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E. Charlton Prather: It's a pleasure to have with us today Mrs. Audrey Ryals, a longtime public health nurse with the Gadsden County Public Health Department in Quincy. And it's because of her public health nursing experience that I'm so excited for her to be here today. She's from Gadsden, a rural county health department.

And the rural county health departments, largely, the nurses were the public health programming, from a personal health point of view. And it's just fun, fun, fun to have you to agree to come today, Mrs. Ryals, and share with us your experiences and your observations from a number of years in what, really, I'd like to think as the early years of county health department programming. Tell us, what really got you interested in public health?

Audrey L. Ryals: Well, let me first say that I certainly was glad that you asked me to come because public health has been my life for close to 50 years. You know, when you talk about—

CP: Yes. I was afraid to say that.

AR: I had worked with the state of Florida since 1948 but the first time, when I graduated from nursing school at St. Luke's in Jacksonville, I came over to work at the state hospital because that was all I knew, you know? Three years of—three months of psychiatry, and that's all I knew. So I went to work up there in the operating room.

And after about a year and nine months of it, I decided there had to be something better because there was ten hour days and on weekends, when I had to work weekends, it was 12 hour days. And you just didn't have—it just wasn't much. You went to work; you went home; you went to work and then home. So it getting kind of boring, especially after OR was not what I thought it was, and I was in ER more than anything else.

So I decided to search for something else. And one of my friends down the street from where I lived told me about this job that was open. That there had been no one in the Chattahoochee area for nursing for several, a couple years, at least I think. So, I signed up and got into public health. And from day one I enjoyed public health.

I had the experiences. Of course, didn't know the town of Chattahoochee, you know, I just lived there. And all I knew was how to go to the state office building and come back to work. But after I got oriented, I decided—I learned about lots of places in the county. And I don't know if you remember, yes you do remember Mrs. Hancock. Audrey Hancock—

CP: Yes, I do.

AR: —was the nursing director. So she took me out on a home visit. And I might add this in, that where the new health department is in Chattahoochee is where I did my first time visit. It was at (inaudible) that was there. And a lot of their people lived in the area, in the housing there.

And this lady had had a baby so we went out to—it was a midwife delivery—so she took me to that one, and we had to wade a little pond aboard, you know, go crossed into the house. So she set up the bag and got me started, and she showed me how to do a home visit. And when we finished it, then she talked to me more and wrote up the notes and everything for the record. And that was the last time she did a home visit with me.

CP: (laughs) The first and last.

AR: The first and the last home visit.

CP: She did two home visits at once.

AR: But apparently she trusted me much more than I trusted myself.

CP: You came out of St. Luke's. Did you have a—

AR: Right. St. Luke's in Jacksonville.

CP: Did you have any public health orientation with the city health department in Jacksonville?

AR: No, I didn't. We had two weeks of public health, in theory. And we did get to tour the downtown building. You know, the lab and the health department building.

CP: The health department building. Yes.

AR: And of course, that's kept me from having to go down there on the orientation after I got into public health. Because I kept saying, "Well, I know all about that."

CP: (laughs) You did.

AR: So I did two weeks of theory and toured the building. But so far as knowing what was going on with public health, I had no idea. But it was easy to learn, and you learned to love the people, and you work with them, and it's always been a two-way street with me. The patients listened and they did what we told them to do. And when we were able to do something that really helped, we were thrilled. You know, really thrilled.

CP: Yes. You could see the results?

AR: We could see the results. And we did all the home visiting. We had, at the time I started in 1950, I think we had about 25 or 26 lay midwives.

CP: You did? That's a lot.

AR: That was a lot of midwives, but there were a lot of deliveries because there were a lot of people that lived on the farm. And we had farms, you know, they had shade

tobacco. And they had a lot of deliveries. Of course, birth control was nil. It wasn't like the pills these days and times, and the shots.

CP: Birth control was a lactating—

AR: Lactating thing, usually. But then, the parents were good to the children. You know, they raised—and recently I guess, sir, you probably read at the—in the [*Tallahassee*] *Democrat* that home visiting nurses, like we did in those days, guided people to do better with their children, and their children were better citizens as they grew up instead of as now.

CP: Yes. I read that report and I totally concur.

AR: As I do. Well, they're planning on getting back to basics but then about the—they're trying to get back to basics.

CP: (laughs) Yeah, give them a few more weeks.

AR: Yeah. Maybe they'll do it. So, anyway, we also had the clinics, and that was prevention more than anything else. Of course, we did some of the maternity things for the midwives—maternity exams for the midwives, but most of the time midwives had their own physicians that—patients had their own physicians and they would go to them but we had to check all the babies that was born by mid—that were delivered by the midwives.

CP: And you went to the home to do that?

AR: And we went to the home to do that, and we had a routine. I remember that in order to keep my routine I had to make me a list. And then tack it to every record that I could, which made sure that I got everything I was supposed to do when I got there. And sometimes they'd have nine and ten children, so I had to go through all of those, which is good because when you're in public health, prevention is the thing that we wanted to do.

CP: It seems to me that's what we're supposed to be doing. Yeah.

AR: What we're supposed to be doing is prevention. Now, it's sort of more like walk-in clinics. But we still do a good job.

CP: You attended a lot of clinics; one of which is maternity clinics. What were some other clinics in the early days?

AR: Well, we had immunization clinics. You know, in the satellite areas where I was, we did everything. We did the maternity and we did the—

CP: All in one day?

AR: —immunizations, and we did the children, and we did the adults. We did it all in by —not necessarily by appointment, that came along. But we were pretty busy, and we did EPST screening—EPSDT [Early Periodic Screening, Diagnosis, and Treatment] screening. And then of course, immunizations was one of the biggest things we did. And later, we all went in to have training for assessments—physical assessments.

CP: That was part of your EPSDT stuff.

AR: That was part of the stuff. And then I took a course at FSU, so I could go further with my assessments, so I could do the women and do the pap smears and bimanuals and things of that nature, and breast exams. So we did that in the satellite clinics. And in the regular clinics, they did all of that and probably more, but we had to often do it in one day. Which made it—made it—

CP: You did it according to what patient presented.

AR: What patient presented.

CP: Presented, indeed.

AR: And then besides the clinics, we had schools.

CP: What did you do there?

AR: At one school—at one time I had five schools. You know, when the nurses would leave, and they'd dump the schools onto what was left, and I had 5 schools. In the schools we did scoliosis screening, the visions and hearings, and any referrals that we were given by the teacher. But that was a routine, that we did those things, and then, of course, we had to do the follow ups on all of those.

We didn't have anybody to do the follow up for us. We either called them or sent them letters or let them come in, and we talked to them about what needed to be done. Of course, the Lions Club[1] always was helpful with the glasses if we found somebody. And some of the other civic organizations helped.

CP: You did eye screenings in the schools?

AR: In the schools. And hearing screenings in the schools, and the scoliosis in the schools. Of course, we had to do the girls separate and the boys separate, and we usually had some help with the PE teachers. Especially with the boys if we found something where we could go ahead and do it. And I did something that was probably unheard of in those days; it was sex education.

CP: Oh, you did? Okay.

AR: Yes. One of the principals in Chattahoochee was very adamant about all these babies that these teenagers were having, so I asked him if I could do this, and he said he would be delighted to. We'd have to screen, you know, to make sure that they wanted it. And he let me go into the school, and for three hours once a week I took a small class of girls—I didn't mix them with the boys—a small class of girls, and I started off in the seventh grade.

And I did the A-B-C of seventh, and then went right on until I got through the 12th. Well now, the first tenth—the seventh through the tenth grade was delights to do, but after you got above that, they knew everything. You know, you didn't have to do it, they knew everything.

CP: Of course. (laughs)

1Lions Club International is a service organization that seeks to meet the needs of communities around the world.

AR: But I had—in each one of the classes I had a girl that had had a baby to come in and talk to them. Or if they were all ready in the class, I let them come to tell them the experiences, and how it wasn't what it was—

CP: It's not like a baby doll.

AR: It wasn't like baby dolls. It was a total responsibility of a child. And I thought that one time I wasn't doing any good at all. One day, the lady from—about four years of this—a lady came to me and she says—this was the PE teacher, she said, "You know, Mrs. Ryals, you must be doing something right." I said, "What do you mean?" She said, "We have two pregnant girls in the whole high school, and they're in the eighth grade." She said, "By now we'd have at least 30."

CP: Really?

AR: (inaudible). That's good.

CP: Oh, my immediate reaction was, we've got two pregnancies, you're doing pretty good, Mrs. Ryals. We've got two of them pregnant already.

AR: (laughs) Yeah. But that wasn't the point. (CP laughs) She was saying that we don't that many pregnant girls in the class in high schools, and that was good. It wasn't just a school-based clinic, the first school-based clinic. You know, it was not—it was—

CP: Many years later.

