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E. Charlton Prather (CP): Good afternoon. We are privileged to have with us today Dr. Charles Mahan, who is the dean of the College of Public Health at the University of South Florida[1]. He came here from the position of state health officer and director of the state public health program with Florida state government.

But indeed his interest in the matters of the public health precedes even that, and as a trained obstetrician-gynecologist, I understand he early recognized the need for a community attitude toward maternal health and, indeed, child health. And as he has progressed in his career with the Florida public health system, he has seen much of those early concerns come almost to fruition at least programmatically.

He has been the guiding light for a number of important public health oriented programs given to maternal and child health. In his present capacity, he has even enlarged that vision to, essentially and indeed, all aspects of the matters of communities and public health. Dr. Mahan, it's a true privilege that we could sit with you today and hear you talk about your career in public health. What in the world got you interested in public health coming from OBGYN?

Charles Mahan (CM): Well, as most people that are now, I guess, of my age in public health, we didn't have much of an introduction to public health in medical school. We sort of had to figure it out ourselves. I have talked to a lot of people about that. In medical school at most places around the US, people usually had three or four lectures in public health and—

CP: And that's it.

CM: —some rather uninspiring person would be brought in to—

CP: From the public health department?

1Dr. Charles Mahan was still dean of the College of Public Health at the time of this recording. Doctor Mahan was the dean from 1995 to 2002.

CM: Right. To get it over with, you know? I think being somebody with sort of a perverse sense of humor—one of the early things I remember was I went to medical school at Northwestern, and I usually chose my rotations. We had a lot of choices in our clinical years. I usually chose them at Cook County at the Cook County Hospital because there was a lot of action there and you could see almost everything. They usually left you alone, sometimes that was good and sometimes that was bad.

But I remember one of the first things that struck me about the need for public health was—and again, I wouldn't have used those words—I was taking obstetrics at Cook County Hospital the year that they had more deliveries than any other hospital in the US has ever had before or since then: 26,000 deliveries in one year. That is bigger than the town in West Virginia that I came from.

So, that was very impressive. There were just babies coming at you from all directions. The average family size in Chicago at that time was about seven. And the first delivery that I helped out with was a woman who was having her 17th pregnancy.

CP: She didn't need much help did she?

CM: No, and that's why I got to take care of her. The place was just roaringly busy. They had these little nurses from the Philippines there who could speak no English. You would converse with each other in charades. I got the impression that she wanted me to come into this one room, and this woman, Mrs. Robinson—I always tell the public health students about this—was having her 17th baby.

So, right as I walked in, the baby came out. And the baby was doing fine, and I cut the cord and took the baby over to the incubator and was sort of playing with the baby and cleaning it up. Then I heard (makes yelling noise) behind me, and it was the Filipino nurse.

And I turned, and to my horror another baby was coming out. So I rushed over there and got the other baby. And she takes off down the hall, screaming and yelling, brings the resident back who proceeds to berate me for delivering twins.

Second-year medical students are not supposed to be delivering twins, but there wasn't much I could do about it. So, he's standing there yelling at me for doing that, and he leaves. And finally, I get the two babies over there, and I clean them all up. And the nurse helps me wrap them up, and I put one in one arm and one in the other arm.

And I go over to Mrs. Robinson, who's got her head turned away from me, and I said, "Mrs. Robinson, this is really great." I was so excited. I said, "You have two beautiful baby boys." And she turns her head over and looks at them, and she looks up at me and she says, "Oh shit." And I was very disappointed with her reaction.

So, then I started asking questions. You know, that was in 1962, and the pill had come out in 1960—oral contraceptives. So I started asking questions about people like Mrs. Robinson and found that the only place that they could go to get contraception or the pill, anybody in Chicago,

was down at Planned Parenthood in The Loop[2], and that the pill was so popular that there was a waiting list of six months before you could get in to be seen, during which, of course, a lot of people got pregnant again.

That was sort of interesting to me, but the thing that really, I think, drilled in the concept that this was important was that Chicago is the largest Catholic diocese in the United States, and the aldermen[3] in Chicago that ran Cook County hospital—when I inquired as to why we weren't providing family planning services in the hospital, they said that that was illegal. And as a matter of fact, the medical students were forbidden to talk to the patients about even being referred down to The Loop for contraception.

Now, we would not have been interested in any of this if we hadn't been told not to do it. And the fact that they made such a big fuss about it, we all started getting very interested in family planning. And we all started working really hard to make sure that people got their appointments down The Loop.

