In some cases, they cut the fees down. The surgeon could stand a cut, but when you cut the general internist's fee, he was going to have a hard time making it. This in turn tended to make crooks out of honest people. As they cut the fees down, if the guy was struggling to make what he had been, he might add in some studies that weren't that necessary. It put an abnormal pressure on the economics of it.

Then they did something even worse, and said, we can save some money if we set up a system where we don't pay every doctor the same thing for the same service. In Charlotte, we'll pay a doctor $28, in Burlington, $25, and in eastern North Carolina, $20. Because it doesn't cost a doctor in rural eastern North Carolina as much to run his practice, so we'll pay him accordingly. At the

same time, the shortage of physicians was in rural areas—this was across the U.S. They asked, what can we do to get more doctors to go to these rural areas? It's hard enough to get that doctor to go to a rural area to begin with, because he doesn't have as many people to sign out to, he's going to be on call night and day.

But another tremendous factor—who did this doctor marry? He had his residency or internship in a large town, and chances are, he married a girl from there. She says, well, you might like to hunt and fish, but I don't give a damn about hunting and fishing. And there weren't any clubs that she wanted to belong to. So if she came with him, she forced him to leave within two or three years. What the government should have been doing was to pay that man a little bit more than the man in Charlotte. Then, they could have gotten doctors to go into these undersupplied areas. But instead, they did exactly the opposite, and still are. They're talking about having every doctor in North Carolina be paid the same for the same service. But remember, they've got more people in the House of Representatives from New York than from North Carolina, so they'll still insist on paying more for the same service in New York than North Carolina. At least all of North Carolina will be equal. That was so obvious to me, when I was trying to get other doctors to come and practice with me. Where did they go? To Greensboro, Charlotte, Raleigh. They went where they would get paid the most for the same service.

Then the government did something else stupid. They overfunded research in medicine in the late '50s and '60s. This course I'm taking down at Duke, it was refreshing to hear someone stand up and talk about overfunding research. The doctor who was graduating and sixteen hours a day didn't suit him

that well, went into research. But there are only a certain number of research minds. You don't just manufacture them, and I don't think you can teach it all that much. These people have to have a drive for this thing. A lot of doctors that we absolutely needed out practicing medicine were taking stipends from the government and staying in medical centers when they were just absolutely overfunded. We had doctors and their wives up here, and would wine them and dine them for a weekend, trying to get them to come, and I was lucky enough over time to find four. But some of them came and left.

When I had surgery down at Duke, they said they were losing men out of the clinic who were going into the private world. The fools knew it was getting bad there with this new system, but they hadn't been out there yet. You've got no place to go. Today, the criteria for an HMO to hire a person is how many patients he can see in an hour. It's the bottom line, how much you can produce per hour and per day. At the same time, the government's talking what sounds like good sense, although they don't go by it, about how doctors need to do more thinking and spend more time with patients, and not order all those studies that are not necessary. So once again, it's a schizophrenic thing. They're talking one thing and setting up incentives that are exactly the opposite.

KKT: So you don't think the HMOs have been able to do anything about the problem you mentioned earlier, with patients who didn't have to pay anything for their own care and abused it?

WB: The patient has a hard time abusing a system where when you call up for an appointment, they won't give you one for four weeks.

KKT: But have the HMOs solved that problem?

WB: Of course they haven't solved that problem. In the paper last week, the head of one of the big HMOs had just bought a four million dollar house in California, and a two million dollar flat in New York City. He's not a doctor, he's a businessman. I was listening to an economist on television about two years ago, and before a Congressional committee, he said that with this system, you're going to have the heads of these organizations making millions of dollars a year in salaries, but don't worry about it, it will be worth every cent. He was talking about the bottom line, and had no concept of what he was saying. If he thought it would be worth every cent in terms of medical care, he's just a fool. You can make two million socks cheaper per sock than you can one million. But all the socks are alike, all the people are different, every one of them. A lot of patient care has to do with sitting down and taking a good history, not ordering every study you can think of. And then you've got to do these added things, like MRIs. I'm not decrying those, they gave Sarah Jo [Blair's wife] and me five years of excellent marriage that we wouldn't have had otherwise. I'm not knocking down the scientific part of it, but just like with computers, nothing comes out of it that some human didn't put in. If you say the best way to have good medicine is with the man who sees seven patients an hour instead of a few per hour, anybody that's ever practiced medicine knows that's not so. I'm afraid that it's being pushed so much in medical teaching now, we'll see a generation of doctors who don't have anything but the science of medicine, and haven't been trained or seen any peers to show them otherwise.