AR: Many years later. And that was good.

CP: I'm curious. I can see back when I was younger than I am now, the school nurse created a relationship with us and I had no hesitancy to ask my school—she was a public health nurse wearing a public health uniform. She came from the public health department.

From your visit to the school, and particularly in sex education, I hope that you created the relationships such that a girl could come in confidence and have a conversation with you if they needed to.

AR: Right. They did. They all respected the nurses. They'd go in with the uniforms on. And that's why I'm so sorry we've gotten away from uniforms.

CP: I am so personally, so disappointed in that. But that's another lesson.

AR: (laughs) Yeah. Well, you know, if they see you on the street, they know you. If you're in street clothes, or you look like everybody else, then they don't know you. But we had a good relationship in all the schools that I worked in. A good relationship with the principals as well.

And I've always felt like that's their school, and they need to run it; I will be their nurse. So that created a good relationship. Another thing that happened was in—I don't remember now when, and you can probably recall that—but I guess it was in 1954, when the Salk vaccine[2] came out.

CP: Yes. That's right.

AR: Well, we were one of the test counties.

CP: Yes, you were.

AR: And we had to give all that and all the paperwork that went with it. It was tremendous, but we managed. And we only had five nurses on staff (inaudible). So when we started all of that, I was just thrilled that we had something because I knew that in isolation at St. Luke's, we were the only isolation unit and we had several polio victims there.

CP: That's right. There's one in Daytona but the closest one—

AR: Jacksonville

CP: —was Jacksonville. I'm trying to think of the next one. I think it's Tallahassee.

2Jonas Salk developed the first polio vaccine in the 1950s.

AR: Probably. But Jacksonville, in our isolation, are studying and working in the working in the isolation unit. We had a number of polio victims. And we had the kiddy packs and the old big old iron lungs[3]. We didn't have the rocking horses and things like that, it was the big old iron lung, and it just scared you to death. It was just pathetic that the children would—

CP: I know. That's the way it was.

AR: So I was just delighted that we were able to have—meet part of the testing of it; that they had actually found something.

CP: Did you have much polio in Gadsden?

AR: We had had a lot of polio in Gadsden County.

CP: Oh boy.

AR: And after we started that, in our follow up of our injections, we had to check on all the kids, you know, of course, with the nurses—and most of them being in school. We had several cases of polio; they had had one shot, but it was not as severe. And after, one or two cases that we had afterwards that had two shots was very mild. And of course, you know, it almost totally wiped it out for those kids that did have the injections. And it was just wonderful to be able to be part of that.

CP: Before we get too far from the uniforms, for our potential audience, public health nurses have been uniformed forever in Florida. But since my time, I've noticed that public health nurses are not uniformed anymore.

AR: I know it.

CP: What's the basis of that?

AR: Modern times.

3Colloquially known as an iron lung, the negative pressure ventilator is a form of medical ventilator that enables a person to breathe when normal muscle control has been lost.

CP: Modern times.

AR: I guess.

CP: Okay.

AR: Because I know that Patsy Justice[4] has hers in uniform. And I think, maybe, Margie has hers in uniform. I'm not sure of that but I think because I've seen them wearing uniforms.

CP: Is it kind of left up to the local health department?

AR: I think it is. I know that wasn't in our case.

CP: That the state quit requiring it—

AR: Yeah. And that was then.

CP: —because the state did require it.

AR: And they should. They should require it.

CP: I think I like the identity.

AR: The respect for the nurses in uniform when they're going into a home is so much different from somebody who's just out in a lab coat or something. They were identified as being from the health department. And they weren't afraid of them.

CP: Yeah. I like that.

4Patsy Justice is a former nursing director of the Washington County Health Department.

AR: They could open up and talk to them.

CP: So, so many occasions in my early life where that uniform, the nurses uniform—

AR: That was the—

CP: —got me in doing epidemiology and chasing down on disease in places I don't think I'd have gone without a cop. You know? But with a public health nurse—

AR: You could go right on in.

CP: We would walk down the street, and folks would speak to her by name when she was in her—

AR: You'd go into the grocery store and you got to give out advice and things like that.

CP: Yes. That's right. That's right. I think it's a step backward not to wear your uniforms.

AR: The community in which where I lived had one doctor—well, two doctors, actually. But most of the time the patients thought more of what I would tell them than they did the physicians. And when I—well, you know how it is with physicians. They just have a little bit of—

CP: They won't take the time.

AR: They would not necessarily take the time, but people just have a little fear of calling them at night. They were afraid they might insult them or something, but I never did.

CP: Yes. As a public health physician, that'd bother me to have somebody say, My physician is just too busy. Can I call you?

AR: Yeah. Because I've answered the phone in the middle of the night with somebody saying they're having a heart attack. And I've gone out in the middle of the night to see a baby that they thought was dying. So you know, this is things you do in public health.

Because when I first went, the first thing Miss Hancock told me was, “You are on call 24 hours a day.” And I said, “Well,” I definitely was on call 24 hours a day.

CP: You learned to live with it.

AR: I learned to live with it. That’s (inaudible) lots and give out free advice a lot.

CP: And that was true for your entire career.

AR: Right.

CP: Yes it was.

AR: And I still get a few calls every now and then.

CP: All right. Back to your clinics. You had the OB clinics, the maternity clinics, and you had some immunization clinics, what else did you have, clinics?

AR: Well, adult health and children health.

CP: Adult health, okay. What did you do in adult health?

AR: Well, we did the pap smears and did breast exams and bimanuals to make sure that they were all right. We did the—you know, it was a general exam.

CP: Did you do much heart stuff?

AR: We listened to hearts. I had learned to do hearts very well. I had to know—I picked up a lot, and lumps in the breasts and enlarged uteruses and things that, you know, a number of people that I’ve had to refer, I always felt bad about it because they were all poor as (inaudible). You know, and once they were found, it was just a little bit late because they never went to a physician.

CP: Yeah, that's too bad.

AR: But it was good that it was found and, you know, I guess they—

CP: You did a little help.

AR: I did what I could.

CP: Unchecked natural history is a painful process.

AR: Yes. That's true. But they were always appreciative of things that we did for them.

CP: Did you do any special hypertension stuff in the early days?

AR: Yes we did. We had set up—usually, we had free blood pressures, or if it had come to the money crunch, we started charging them a dollar to do blood pressure. But if it was high, we referred them; if they were already under the care of a physician, we helped with the follow up. We did a lot of blood pressure screenings and a lot of referrals. And we'd go back, and that was the general idea with the clinics.

The schools, I went into the schools. At first, I initiated the worm treatments, the parasite treatments that you see at the Gretna Elementary; it was called Springfield at the time. But the reason we started there, or I started there, was simply because the children would go to the bathroom and pass these worms, and it would scare the teachers to death. They had no idea what this was.

They thought it was intestinal stuff—tract coming out. But I got permission from my nursing director to do that, and I went in and did hemoglobins[5] on all of them to see if it was going to make any difference in the treatment. And then we got permission forms from the parents to do the treating and, of course, they were delighted.

CP: And you treated them right there in the school.

AR: That's right. Right there.

5Hemoglobin tests are administered in order to determine the severity of hookworm cases.

CP: You supervised the taking of the medicine.

AR: We poured—we measured the medicine. We had the teachers weigh them, so they'd come to us with name and weight. And we weighed them—we measured out the medication, and they drank it right there. We tried to do it on Fridays so it wouldn't frighten all the school—all the teachers to death. But we found that it was very good in that school, and then we initiated it in every elementary school. This was in the elementary school.

CP: Did you do any parasite surveying?

AR: We actually didn't have to. We knew there were plenty of them there because of the —no, we did not test them. We did not test them.

CP: Oh, okay (inaudible).

AR: Because we knew that they were there because every clinic—now, that's one of the other things with the children. We did do parasite treatments in the clinics. They issued the medicine and—

CP: They drank it down.

AR: —they drank it down right there. We did some, but it was pretty expensive for the parents. You know, to send the bottles to there, and we knew that they were quite prolific in the area. Well, outhouse—

CP: This was the large round worms?

AR: Large round worms.

CP: About hookworms[6].

6Hookworm is a parasitic worm that can inhabit the intestines of both humans and animals. It often results in severe anemia.

AR: And some hookworms. The ones we would test did have the hookworms.

CP: I would bet.

AR: And we—this medication that we gave was to your anthelmintic[7]. And it was to take care of all of it. And then we wrote a note to the parent—parents to see if they passed worms, then we would repeat it again in two weeks. We did that, and the hemoglobins did come up; they came up.

You know, they had hot lunches back then even if they brought—they finally got lunch rooms in they could have hot lunches, and that was helpful. And then when the fluoride mouth rinse program came out, do you remember when we (inaudible) the school children?

CP: Yes, I do.