CP: And didn't have to have 19 children.

CM: Yeah, that's right. And so I sort of backed into my first interests in public health through contrariness, I guess. And understanding that the suicide rate was pretty high for families that were—for women that had over 10 kids, they just sort of gave up. Postpartum depression psychosis was a very serious problem.

And it was very interesting that is in relatively rapid fashion the next few years, as family planning became available to people the suicide rates just went down with it because women could choose when they wanted to get pregnant. And they could cope with three or four kids, but not 17.

CP: Yes, 18 in this particular case.

CM: And the other thing that was, I think, a great sociological experience was that we were one of the last medical schools to participate in home births. In our senior year, we spent a month on the home births service at the Chicago Maternity Center and Maxwell Street Dispensary. And we would go out in the tenements in South Side, Chicago.

And if you're out there waiting for a woman to give birth, you would have to spend a whole day with she and her family and friends, and you would talk to them all day. And you would get to learn that if they were going to have the baby in this bedroom, they had to go to the neighbors and borrow light bulbs so that you could see what you were doing. And you really—I mean, I grew up in West Virginia and saw a lot of poverty there, but it was nothing like people lived in in the south side of Chicago.

2The Loop is the central business district of Chicago, Illinois.

3A "Board of Aldermen" frequently refers to a governing executive or legislative body of a city or town in the United States. It can sometimes be referred interchangeably with a city council, or an executive board independent from the city council. However, some cities such as Chicago use alderman as a title for members embodying as city council.

And so, I guess I've always said that was a terrible obstetrical experience because we ran into some terrible problems of people that shouldn't have been giving birth at home. Most of them worked out fine, but it was a tremendous sociological experience—

CP: I can imagine. It didn't warp your mind, it squared it up as history has shown.

CM: The other thing that was interesting was that most of the women that chose to deliver at home had already delivered at Cook County, and they just hated it. And they would tell you all about that, "Well, I had the first two babies at Cook County, and then we had—George was born at home. And, you know, you were treated so much better at home by the people that come to take care of you."

And then you also figured out that you were on their territory, and they weren't lost in the hospital's territory. That's another thing, that idea, I guess we call it customer service today. But that I have always been really interested in that we are working on it in a big way right now with the Disney Institute[4].

CP: Yes, yes, yes. That's a fascinating beginning. But you went from there on to very, very formal obstetrics and gynecological training, did you not?

CM: Well, yes, I went up to—I did one of the last rotating internships at the old Minneapolis General Hospital, and that was wonderful. And so I stayed on to University of Minnesota for my residency, but I elected to go back and be chief resident at the county hospital because I really liked that better than formality.

CP: County hospital in Chicago?

CM: No, at Minneapolis.

CP: At Minneapolis, okay. That would have been a good experience.

CM: Oh yeah. And then after I served my time in the Navy, I came back on the faculty of Minnesota, but again, at the county hospital, and helped set up the OB service in one of the first community health centers back in the '60s with the OEO, Office of Equal Opportunity. I got to know Hubert Humphrey[5] and got involved in the WIC[6] program, and just saw a lot of great sides of working in the community in things that I really liked to do.

4The Disney Institute is the professional development and external training arm of The Walt Disney Company. The company showcases the business models the Walt Disney Company follows through seminars, workshops and presentations. It started as a residential community and later changed into a resort. After various attempts to raise attendance, the institute closed down in 2003.

5Hubert Horatio Humphrey (1911-1978) was an American politician who served as the 38th Vice President of the United States under President Lyndon B. Johnson.

6Women, Infants, and Children (WIC) is a nutrition program run with federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

CP: But you didn't know this when you went through medical school?

CM: No.

CP: That you were going to find this community bent, that tells me something about your heart, Dr. Mahan.

CM: Well, thanks, but I think it is a concern that we all have now. That there are probably other people out there with good hearts too that would go into public health if we just got to them a little more effectively and a little earlier.

CP: I am glad to hear the dean of a college of public health say that. That is so true that it is so exciting as you are telling us. But it was this background—how long did you stay at the county hospital? I am aware that you came to Florida to head up something that we call the MIC[7] project. Tell me about that.

CM: Well, in Minneapolis I worked, as I said, in the community that was mostly the part of town that was the black and Indian community, and trained some of the first Indian practitioners, Chippewa women, who were great. And then, a former Minnesotan, Bill Spelosy became chair of the OB department in Gainesville and recruited me down.