KKT: All of these things we've been talking about, Medicare, insurance, HMOs, it seems that they were all attempts to get the best care to the most people, even if they didn't succeed.

WB: They were honest attempts to cut down the costs of medical care, which we should all try to do. The problem is that nobody in the political arena, Republicans and Democrats—Bush and Reagan weren't interested in medicine, Dole wasn't interested in it, but Hillary envisioned herself as setting up a system that would be the answer, and she was going to be president of the United States when he quit. You think I'm kidding? We haven't had anybody genuinely willing to carry the fight. One of the reasons they're not willing to is that they've got to be re-elected. When they have to fight the trial lawyers, the press, and the multi-billion dollar insurance companies, they decide they can't do it. They fight we ought to be carrying is trying to get rid of the 25% that hasn't done anything to deliver a nickel's worth of medical care.

The Supreme Court's partially responsible for it. When I started practicing, lawyers and doctors could only put a three-line notice in the newspaper, announcing they were coming to town. Otherwise, the medical or legal society wouldn't accept you. This was just like the law. So the Supreme Court in its great wisdom, and they've got a lot of it, said that that was killing freedom of speech. So now we've got doctors, lawyers and hospitals spending millions on advertising, and it hasn't accomplished anything. You'd think it would make things more efficient by encouraging competition, but it's driven up costs. These are the things we ought to be after.

The one thing I don't think we can solve, which has added the most to costs, is new technology. When I started practicing, the only thing you had in the hospital besides the lab was an x-ray machine that cost maybe 25 or 35 thousand dollars. Then ultra-sound came along, and cost maybe $200,000. Then a CAT scan, which cost half a million dollars. Then MRI, which cost $2 million.

They've got one now that costs $10 million that they won't even release. Have these things added to care? You bet they have. But all this advertising hasn't added anything but expense.

KKT: From the research I've done, I think people were very concerned about health problems, especially when they found out about the huge number of draft rejections.

WB: Step back and look at the broad picture. Two hundred years ago, the life expectancy wasn't even 45 years. Somebody's done something right. It hasn't been all the medical profession, some of it's been clean water. But when we sit around and wring our hands about how unhealthy we are, it's a little amusing. Of course, a lot of our unhealth is smoking cigarettes, eating fatty foods, and not exercising, not because somebody couldn't go to the doctor when they needed to. But we're not treating ourselves too badly, or we wouldn't be breaking up Social Security by living too long. It's sort of like that phrase, take care of the children. Hillary has been on the children's board for years. But when you get something with a ring to it, you've got to say it at least fifty times before the public gets it.

They were giving the doctors hell about spending money when the doctors weren't getting but about 20% of the total amount being spent, for three or four years, that's all you read about, how inefficient it was to have this cottage industry. I didn't think I was so inefficient when I was doing it for a third of what the big organizations were. The question you just brought up was somebody with an ax to grind, and they had decided that's the way it was and were going to make everybody else believe it. So they brainwash you. As far as lack of care is concerned, in this town, I never remember a time when if somebody got sick,

whether they had money or not, they didn't get cared for at the emergency room. And they could be put in the hospital, whether or not the hospital got a dime for it. Since I was practicing medicine in Burlington, North Carolina, that's been the case a hundred percent of the time. They weren't sent away. Today, Medicaid picks up a lot of that.

It wasn't just poor people taking advantage of it. Some of the more knowledgeable people would walk into my office and demand an MRI, and they didn't need an MRI any more than the man in the moon, just needed to quit drinking so much. So it's not a class thing so much, it's just pure simple human nature. If you don't have to pay for it, you want more of it, if it's a good thing.

KKT: Have you ever heard of the Simkins versus Cone case? There was a separate but equal clause in the Hill-Burton Act, and this case declared the clause unconstitutional, and the government could only fund desegregated hospitals after a certain date.

WB: When I first came to town, the old Alamance General Hospital was segregated, but not my office. The blacks were on the first floor, and the whites were on the second and third floor. I couldn't tell you when that changed. When did they desegregate schools?

KKT: The court decision was 1954, but Greensboro didn't desegregate their schools until 1972, so it depends on where you were.

WB: When Alamance General closed and Memorial opened, Memorial was never segregated. But I don't know if the old General was desegregated before that.

KKT: I know your practice was never segregated. In your experience, did you ever see race as a factor that made it difficult for African Americans to get care?