AR: I went into the Chattahoochee Elementary School and did teeth exams, just did dental exams on all the—at that time, I guess it was first through sixth grade—and had a chart in there. One of the dentists at the hospital gave me a copy of it, of the mouth, so I —of the teeth, so I made different copies and put it in the—

CP: Classroom?

AR: Well, I put it in their folder. They come to you and you put it—

CP: Oh, their individual—

AR: —in the individual folders.

CP: You're keeping up with individual charts. Okay.

7Anthelmintics are a group of drugs that are used to expel parasitic organisms from the intestinal tract of a person or animal.

AR: So I had different colors. One for caries, and one for missing teeth, and one for fillings, and one for good teeth. You know, and so I would use a pencil to check them off. And when we—I followed them for three or four years with the mouth rinse program. And there was all kind of differences in the world with the kids, as they grew older. As they grew up—older, they get—

CP: Growing up. Oh yes. Those data were so outstanding.

AR: And that's preventative.

CP: That sure is. What do you do now? Do you have fluoride in the water or you still doing rinses?

AR: Well, Quincy has fluoride in the water. We tried to get it in Chattahoochee but they didn't seem to think it was worthwhile, although I knew it was. But we do have the program, the mouth rinse program. A lot of times, though, the teachers don't have time to do these. You know? They're so bombarded with trying to teach and trying to keep discipline and the—

CP: There's so many other things they have to do.

AR: —other things they have to do.

CP: I wouldn't want to be a schoolteacher.

AR: But I—I wouldn't either. Irene Clark oversees the fluoride mouth rinse program. And she tries to keep people in there. With the money crunch, though, we haven't gotten—we don't have nearly enough nurses for schools. It's real sad. And then we had tailgate clinics.

CP: Now tell me, what's a tailgate clinic?

AR: Tailgate clinic was—and you know, they're always talking about going out and doing public health or doing immunizations?

CP: Yes.

AR: We would go out into these farms; they were real big farms with shade tobacco. And we would set up our immunizations either on the trunk of our car or we would find a home that was willing for us to set up on the porch and get a table and a couple of chairs. And I carried a secretary with me.

And we carried all the cards and everything that we could. And we would start the immunizations on that farm. And they would come up, and we'd tell them when we were going to be back there the next week—the next two—in a month. And then, you know, you had to give them a month apart. Now it's two months.

But when the next was due, we told them we would be back, and then they would gather up again, and we'd repeat the immunization things, so that we could keep them immunized. And, we did them in schools, but we wanted to have the prevention of the ones under school age.

CP: Under school age, yeah. You also went into the school and gave injections.

AR: Oh yes, every year.

CP: When did you stop that? And why did you?

AR: It's real hard to remember because when they started requiring them now, before they entered school, then we sort of weaned off from it because it was foolish of us to go into school if they were going to require them. We weren't helping the program at all if we were going to go into school and do them anyway, because parents just weren't going to do it.

I have a cute little story to tell you about one child, got up into a senior in high school. Well, I had given him his immunizations on up until he got to the seventh grade. You know, they required DT[8] right on up to whatever. And he came up to where I was at and he said, "I want to know who the culprit is that found out that I wasn't getting my shots."

8DT immunization is a colloquialism in the medical field the inoculation(s) children receive to prevent diphtheria and tetanus.

I said, “Well, I guess you’ll have to blame me and your mother.” He said, “How come?” I said, “Because she saw me in the grocery store the other day, and she said, ‘James hasn’t had his shots in I don’t know how long. I know he’s got something, too.’” I said, “Well, I send a permission home every year. You don’t get it?” She said, “No.” I said, “Well, let me get your permission first.”

She said, “You’ve got my permission to do it. Just go do it.” So I called him, and boy, he was very upset. But anyway, he got his shots before he finished high school. There were a number of people like that, that were just—one young man tore shot card up, his immunization card up and flushed it in the commode, and he was in the second grade.

CP: Second grade. (laughs)

AR: I told him, I said, “Well, son. I won’t do anything for you; I’ll never give you a shot until your daddy brings you in.” So when he was 16, he had to have his DT shot or something, I don’t remember whether it was for football practice or for whatever. But anyway, it was required.

So his daddy brought him in, and I gave him his shot. And I said, “Now, see what all the trouble you went through? You know, I told you I wasn’t going to do that until your daddy brought you in.” And he says, “Now, wasn’t that silly of me?” It didn’t hurt him a bit. He said, “Wasn’t that silly of me?”

CP: Yes, it was.

AR: But anyway, he got his immunizations, and he was real pleased that he could get that and not have too much pain. I don’t know of any—well, I could talk about the home visits for a little bit with the midwives.

CP: Yeah. I want you to.

AR: They either came to us, or they went to the family physician, the client did. And then we went into the homes as soon as the midwife let us know, and they let us know as quickly as possible. So that we could get into the home and get—weigh the baby, examine it all over and make sure that everything was all right.

Check the mother over and make sure that she knew how to nurse the baby and the right kind of food that she was supposed to eat. And so that she could feed the baby, because breastfeeding was popular back then. Occasionally they did some—used some formulas, but most of the time they did the breastfeeding. And then we would go back in about a week later to make sure that the baby was okay and the mother was all right.

And we'd talk to them about cleanliness and all of the things that they used to rile the baby and to cover the—make sure the breast was cleaned off with tissues and, not necessarily soap and water but just something to clean the breast with. And then but anything that went into the baby's mouth was at least for the first three months should be clean. (CP laughs)

You know, we knew better, but we were trying to teach and sometimes they would listen. But when we got into the point of bringing them in or getting them in for the immunizations, we told them when to come in for that. And then we visited again in about a month. We had lots of visiting to do and we had—

CP: And that was every newborn.

AR: That was every newborn. Getting five or six nurses to do that.

CP: Yeah. But I think you also visited babies born by the local docs, too.

AR: If they were born at home. No, this was only the home deliveries that we had to do because the ones in the hospital had their own care. Unless the doctor called us and said they were having a problem. The midwives were so well trained that we had, and I guess that was everywhere, that if they got into problems, the mother got into problems, they just either loaded them up onto their car and took them to the hospital and met the doctor there. And I can't recall a lot of deaths, infant deaths, due to midwifery. Might have been but I can't—

CP: No, not in modern times.

AR: Yeah. And they delivered—

CP: Not since the public health departments have been directly involved. It dropped the death rates down astronomically.

AR: Right. But it bothers me that midwives don't go into the homes anymore, you know. I guess maybe I shouldn't feel that way, but the atmosphere was different.

CP: Speak to that. How was it different?

AR: Well, it was a home thing. You know, the children knew they were going to have a baby there, and they were exited about having a baby there, and the father was involved, and the mother was definitely involved, and grandparents were involved, so it was a very homey atmosphere.

CP: I see what you're talking about.

AR: And the midwife was a welcome person. They always welcomed the midwife there because they knew that she knew what she was doing and was going to take care of the whole situation. And if anything went wrong, she just took them right on to the hospital or called the ambulance and got them to the hospital.

CP: Do you think we may have done a disservice when we moved—it was a trend to move all deliveries into the hospital. It's beginning to reverse now, something called birthing centers.

AR: Yeah, because the families—the birthing centers are having the family involvement and that's good, I think. But the home environment was very good. And the midwife would go in and tell them, show them what to do to prepare. And we would, when we would make our home visits to the maternity, to the pregnant persons when they weren't able to come in.

We would go into the homes and have them to arrange to get ready. And as I told the students on the tape that I hope I'll get for you, that they baked everything in the oven to sterilize it. And when a small baking potato was done in the oven, then their stuff was sterilized. And they sterilized everything.

CP: I appreciate that's what you all taught them. The potato.

AR: Yeah. It was about this big, a little potato. And they put it in there with their package; everything was packaged. And then we taught them how to make the liners for the bed by using newspapers and old sheets to cover them. They stitched around it with hand stitching to keep the bed from getting all messed up. That was public health in my situation; I do miss it all, missed all of it when it stuck. When we stopped doing it I really did miss it all.

CP: And you did it. And you had the famous nurse's bag.

AR: The nurse's bag that had everything in it. Even a trash bag, I said, "We learned how to make the trash bag—

CP: From newspaper.

AR: —from newspapers, and of course, we carried soap and all the gadgets. The thing to weigh the baby with was a little tiny scale, and we had to calibrate it every time and tie the diaper up into a square, knot one corner and then put the baby in just like the stork would carry the baby to weigh it. And, of course, after my vision got worse, it was hard to see those little markings, but it was exciting for the little ones to see us weigh the baby.

CP: I'm sure of that. And you made your visit a family affair too?

AR: Oh, yes.

CP: I love it.

AR: We had these forms, you know, we always have papers to give out.

CP: We always have forms.

AR: And the green form that had the household data on it had to have the name of the parents and the address and how to get to the home, and every child and birthdates and, you know—

CP: It's listed on your family folder.

AR: It's listed in the family folder. So needless to say, back then, we had everybody in one folder. Now it's not; everybody's individual. But we had everybody in one folder, so that when we went we didn't have to take over four.

CP: But you were family, very family centered in the early days. And we've moved to individuals today.

AR: And I will have to mention to you, you remember the home visits you made with me?

CP: Yes. In Chattahoochee, I do.

AR: In Chattahoochee. And we went into this home where the newborn baby was, and there was child in there with a rash. And I asked you to come see that and see what we could determine about that, and of course, you were glad to look at it and see. And then we went to visit Dr. Thompson's office and met him. There were some other problems that I needed to square away, so. He was delighted that I brought you by, by the way.

CP: For the audience, I need to remark on that. We went to see the newborn baby, but we really saw two newborn babies. Mother and daughter had both recently had babies, so we saw two newborn babies all in one house.

AR: All in that one house. That's because that's how they lived; everybody lived together pretty well in those days. Going out into the country where they had vegetables and stuff, that's where I got a lot of my food. It's amazing. And that was the rapport we had with the people that lived on the farms. If they had anything, tomatoes or whatever, they shared it with us. And we didn't dare turn it down because it would have hurt their feelings. And it was always good so I never turned anything down.

CP: I can understand that.

AR: We had—we did home visits for the elderly, too.

CP: Oh, tell me about that.

AR: Well, you had people that were anemic[9] and had to have B12 shots, or some others. Sometimes it was other injections that they had to have. And we'd go into the home, and we'd do the initial blood pressures and talk to them about medications and then give them their shot.

CP: Did you call this home healthcare?

AR: We called it home healthcare. It wasn't home healthcare, it was just part of us. But it was a home health (inaudible).

CP: Yeah. You were doing home healthcare before there was home healthcare.

AR: Yes, right. We were doing home healthcare before it was home health.

CP: I see.

AR: And—

CP: And it was part of your routine job?

AR: Part of the routine job.

CP: Okay.

AR: I recall one person, an elderly person that—I think it was Hardaway area that I was going out to visit. Somebody had asked me to come visit him. He and his wife lived out there, and I went in and introduced myself and was talking with the gentleman. He was a precious person; he had just come from the VA hospital and he was—I tell you, he just slept all the time. I said, "Well, give me your medicines. Let me see what you're taking." And he had Tofranil and the Imipramine[10], whatever you—

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9 Anemia is a condition that results from a lack of red blood cells in the body.

10 Tofranil is the brand name for the drug Imipramine, which can be used to treat depression and nerve pain.

CP: Yeah.

AR: —And I said, “You’re taking this and this?” He said, “Yes, I’m taking one three times a day out of each bottle.” And I said, “I don’t think that you need to do this.” And he said, “How come?” I said, “Because they’re the same thing.” I said, “No wonder you’re sleeping all the time. So we went over all of his medicines and got that straightened up. I just took his bottle and poured them all together into one bottle. He said, “They didn’t tell me a thing down at the hospital.”

CP: No. They probably—the doctor thought he needed this, and he prescribed it and forgot to look at the chart that I had prescribed it or another physician.

AR: In another name. Under another name. And so the druggist filling it didn’t notice it either, I guess. So—

CP: No. He would have to do it by memory.

AR: And he was one that had raised a lot of vegetables, and so I got a lot of sweet potatoes and things like that from him. It was just wonderful to be in public health. These are just sort of by-stories that I can tell you.

CP: Yeah. Those are valuable to us.

AR: I went in to do a home visit in Mount Pleasant with this young lady that had a baby kid, several little children there. The name was—do I need to call names?

CP: No.

AR: This lady was having a problem sewing some clothes for the baby on the sewing machine. And she said, “I can’t make this sewing machine work.” Well, I’ve worked on sewing machines for my own, you know. So I went and looked at the sewing machine and said, “Well, you need to do is—let’s do some tension typing, or we’ll play with for a few minutes.” So we got the sewing machine to work, and she was very appreciative with that.

Of course, all of the home visiting part with the baby and all the other children, getting them written up so we could get them started on their immunizations or go back for the second or the third one. So, later on, I don't know if it was over a month later, probably, that I was going into another area in Mount Pleasant.

This lady came out of her house. I had stopped to ask for directions; I was almost, I thought, at the house but I thought I'd better for directions. She came out and she said, "Oh, you're the nurse, you're the nurse." And I said, "Yes." And she said, "I've got a sewing machine I want you to look at." (CP laughs) I had never seen one like that. I mean I had never seen one like that.

And I went in to look at it, and I said, "Well, I'll just have to sit here a minute and look because I've never seen one like this." It had an unusual type of bobbin. And we got to looking at it, and it was threaded wrong. And then we did a little oiling. And finally, as luck would have it—the Lord was blessing me that way—that I got it to go in. And she wanted to pay me. Bless her heart, she wanted to pay me for it. I told her, I said, "I won't charge you anything for this." She said, "Well, I'm going to give you a dollar anyway."

CP: Yeah. You public health nurses have some funny duties.

AR: Uh-huh. We did. It's not all just public health, I mean, just all nursing. You know, if you're going to teach somebody something, and they're going to learn—

CP: You better get their attention first.

AR: —you've got to do something for them. It's like feeding them food, and while they're relaxed they will listen.

CP: Yeah. Get their attention.

AR: That's part of public health.

CP: And you learn that early.

AR: Yes. And because I always knew how to do a lot of things for myself because when you have to do something—I mean, if you want something done, then do it yourself. And another story that I can tell you, this elderly lady, was talking about going in to do blood pressures and getting B12, she—her blood pressure was sky high that morning.

And I said, “What is wrong with you? What are you worried about?” And she said, “I can’t do my washing.” I said, “Why can’t you do your washing?” “Well, the washing machine is frozen.” I thought, well, where is the washing machine? It was outside of the house. You know, the building (inaudible).

CP: In a washhouse.

AR: In a washhouse. That’s right. But I said, “Well, let’s go look at it, and see what’s wrong with your washing machine.” There were two copper pipes. The hose—both the hoses had water full and was frozen solid.

CP: This is in the wintertime?

AR: This is in wintertime. So we thawed them out and we got the pipes fixed and cleaned out the others, and put the pipe—the hoses back on and turned on the washing machine, and it started working. She was—I checked her blood pressure after all of that was over, and it was beginning to come down. So I said I felt like that I had really done something good for her that day. (CP laughs) Not just being—giving her—taking the blood pressure and doing the—

CP: How many modern public health nurses would take the time to do that, you reckon?

AR: Probably not any, I don’t know. You know, you have to just come up in that kind of atmosphere. And I think I came up in that atmosphere.

CP: I think you need to be born and raised up there.

AR: You know, I’d hate to date myself but I came up during the Depression. And during the Depression, everybody that was around there, poor alike, and if you didn’t do it for yourself, and your family didn’t do it, it didn’t get done. You know, going to school and trying to milk the cows and tending the horses and the crops and everything. So I knew

how to do quite a bit of stuff. It was always a pleasure for me to work and do those little extras for patients.

CP: Yes, yes, yes. And that made them love you, I hope.

AR: We had a good rapport. As I said it's always been a two-way street. I enjoyed it, and I'm sorry that we've taken, as you said, a step backwards into public health.

CP: It's my feeling that there's not much home visiting done anymore by public health nurses.

AR: One of the questions that was asked when I was doing the talk at Carter Parramore School [Academy] was, What was the difference in these home health agencies in public health? And I said, "Well, they go to see one person, and they do for that one person. But public health nurses went in to do for the whole family—"

CP: When into see the family.

AR: "—And to teach the whole family." I said, "They looked at everything from the front steps to the back door and inside and checked the refrigerator and checked their furniture to make sure to see if everything they had was adequate. And if there was enough food in the house, enough clothing for the children.

And if there were not, we tried to get some agency to help them out, or to get them down to the welfare office and see if there's any help that they could get. And some of the agencies would be helping. So we—that's the difference. We'd give a total assessment and they only assess one person. And that's the difference in the two."

CP: They are a difference. And they get paid for it, and you didn't, as part of your—

AR: And as part of our home visiting, and this goes in to the communicable diseases, you know, we had to do all the follow-up on all the syphilis and gonorrhea that we found.

CP: You nurses did?

AR: We nurses did because we didn't have the eyes and VIs and VD investigators and those kinds of people. You know, Bill Morris, I guess was one of our first ones.

CP: Yes. I think he was.

AR: But before that time, we had—if we found a case of syphilis in our blood testing, because we did random blood testing, people would come in and want their blood tested, and we did restaurant health cards. Do you remember them?

CP: Yes. The (inaudible) syphilis serology public health cards. That's right, you did.