WB: The old general hospital was built by Dr. George Carrington. A friend of mine from the fraternity at Chapel Hill had a father was a pharmacist in Mebane, and I knew him through Jimmy. Mr. White said one time that never in his entire long life of running a drug store in Mebane did he call up Dr. Carrington, who paid all the expenses at the hospital, and refer a black person to him, that Dr. Carrington didn't take care of that guy, put him in the hospital or operate on him if he needed to, and knew he wasn't going to get a damn dime for it. But I'm sure it depends on the individual.

In my practice, I had one examining room and charged everyone the same thing. Some of them paid and some of them didn't, but it took me the same time to do a physical on a white as it did on a black. And I think there was more of that than there was the other way around.

KKT: Did you ever know any black physicians that practiced in Burlington?

WB: Oh, sure. When I came to town, there were three, and before I opened my office door, I went by to see every physician in town, there were about fifty at the time. I went to see the black physicians, too, introduced myself, told them I could help them with heart patients and so forth, and they were all very cordial to me. The oldest one died not too many years after that. One of them is still alive, and we have a cordial relationship.

[end of tape 1, side B]

[begin tape 2, side A]

[Blair mentions a black physician he knew, Dr. Shanks, while a new tape is inserted]

KKT: So, Dr. Shanks practiced in Burlington?

WB: Yes. I think he had been here a year or two before I came. There was one who practiced down in Middletown that retired not too many years after that. As far as now, I have a black physician, a woman. She's a damn good doctor. The trouble is, she's in with a group, and they run the situation by the numbers. [Blair describes getting the flu before Christmas, having chest pain, calling his doctor and being unable to see her, and going to the emergency room for $900] If it had been a patient of mine calling me at the office, the EKG would have been thirty, the office would have been twenty-five, as opposed to nine hundred. [Blair describes getting tests done, refusing a CT scan, and then finding the next day that the pain had been the onset of a case of the flu instead of a heart attack].

Blair goes on to say that doctors receive the same sum for Medicare patients, regardless of how much time they spend with the patient, and that the system doesn't make allowances for physicians spending extra time with difficult or serious cases.

All of what I'm saying gets back to your question, did I believe in socialized medicine. I tell you, hell no, I don't believe in socialized medicine, or socialized anything else. Socialization is why Russia is where it is today, and non-socialization, to a degree, is where we are today. It's that simple.

KKT: It seems, though, that HMOs aren't the answer either, even though they're not socialized.

WB: The answer is to get rid of this stuff I've been talking about, and I'm very pessimistic that we have a chance. But the bad reputation HMOs have gotten in such a short period of time makes me think that not so many people will be out on a soapbox, saying this is the way to go. You've begun to see more articles against them than for them. And the further they go, the more they hang themselves. It's the bottom line. It's not being run by doctors, or anybody that knows anything about delivering good medical care. It's being run by masters in business administration. They're sold on advertising and making money, but they don't understand how to deliver good care. That's so far down the list, I doubt if the top man would even allow a doctor in his office. That's not much of an exaggeration. Unless it's a doctor who decided practicing medicine was too tough for him, and decided to go into the business side. They've got a few who have degrees on both sides.

KKT: It sounds like from what you've said, the system where the individual physician was in charge of providing care for the patient was better than health insurance and Medicare...

WB: That's not to say that with increased technology and all, we wouldn't have had to change. If the federal government had never stuck their finger in it, that includes the Supreme Court and its decisions, and had sense enough to stay out of it, we'd be seeing medicine just as good or better today, and one hell of a lot cheaper. Anytime the government puts its finger in anything ten percent, they insist on running it a hundred percent. And this is not just medicine. This is anything the government touches.

Back in 1942, when we were on the same side with Russia, honest men were a hundred percent wrong. I don't think Alger Hiss was a bad man. He was a

communist, and he believed what he was doing was right. At that time, a professor wrote an article that said that the government taking over and trying to do good things was a sure road to totalitarianism, to dictatorship. You can imagine what reaction that guy got. They were about ready to take him out and hang him. Not literally, but just about. They said, how can you be so wrong, when socialism and communism is the flood of the time, and there's no way we're going to stand in front of it and stop it. Yet the man was a hundred percent right. Every time the government takes over something new, like Hillary Clinton would have taken over the entire medical care system under government supervision, we're headed just as straight to a dictatorship as Hitler or Stalin was. And look what happens with complete government control.