AR: We did the health cards. And we also did some of the stool testings for that as well. So when we had found them positive for syphilis or gonorrhea, we had to go find them. And it was very difficult sometimes because they would give you a phony name or they'd give you a nickname.

As I recall, out in Sawdust area, I had a name of a person with an address and knew exactly where it was at. I had one named "Sister." So I said, "Well, what am I going to do? I don't know who Sister is." So I stopped by the house and I said, "I want to find—I'm looking for Sister." They told me exactly where Sister lived. They knew her by Sister. Because we had the—

CP: Yeah, you public health nurses know how to find them. I can relate a number of outstanding stories of going back to the health department to get the public health nurse to come out here and communicate and help me find.

AR: Right, because we knew every nook and cranny, usually. But we enjoyed, or at least I know I did. I wouldn't have been in it as long as I've been in it if I hadn't been—

CP: Obviously.

AR: —loving it. I wanted to really be a pilot on an airplane.

CP: You what?

AR: Yeah. I wanted to fly planes.

CP: You and Amelia Earhart. You would have flown around the world with her with you?

AR: And my daddy—I don't know but my daddy said, "No." So when he said, "No." I said, "Well, I'll do something else."

CP: I'll go into nursing.

AR: I'll go into nursing. And I've never been sorry.

CP: Good.

AR: I could probably still learn to fly a plane now.

CP: I'll bet you could.

AR: I'm sure I won't do it.

CP: Well, it's available to you.

AR: It's available.

CP: You're now retired, so you need something to do.

AR: Well, I've got plenty to do. I have plenty to do. I have—I've been thinking of taking a computer course now at the college there in Bainbridge because I bought—when I retired I bought the computer and all the things that go with it. And I need to get acclimated to it. I can do what I normally would do, but there are some other things that I would love to do with a computer.

CP: I encourage you to take that course.

AR: So I’m going to look into Bainbridge having a day course. I’d like to do that.

CP: Yeah. And it’s valuable—we’d want you to be able to do that, where you can look at this tape and other tapes on your computer online.

AR: It’s been a pleasure to have that. I know I’ve probably weighed a lot of hours on that —

CP: It’s okay.

AR: It’s okay. It’s my time. And I do a lot of church work since I’ve been retired. Of course, I was doing that beforehand. Now I teach a Sunday school class.

CP: And drive a school bus.

AR: And drive a church bus.

CP: You drive a drive bus. I’m aware of that.

AR: We go to nursing homes.

CP: Oh, you do. All right.

AR: And we line up one every year—every month. And of course they go out to eat. We always go out to eat.

CP: You must be Baptist.

AR: We’re Baptist. We love to eat.

CP: Yeah. Baptists gather to eat.

AR: Yeah, we were at the—let's see, it was a Methodist church that has the adult daycare center in it, over on Old Bainbridge Road?

CP: Yes. Yes. Yes.

AR: We were there not too long ago, seeing them.

CP: Very good.

AR: I thought that was wonderful that they have a place for daycare for the elderly. We need lots more of them.

CP: Yes, we do. Let me carry back to your semi-medium public health days. How did the 1969 reorganization affect you? That's when the State Board of Health was abolished.

AR: And merged into HRS [Health and Rehabilitative Services]?

CP: Yes. That's when HRS came into being. I think it was '69. Did that impact you all?

AR: Well, I don't know if it impacted me, necessarily, because we just did our work, you know, but I'm sure it did—

CP: You just went on doing everything you've been doing.

AR: I'm sure it impacted the administrative part of it because it got so big, nobody could reach the top. And things had gotten so slow. You know, hiring practices were terrible. You could just go hiring. Now it's different. Of course, I hope one day they'll sort of go back to it, but I don't know.

CP: And then in '74, it was in '75, it was the next big reorg and that's when districts—when we got districts that were put into place. How did that impact you as a county health department?

AR: Well, it helped in some ways, I think, that we were able to call on districts to help each other, you know, with information and maybe trading information or doing different programs in the different areas and having them come to us to do—for teaching purposes, and learning from each other. You know, you do learn from each other if you—

CP: Yes. If you would just listen.

AR: If you just listen you can learn from the different counties. If they were doing something, and the wheel had already been invented, we didn't necessarily need to reinvent it, and we could pull from their resources. And if we were doing something, then those other counties could pull from us.

CP: You know, that's some—I'm very interested in hearing you say that because I'm aware the health officers for many, many years have kind of identified regionally, the health officers have. And they would gather—I'm recalling into the early '50s when groups of health officers.

And I remember going to Walton County, personally, where as I recall, was called the panhandle health officers, had gathered in, and I was invited to come over to talk. And you're saying a highlight of the '75 reorg in our district, it had caused the, in your case, nursing folks to get together periodically and you could do some mutual problem solving. You didn't have such a thing prior to '75?

AR: No, not really. Not as I recall.

CP: That surprises me. I'm disappointed in that.

AR: Not as I recall. Because usually the health departments were pretty well self-sustaining.

CP: Yeah. They were very autonomous.

AR: And the county commissioners in all the counties donated—put in their budgets lots of dollars to support that. And they've gotten away from that now, and that's sad because the health departments, usually, and I can only speak for Gadsden, that they keep a lot of people out of the emergency rooms by doing health preventatives. And that saves the commissioners a tremendous amount of money because they've got to pay for it.

CP: Yeah. You know, it's kind of hard to put a finger on it. You can't put that on black and white paper.

AR: Yeah. Well, they can at the end of the year when they look at the multimillions that they have to pay out to the hospitals.

CP: They should be able to see that.

AR: (laughs) They will be able to see that. That's for sure. But they just don't put in any —well, as you noted with all of this and that going down the tubes now, that money is not being put into the health departments.

CP: Apparently not.

AR: And my advice and to them and anybody else, if they want good healthcare, they would have put it in the health departments so that they would have the people to do it with.

CP: And to state it in another way, you kind of get what you pay for, don't you?

AR: Right. Absolutely. Because when we have to delete positions, and when there's a body in that position, it really makes it tough on those left behind. Absolutely.

CP: Oh, yes. You've served under a whole bunch of health officers. When you first came, your health officer came out of Leon [County] didn't he? When you first started?

AR: No, he was local.

CP: Oh, you had a full-time local health officer?

AR: We had a local health officer.

CP: Oh, you did?

AR: Yes. A doctor was there. You know, we had doctors until we got Jerry.

CP: Yes. But you shared them with other counties, I thought.

AR: We did. We did that. Now we did share them with other counties but ours were local. We didn't at first, as I recall—yes, we did, too, because we were with Liberty County and Calhoun. We shared the health office with Liberty and Calhoun. And we did for a long time. And we even shared nurses with Liberty County, not Calhoun though.

CP: Oh, you did? Talk to that.

AR: Mrs. Guel(??)—

CP: Tell me about that some.

AR: —she was—lived in Gadsden County but she was a nurse in Liberty County. And she would meet with us every Monday morning to go over things and to talk about records and things that we were having to do so then she'd go on to Liberty County. She had the clinics over there, did the schools and the home visits—

CP: She did?

AR: —in the county. In Liberty.

CP: But she was associated with you all?

AR: Yes, because our health officer was.

CP: Oh, he was also in Liberty?

AR: Liberty and in Calhoun. Then later on, the physician was over—Calhoun decided to go out on their own, maybe join with another county one way or the other. But we had picked up Jackson County. We had Jackson County, Liberty County, and we shared the health officer; that was always shared, the health officer. And the nurses in Liberty County was part of us. But Jackson County, we only shared him.

And he would arrange the clinics, rearrange the clinics so that he could go to one and go on to Jackson County because they were out behind us, and then he would do his clinics over there. I think he had one in Mariana and one in Graceville. Then he would go do those clinics, and then he had Sneads, then he would come back to Chattahoochee, and then he would go home.

And then on other days he would be doing our clinics. So he was spread pretty thin. And of course, that's bad because you have a doctor that sees patients once a week, then what are they going to do after that? But that was how we had to do it, you know, in order to have doctor coverage. And he, I guess he was considered the health officer for all three counties.

CP: He probably was.

AR: And did all the paperwork and whatever else had to be done. And all of that so.

CP: He probably did.

AR: Then Jackson County split off and got their own. And Liberty split off, and they were the same. But it seems to sounds to me like that we may have the same thing happening with administrative people, that we may have to go to multi-counties with them and administrators.

CP: Is this because of budget, budget cuts?

AR: I've been hearing that. I don't know if that, you know, because of budget. And I wonder, especially since we've gone back to health departments. That's something we've been—that I've heard talk.

CP: Yeah, you were there a little while after you went back to the health department. Not very many months, but did you detect any difference? You also became director of nurses during then—

AR: Yeah.

CP: —and thus carried some administrative responsibility.

AR: Well, you know, Mrs. Martin was the nursing director and had been there for a long time, and when she suddenly decided to retire, I became—I was already the assistant nursing director. I had been a senior community health nursing director—nursing supervisor up until about ’96, I believe, and then I became this nursing director.

CP: Yes, you did.

AR: Let’s see. At the assistant, that was ’96, I guess it was in ’96 where I became the assistant. And then got in—I guess it’s earlier than that because I was a nursing supervisor up until around ’90, I guess, and then became the assistant nursing director. And of course there was—I was a working nurse assistant—nursing director.

CP: You had your own clinics, et cetera.

AR: I had some of my clinics as well. I had nurses covering with them some of the things that they didn’t cover or couldn’t cover. And then in October, I guess, of ’96 was when I became the nursing director. And then in January, we hired the assistant nursing director, and then when I retired, he has taken over as the nursing director.

CP: Yeah, as nursing director, you were in the position of nursing director when you became a county health department again—

AR: That’s right.

CP: —due to the 1996 reorg. act.

AR: Right. The reorg. act, right.

CP: You've lived through three significant ones, could you tell any difference as nursing director? Because of the '96 reorg, you lost your relationship to a district; you quit reporting to a district.

AR: That we miss.

CP: You begin to quote, look back to the state headquarters. Tell me about going through that transition.

AR: Well, it really was sort of difficult because we never knew from one day to the next about the budget, you know? It was always a bad—we couldn't get a handle on the budget, it didn't seem like. And they were always saying, Well, we were going to cut positions, and you know, that always scares everybody to death and puts low—

CP: Moral just goes out the bottom.

AR: —lowers—it goes out the bottom, that's for sure. And we were losing nurses and Mr. Wynn says that we needed to—I needed to lose two nurses and I said, "Mr. Wynn, I can't do that." I said, "The nurses are the ones that make money. The LPNs don't." And I said, "And I don't want to lose any of them."

So I searched my brain, and in the middle of the night, one night it says, Put one of them into school and put the other one in the pharmacy. Because Mrs. McMillan retired, and when she retired, I said, "Let's put one there because she'll at least have a medical background and put the other one in the school, so that she can work with the children," and save the jobs, so we did that.

And you know, that's always heart rendering to think of who's—somebody's going to lose their job because our funding is not what it should be. But they really do need to think about funding, the health departments, because that is where public health is.

CP: It's where it's done. It's done through the county heath departments, not healthcare.

AR: I read in the papers all the time about this new drug-resistant—

CP: Strep, Staph.

AR: Strep, well, bacteria and all the—

CP: All of them.

AR: All the things, even syphilis and gonorrhea is—some of those because Penicillin has been used for everything from ingrown toenail to—

CP: Discolored hair.

AR: Right. So it really is—and I predicted it for years. I know you have because we're going to have drug-resistant—

CP: It's going to get worse. It's going—

AR: And it's not going to get any better.

CP: And it's already beginning to show its ugly head.

AR: Right. They can't find cures enough for it. But that's happening and that's simply because of the misuse of drugs.

CP: Yes, it is. Misuse of antibiotics. And that's sad to me because we're losing some good stuff and there's no light on the horizons as they'll be replaced. No.

AR: No, that's true. You know, when we started off, and this is digressing just a minute, with health officers who were physicians to administrators like we have. Well, we didn't know just exactly how to accept it except that we just love ours.

CP: You do now.

AR: Yeah. We love him. Well, we loved him to begin with, you know? And he just impressed us when he first came for orientation.

CP: Oh, marvelous.

AR: Not for orientation but for us to chat with.

CP: Meet him?

AR: Yeah, meet him. And grill him, it's what he said we did; we grilled him. But we just —he just endeared himself to us. We were a little apprehensive, you know, because he didn't know medical.

CP: He had no medical background.

AR: No medical background whatsoever. But he has always been approachable, and he's always told us this, "Now you are the ones that keeps me straight. You have to tell me what's going on. And I'll ask questions as long as I can find out and need to ask questions."

But he said, "You will need to keep me informed on what's going on, especially the medical part of it." And we've done our best to do that. And he's been very open-door policy, and he's been very approachable. And although we missed the physicians, but they worked all the time.

You know, they were back in their clinics doing work. And I marveled at how they did their paperwork, because there was lots of paperwork. If they hadn't had good secretaries they wouldn't have been able to do it. And especially traveling from one county to the other. But he's been very good for us, I think, and we've enjoyed having him there.

CP: Okay. And that's testimony that our audience needs to hear.

AR: And he's always available unless he's at meetings. And you know, there's lots of meetings.

CP: There's a lot of those.

AR: There's lots of meetings. So we've certainly tried to stand behind him and tried to support him and all in all ways that we could.

CP: That's good testimony because there was a lot of controversy over using non-medical administrators for county health departments.

AR: Some of them may have had a bad impression, or they may have gotten somebody they didn't like or, you know, they're not happy with. But we were delighted with him because of his personality.

CP: And you've got a new building since he's been there.

AR: Well, he's gotten us several new buildings. You know, the one in Chattahoochee, the one we're in now, for instance, in Quincy? And the one in Gretna, and that, and the one in Havana. He was instrumental in getting all those built, instrumental. It's just too bad that when they were doing all the buildings, they didn't put a lot of money in our checking accounts, so we could keep them up and keep them supported. But we can't see too far, we need five-year plans, ten-year plans, lots of planning.

CP: Yeah, we do.

AR: I can go into all of that. One of the other things that I would like to speak to is the FSU clinic that we had in Gretna.

CP: I'm not sure I know about that, but keep talking.

AR: Sally from FSU, well, actually, Sandy Johnson, the representative Dewey Johnson's daughter was very interested in it. She was working at FSU, at FSU as the fundraiser. And then they decided they wanted to do some clinicals in a rural area. So she speaks up and she says, "Well I know just the place."

So it took us a while to get it established, but Sally Lee was the nurse ARNP [Advanced Registered Nurse Practitioner] that helped us get started; she had her doctorate. And we

opened that, I think it was about seven or eight years ago; I don't know the exact time. FSU did their clinicals.

The ARNP students came out there to do clinicals. And there, we took care of everybody with everything. It was backed by AHEC [Area Health Education Center] and they, furnished the money to pay the students for travel if they wanted to get to travel. And they were assigned from FSU to come train—

CP: This is the school of nursing, FSU?

AR: The school of nursing, the school of nursing. And we had a—they did adult health, child health, sick children, sick adults; we followed them for diabetes. They did all of that. They were their physicians, really, they were their physicians. Now, they had their own physicians, but most of them didn't have insurance. And, you know, you have people that they're not going to the doctor. They got to pay, well, they don't have the money to pay. So, we did their health follow-ups and everything for them.

CP: You were their doctor.

AR: We were their doctor.

CP: Is this clinic still going on?

AR: No, it's not going on.

CP: What happened? What happened? What happened? That sounds like that would be a marvelous service.

AR: Well, it did. It was a marvelous service but we, and I may have to speak of this (whispering) afterwards. I may have to talk with you later about that, but it closed. One of the reasons, FSU was not—the school of nursing was not assigning, they had stopped assigning patients, I mean the ARNPs and even the generic students, to us and we would be out there with no pay—no—

CP: With a crowded clinic and no providers.

AR: With a crowded clinic and no providers. And we would then sometimes we would have students running out of our ears and no patients because we didn't know to put the patients to a schedule.

CP: That's some problems with coordinating.

AR: Well, it was, and we told them. We sent them a copy of the appointment list every week, and we'd give it—it was always on a Tuesday and we needed to have knowledge from them when we were going to have the ARNP people. You know, because each one of them, we couldn't operate just for students, we had to have their staff as well.

So sometimes they'd be in class or be gone, and we'd never know it, and it was things of that nature that, finally, we just decided that we couldn't. And they had—they had gotten involved in it and the money was not coming forth from nursing, so we decided to just curtail it and get our—It was a wonderful program. I presented the program to CASE several years ago, it had slides and everything. And we had—I had quite a bit of fun doing it.

CP: Okay, we've used two acronyms that we need to find. AHEC, Area Health Education Center, a federally-supported effort for training medical providers, and you use CASE, C-A-S-E.

AR: CASE is Consultants, Administrators, Supervisors, and Educators. They come together all over the state in one place, they come together at a meeting place and go look to the past a little bit and talk about the present, and then plan for the future.

CP: This is nurses, this is a nursing organization.

AR: This is a nursing organization.

CP: Which is done under the auspices of the public health nurses.

AR: Right.

CP: But this is administrators from hospitals, management—

AR: We have administration from different areas—

CP: Everywhere nurses are, are partial too

AR: —in health. Right. In where ever—and usually we have speakers, Dr. Mahan has been the major speaker. Dr. Howell was there. Actually, he wasn't there, he was trying to get monies and he sent a tape. So we did get to listen to him and watch him on the video so that we could all hear.

CP: Okay. How long ago was this? This was since his (inaudible).