[Describes his trip to Russia twenty years ago, where he saw that collective farms were less successful than individual plots].

This system with HMOs is certainly not socialized medicine in the sense that there's a profit motive, but it is socialized medicine in the sense that there are people at the top running it who are disinterested in delivering medical care.

KKT: So you might say that rather than socialized, it's bureaucratized.

WB: Yes, if you think of a bureaucracy as running something without being concerned about the end result, good delivery of care at a reasonable price. When HMOs started, the federal government would subsidize anyone who wanted to start one. One of Clinton's ways of saving money in order to balance the budget has been to take away the subsidy, and require them to deliver care as cheaply as it's being delivered by people who are not in HMOs. You hear a lot of talk about how much the HMOs are saving. Just yesterday, the Greensboro

paper said that HMOs are charging more than people providing care on a fee for service basis.

KKT: Do you feel like a lot of the concerns that people weren't getting care, or not good enough quality care, were valid?

WB: I think the driving force was that the cost of medical care was going up so fast. The whole point of HMOs had nothing to do with the care. They thought this was the way they were going to bring the costs down.

KKT: Originally, the costs were due to technology?

WB: No, we didn't have that much technology in the '50s. I bet the year the costs started going up was the year the government got into it.

KKT: Hill-Burton started in 1945.

WB: But Hill-Burton is so different from the rest of it, in my way of thinking. That didn't make costs go up.

KKT: But you were talking about when the federal government started getting into it.

WB: When they started building hospitals, [the government] didn't really tell them how to run the hospitals. When the government passed Medicare is when I'm talking about. That was about the same time the Supreme Court declared it unconstitutional for medical and legal societies to prevent their members from advertising. And that was about when we started getting CAT scanners. So you had the technology, the increased advertising, and massive beneficent bureaucracy. When I stopped practicing, I was spending over twenty percent of my time every day putting meaningless figures, trying to justify what I'd done, who I'd seen, what type of visit it was, and the number of diagnoses the patient had. Twenty percent is a lot of time. If you see someone in fifteen

minutes, and it takes five minutes just to fill out the forms on them—some people would ask why I don't hire somebody to do that. A lot of doctors did, but what they put down was so far from the truth, where as I put it down like it was supposed to be. A lot of them got a lot more compensation than I did, because they were specialists in putting the right numbers down. It made liars out of basically honest folks.

KKT: It does seem like it built up, beginning with the draft physicals during World War II, then more technology, and more people getting health insurance. But you're saying that '65 is really the turning point. It seems like people were concerned about rising costs and providing care to more people starting back in the forties, before the federal government really got into health care. Do you think those concerns were exaggerated in some ways?

WB: I think the people who made the decisions were politicians who knew that the public will buy anything as long as they're promised something for n o t h i n g . A lot of that talk was about doing it cheaply and how much money they were going to save, and look what we're going to give you. I think the driving force was promising people something for nothing, which was a farce to begin with. When the prices started going up, the driving force that produced HMOs was all these theoretical folks saying how we're going to save money and bring costs down. I'm not so much cynical as I am a realist. You're kidding yourself when you say that the driving force is delivery of better medical care.

We were talking about the overfunding of research. You know what caused that? When Sputnik went off, we had won World War II, we thought we were the greatest in the world, and all the sudden the Russians put a man in

space. We tried to a couple of times and failed. It was just like us going to war. For the next ten years, the American public backed it and the Congress just couldn't spend enough money on anything to do with scientific research. I forget the cost of putting a man on the moon, but people backed it. I know it scared me to death.

KKT: Even the interstate program started because we were afraid we would be invaded.

WB: That's one thing that's worked out. There are a lot of people today who think that when we put a man on the moon, it gave us a sense of national security and superiority, but it accomplished very little else.

KKT: I had one last question. You'd said one of the reasons you wanted to come to Burlington was because it was near Chapel Hill. Was it because you wanted to be close to a research institution, or for professional reasons?

WB: I became an associate professor at Chapel Hill. When I first came back in 1953, they had just built a new hospital, and started the four-year medical school. They didn't have the tremendous staff they have now, so for the next fifteen years, I went down one day a week for part of the year and volunteered to teach—I got paid maybe a hundred dollars a year. I ended up an associate clinical professor. Then I decided I needed to spend what extra time I had going to meetings and keeping up myself.

KKT: That's all the questions I had. Was there anything you'd like to add?

WB: No, I don't think so.

[end of interview]