AR: This was April. This was April of this year, which was probably will be my last case. I'd love to go down just to be part of it.

CP: I don't know, you could go. They won't pay your way anymore.

AR: No, well, I had to pay my own way that time. Took annual leave then.

CP: Well, I encourage you to just plan to go to the next one. You would be so welcomed.

AR: Yeah, I'd just love—I love being with the group. They just always have so much going on and so much to share.

CP: I like this thing of the preceptorship that the FSU was doing with you.

AR: Well, it was good. It's wonderful. And we're looking at—and I don't know how it's come since all the money crunch has come, but we were looking at family practice as something maybe doing something else, some other organization that would need to have some trainees.

CP: Clinical?

AR: Some new clinicals there.

CP: Tell your, tell your cohorts over at the health department and talk to AHEC. AHEC can use its influence to help get you organized again with just one party. That's a justifiable service from AHEC.

AR: It is, because the need in Gretna was so great.

CP: Yes. It still is.

AR: It's still there and it still needs it.

CP: And it has been forever.

AR: Forever. And it's hard to fathom some of the things that—

CP: That goes on in Gretna.

AR: —that goes on in Gretna. And it's such a nice little town that—they have a new, big police department there, and that has made a big impact on the things that used to go on over there. And I really am glad that they have been able to—I know they've been in the newspaper lately about six or seven months ago. But anyway, people gripe anyway. After you get caught speeding, it's always somebody else's fault.

CP: It naturally is.

AR: Always blaming somebody.

CP: Yeah. I was just following the car ahead of me. I was charged personally back in about 1961-ish, two-ish somewhere in there, to evaluate the sudden decrease in infant death rates in Quincy, I mean, for Gadsden County, which was astronomical from the state's statistical point of view, that Gadsden had been leading the counties of Florida in infant death rates as long as we had been keeping statistics. And then this one year it just popped. It fell out the bottom. Do you remember that? I want you to speak to it a little bit. Talk about that some.

AR: When we were able to get into the schools, and I think that Shanks Clinic had a big impact on the children. They have been doing a lot of teaching and a lot of working with the students. And we have—one of our other staff that works with them at the school, and they call it the ladies—I can't remember what she calls it, but anyway. They talk about problems and they air their own feelings and get together in little groups and they have things like clothing shows.

CP: Oh, that's a girl term—fashion shows. Don't ask me about fashion shows, that's girl stuff.

AR: Fashion shows. Too add more—my notes are a little bit better but we've just been going from one thing to the other. But we have the nurse out there now, too, that will be able, I think, to do a lot more in the schools. We have the Jefferies, Camilla Jefferies, she's there and we brought the other girl back to Chattahoochee.

She's done public health in Pinellas County, and she's done programs in schools, and she worked with students. And she herself was a teenage mom. So she could really relate to them and give them a lot of encouragement and a lot of pointers on getting an education and being—not a dropout but—

CP: Responsible?

AR: —be responsible for themselves, and I'm looking forward to hearing Terry tell me that things are going better. I think that the nurses being in the schools has helped some, but that place, the Shanks Clinic, has, I think, done a marvelous job with the students in getting them to get responsible for themselves and get an education, so that they can do better for themselves.

CP: You're kind of famous in Florida, too, Gadsden County, as having the first school-based clinic in which you sent nurse and medical staff in to the grounds of the school to hold medical clinics and to treat stuff. That was done with great controversy.

AR: Definitely. Definitely.

CP: Speak to that some. What happened and how's it doing?

AR: Well, the clinic's doing real good now. Getting it started, we had to overcome a lot of outside help. You know, it really was not the county because the area that school was in, they did the started, we had to overcome a lot of outside help. You know, it really was not the county because the area that that school was in, they did the survey with the parents and the communities and the churches and everything and found out that they really wanted it.

And if they had not really wanted it, we would not have gotten it. We met with legislators and spoke with them about the need, under the funeral directors. There was a great big booming voice, we met with the legislators and he just practically turned them around. So he—but we did have to meet with a lot of people in order to get that started. And we had to just sort of turn deaf ears to the people that were outsiders trying to interfere.

CP: Yeah. You didn't have outsiders, I mean, real outsiders from out of state come in to picket you.

AR: We had lots of outside help, a hindrance.

CP: That you did. How's it doing now?

AR: I think it's doing real well. There's been a change in the school curriculum that says that, you know, they have the hour and—what is it? An hour and 50 minutes classes, so they don't have time in between; they don't have anything left that they call recess or study hall. Study hall so that the children are kind of handicapped to get there, so they're going to try to work out something that they can get the pass and go to the clinics and not spend a lot of time.

CP: Yeah. Your school superintendent over there probably is very supportive of this.

AR: Yes, he is. He's very supportive of that.

CP: And I suspect he had help with any dialogue you needed with principals and others.

AR: Yeah, they were going to—since I retired, the administrator and the nursing director is setting up, maybe they've already met, with a lot of the principles to work out some of

these principles to work out some of these problems because all the high schools have the same things, I believe.

CP: I would imagine.

AR: Havana, now has a clinic in its [school] and they have a “Baby Think it Over,” they have four Baby Think it Overs. You’ve met those haven’t you?

CP: Now, what’s a Baby Think it Over?

AR: Baby Think it Over is a doll that does everything.

CP: Oh, it does everything.

AR: It cries. And if you don’t hold it just right, it scrawls and I mean its cry is terrible. And if you don’t feed it on time, it cries, and if you dry it on time it cries, and if you don’t lay it just properly on the bed, it’ll cry. And what—

CP: I hadn’t heard about those. I like that.

AR: Baby Think it Overs were 200 dollars apiece, and they had some community help with that. PTA bought a couple of them and some of the organizations—typical organizations bought two. And they do select the couple that takes this baby because of this expense and everything and they have to promise to take care of it.

When the baby comes back, they can tell if it’s abused. I don’t know just how they do it but there’s a key on it and they’re not allowed to get the key; it turns it on and off. But they have to take the baby, they promise to take the baby and to do for that baby.

CP: Take care of that baby.

AR: And one of the stories that the nurse told me about was the boy had the baby and he had to take it to work with him. And he worked at something like Subway or something, I don’t remember, it was one of those short order things, restaurants. And the baby cried and cried and cried and he couldn’t get it to hush.

And the manager had to write a note. Yes, he did have the baby, and he didn't abuse it. But I tell you, she tells me that these people, these couples that do this, that take this baby with them, just say, Babies, we'll wait. Definitely, Babies, we'll wait.

CP: Are these married couples?

AR: No. They're just a pair, boy and girl. They don't live together or anything like that. But one of them is responsible for the baby at certain times, and the other one's responsible for babysitting other times.

CP: I think that is excellent.

AR: So she had to take the babies in to do what they needed to do, then she worked them out a welfare formula for money. They had to buy food with it, and to buy—she gave them a certain amount of money, and these things they had to buy, you know.

The rent and the food and the baby's clothes and their clothes, and the whole thing that it would take to run a household. And she tell us how some of them are real good at trying to save and live within the budget, and the others would throw up their hands and don't know what they're going to do, you know. But it's a learning process.

CP: Man, that would be tough.

AR: And I'm telling you, a teaching process that can't wait.

CP: Yes. I love it.

AR: You remember the lifestyles that they had a long time ago, that you had the egg; it's very similar to this except this is a baby doll that looks like it's living. And it cries, and it laughs, and it'll do those things that babies do. So, if you're in Havana, just go by and see them.

CP: You, during your tenure, there's been a significant shift in your population base with the great influx of migrant laborers into Gadsden County. Speak to the impact of that on

your public health programming since you're unique, from having them before when we didn't and now we do.

AR: We do our very best to try to help these migrants because they come there with nothing or they come there with needs. And of course, they are migratory, they move from one area to the other. Some of them's been taking up and bought homes there and living there, Greensborough especially. And of course, we follow their pregnancies and we try to give the immunizations and other things of the needs that they present.

The problem that we have is interpreters. It is almost impossible to wait on them to do physicals and to do histories and everything without an interpreter. And we have been working with AHEC and with another group there about interpreters. We try to tell them to bring their own interpreter with them, but sometimes it's a child.

You know, when it's a child it's awfully hard to go through medical terms with a child doing the interpreting. But our greatest need in that area would be funding for interpreters. Greensborough and Quincy has the biggest populace of migrants, and that's where, of course, we have the biggest clinics of the migrants.

CP: Did that importantly increase your caseloads? Your workloads?

AR: Very much so, very much so.

CP: And you just absorbed it? And did you get more staff?

AR: We just had to absorb. We did not. No, we lost staff. We lost staff.

CP: What did you quit doing in order to do that?

AR: They just work harder.

CP: They just work harder. (laughs)

AR: They just work harder and more diligent. They just—it's just amazing.

CP: Okay. So they brought a special problem to you, one. You absorbed the staffing and the clinics, apparently, without a lot of difficulty, but you did that. But you have a problem with communicating and you feel like you aren't providing the service you probably want to or need to.

AR: We would love to have more interpreters. In order to do that, what we really would like to have if we could put on staff was have bilingual nurses.

CP: Of course. Yes, yes, yes.

AR: But you know, we've been sort of blessed, I suppose, or fortunate with having some of the ARNPs or the PAs that come in, physician assistant students come in, they're bilingual. And that has helped some but that's not all the time, see, they just come in as they happen—

CP: Where do you get these students? The AP, I mean—

AR: The PAs.

CP: —the PAs and the ARNPs?

AR: Gainesville.

CP: Oh, you haven't mentioned that. Now talk about that.

AR: Gainesville has an agreement with us that they can send some to us from down there. We don't have a—

CP: Oh, they come up and stay with you for a while?

AR: They can—they have—I don't know just exactly how long they stay, three or four weeks, maybe. But we also have the FSE—FSU students, as well as the ARNP students.

We have occasionally, we have those come in. Although we also have FAMU students that come to us. And it's always a delight to have students in there.

CP: Yes. Yes. But you, I gather, that you can't depend of them year-round?

AR: Oh no. We can't because they're students and they couldn't. We need some funding for interpreters that we can keep on our staff.

CP: Yeah. I can see why you might need them.

AR: Either by nursing or someone that can be their—

CP: I like your idea of bilinguals.

AR: Bilinguals on staff would be—and we could have several of us taking lots of courses in Spanish but, you know, it's—

CP: You all haven't gotten there yet.

AR: We haven't gotten there yet, no. I can hardly say, "Si," anymore, but it would be good for us to have people on our staff, so we could serve them better.

CP: Yeah. Any sort of different health problems from your standard population?

AR: No. I don't think so. I guess it's sickle cell[11], we would—that's a group, that would have sickle cell if they were going to have it. And we do test for them. As to all them when we doing our EPSDT screenings. But I don't believe they've brought any—

CP: Nothing unusual.

AR: Well, we call them, fancy problems with them, they're usually just old problems.

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11 Sickle cell anemia, also known as sickle cell disease, is a blood disorder wherein red blood cells take the shape of sickles, causing severe infections, pain, and fatigue.

CP: Just plain problems.

AR: Plain problems that we've always had in Gadsden County. So that—we just sort of go with the flow. But the interpreters would be the one thing that we really would need to get.

CP: That's a good point. All right, for planning for healthcare, we need to consider the language problem.

AR: We're hoping to add another ARNP our staff. We've lost two, but we have the money for another one, so we'll add one or two, but it won't be—she won't be bilingual. But if we have somebody out at the clinic, and that was one thing that we had to share when we were doing the FSU clinic from nursing, was we had our clinic on Tuesday and the Greensburg clinic was on Tuesday, so we shared.

We had to share, and you're talking about juggling schedules, well, we had to have the migrants come in on—in the morning for the day in one place, and in the evening at the other place. So she could travel back and forth to the two different clinics. And sometimes she'd have a baby that's sick, so we couldn't—it was always a problem. But so far as bringing anything necessarily in that was different, I can't think of anything that would be too different that we weren't already used to.

CP: Okay, from your health department planning being ready is what I'm trying to get at, for future [audience]. What have we left out?

AR: Well, I really don't know if we've left out anything. I think I've covered all my notes. I didn't—when I was typing this up, and I got to thinking during the night that I've left off sex education, but we've covered that. Then, of course, you know, public health nurses did then go into the communities and do civic speaking.

CP: Yes. And you don't do that anymore?

AR: We don't do that anymore.

CP: That is sad.

AR: A lot of times the administrator is invited to do that and sometimes he will want us to give him information. And occasionally, they will ask us to do something, but usually it's usually just usually from the administrator's point of view.

CP: I want you to get back with your technical knowledge and on sight, your eyewitness accounts of problems and talk about them. If you're looking back over your very, very fine career, what would you identify as the three highlights?

AR: Well, just getting into public health was—

CP: That was one of them.

AR: That was one of the highlights.

CP: Now, I worry that that may be because you got out of a frying pan, is the reason you're so happy with that.

AR: Well, I'm not sure that that was exactly true. It was something I didn't like, but when I—as I said, that when I got into public health and my first initiation of it, I just fell in love with it. So, I guess, maybe you might be partially right in the fact that I didn't like the other part simply because I wasn't doing what I wanted to do in the operating rooms.

So, getting into this job, it gave me contact with people and established a rapport. I think that I've spoken to most of the things that would be the highlights. Being a part of the county. Just knowing the people and being able to function as their nurse would certainly be a highlight.

CP: Yes. Yes. A lot of personal satisfaction in that.

AR: Personal—personal satisfaction. And as I always said, it was a two way street because the clients always looked forward to visits. And I guess the, maybe the last part would be the—being elevated to the director of nurses even though I retired shortly after that.

CP: Yeah, but you had been there—you had been there, I couldn't figure out the years. You've been a part of that nursing staff a long time.

AR: Since 1950.

CP: Yeah. And you finally made directorship.

AR: I finally made directorship and then retired. (CP laughs) But that would be the highlight. It certainly helped my retirement.

CP: I'm sure it did. (AR laughs) That's great.

AR: Yes. I know it.

CP: What's the low points?

AR: Well, I think of the low points in the terms of bad outcomes.

CP: Bad outcomes. Okay.

AR: You know, your heart always bleeds for people when they have probl—

CP: These are the cancers for which you could do nothing.

AR: The cancers where we could do nothing.

CP: Or maybe that died in spite of all your efforts.

AR: Or with the [arrhythmic] hearts disease where we could do nothing.

CP: Oh, boy.

AR: One of the stories that I will tell, was a 12 year old girl was—had cardiac—no, not cardiac—myocarditis[12], myocarditis. And I had to give—it was the day of the bocillin. You know, we have all kinds of penicillins these days, but this was bocillin and she had to have eight CCs, four in the cheek, every day for two months. And that was Saturday, Sunday, Monday. And she would—I always wanted to cry. And I got it because she would just scream and holler and she would just be so terrified.

CP: She's still hurting from yesterday—

AR: Well, sure. Again

CP: —and you're going to stick her again.

AR: Finding places to stick that child. And after two months, she died. And I said—you know, it just broke my heart. It just broke my heart. Those are the low points. And when you go in and talk to people and try to educate them into getting them to do the things that would be best for them and they pay no attention to you. That was pretty rare but it happens.

CP: Yes. Yes. And I'm sure it happens.

AR: And the SIDS babies. That was always very sad. The death of an infant, regardless of the cause.

CP: Yeah, SIDS we need to define. SID, sudden infant—

AR: Sudden infant death syndrome. And the parents were always blaming themselves. You know, it was a guilt trip. Then their denial, and then the guilt and all the things that goes with grief. And it was—it would be very sad for me to have to go in to talk to them and revive memories of what happened. And then they had all these papers to fill out. So I would grieve over that. And those are, I think that I would just sum that up and say inevitable death would be a low point in my career.

CP: Yes. Realizing there was nothing you could do about it.

12Myocarditis is an inflammation of the middle layer of the heart wall, usually caused by a viral infection. Severe cases can result in heart failure and sudden death.

AR: Right. Just sit by.

CP: Well, when your great grandkids are watching this tape 75 years from now, what would you want to tell them?

AR: I would say, Hang in there.

CP: Hang in there.

AR: It's going to get better.

CP: It's going to get better. (laughs)

AR: Sooner or later it's got to get better.

CP: Okay. And also watching these tapes will be students and historians, but students especially. What advice do you have for a young student?

AR: I would admonish the students to continue their studies and to make best of the opportunities that present themselves because if they look for opportunities, they will be there. And medicine and nursing, as far as I'm concerned, is the best career that you'll ever have because you're able to do things for people that you could see progress in, and save a lot of people from getting into difficult situations, medically.

CP: A very rewarding field, but you and I are biased now.

AR: Yes we are.

CP: You know, but it's still the most rewarding of all the occupations.

AR: Right. I tell everybody I'm biased because I'm in nursing. Because, you know, I mean, I can't speak to anything else because I've been in it for so long. But to students, study hard and take advantage of every opportunity that you can and be kind and good to people.

CP: And watch for the opportunities.

AR: And, yeah, watch for those opportunities. They'll be there.

CP: That is great. Well, Mrs. Ryals, on behalf of the University of South Florida and its school of public health, and myself and Jane, I say thank you sincerely for coming by today and sharing with us your long and colorful career in public health, in particularly in a rural county because this has been most enlightening to me. And I thank you sincerely Miss Ryals.

AR: Well, I appreciate the opportunity to come very much.

CP: And I'm Skeeter Prather.

End of Interview