And I love Minneapolis, I probably wouldn't have left, and I loved what I was doing there, but I had also been reading a lot. There had been a lot of good publications coming out of Gainesville about the 13 county Maternal and Infant Care project. And it was one of only two rural projects in the country, and I grew up in a pretty rural area, and I really—

CP: You got your training in the city.

CM: Yeah, and so I came down and looked at it, and for the next 12 or 13 years, I ran the MIC project out of Gainesville. That was a nice mixture of—I had a private practice too, an OB/GYN, mostly faculty wives and so on. But going out each day we would send three teams out to the 13 counties around Gainesville. We would be the guests in the health department when we went out.

And the teams were prenatal care, family planning, and infant care in three different counties each day. I'd go out generally with the OB team or the family planning team. That project was one of the first to extensively use nurse practitioners. And that was before I got there, and we just expanded on that. It also was one of the few where medical students really went out to a health department site.

And what I always tried to do was—the first day that they were out there was to have them spend the first hour in the morning making a home visit with one of the public health nurses. And found that after you did that, you generally didn't hear people talking about those people and the fact that those people can't make their appointments, and those people aren't showing up on time.

7The Maternity and Infant Care Project (MIC) is a program that has been run by the University of Florida Department of Obstetrics and Gynecology since 1966. Its mission is to provide high-quality prenatal care to women in the region. The women receive prenatal and post-partum care as well as help with delivery.

And once they spend a little time in somebody's home, they realize that people don't have alarm clocks, and they don't have calendars, and their life is chaos, and their cars don't always work. So, I think the students generally rated that as the best experience of their two clinical years.

CP: Really?

CM: I thought that was always good. Even if they went into surgery, they thought it was good.

CP: A strange remark, my professor of medicine allowed for a general practicing physician—he must, with every new family, visit them in their home. Make an excuse to go to their home because you cannot be a physician to that family unless you know the family situation. I think that is so true in public health. And it just thrills me that you endorsed that as a philosophy as the dean of the College of Public Health. You are going to get some public health folks trained around here.

CM: I loved my job up in Tallahassee, but the thing that really attracted me to come down and be dean when the job opened up was the caliber of the students that we get. The majority of the people are just fantastic people that want to come in. Most of them are midcareer, maybe they have either been working in public health or social work or nursing or medicine, and they have decided that they really want a bigger focus on things.

I think—I can't remember the woman's name that worked with us up at the state health department for a while, a pediatrician. It wasn't Dr. Gates, but it was somebody who came after her. But she said the way she had been in private practice pediatrics for a long time. She said that the thing that attracted her to public health pediatrics was that instead of dealing with a couple of thousand children and babies each year, she was responsible for a couple of million. And she really felt that she could have—

CP: An impact.

CM: —by the time she ended her career, have a bigger impact on a lot more people if she did a good job up there—

CP: —than doing it one at a time. Yes, well what attracted you to Tallahassee, though? We're well aware that you served some seven, nine years as a state health officer, or was it 37 years?

CM: I spent two weeks in Philadelphia last Thursday. Well, it was about time. I was working really hard in Gainesville; I was running the project. I had been doing that for 10 years. And I had been at the University of Florida medical school long enough to take a sabbatical, and I was thinking about that.

And one day, Dr. Steve King, who was the health officer at the time—he was on loan from the public health service to serve in Florida, and I had met him in a couple of meetings. And he stopped in my office and plunked himself down next to my desk and he said, "Why don't you take a sabbatical and come up to Tallahassee for a year and write us a plan to help lower our infant mortality," because we had had some meetings the year before.

It was about the 10th anniversary of the founding of the Children's Medical Services Program[8] and that was going well. It was one of the best in the country at dealing with kids with special needs. And the pediatricians all got together at Dr. Scheebler's (sic) behest, and they invited me to the meeting.

And they said, "The CMS program was going really well. Everything's going great. But we are all concerned that we haven't made a dent in the number of sick babies we are getting and the moms that are coming in with no prenatal care and having sick babies," you know, very low birth weight or some other problem. And they said, "We know we are doing this backwards, but now is the time to put in a prevention piece, which we should have done first."

So, I sure agreed with that and said, "Well, I'll think about how to do that." And a couple months later, Dr. King came in, and that's what he had been thinking about too because he had been at the meeting. And so, I agreed to do it.

I kept my practice going in Gainesville, but I spent a year driving—I kept running the project. I kept doing all the stuff I did before. I'd go up on Sunday night and come back on Friday morning, and, eventually, lost most of my patients because they figured the odds were that I wasn't going to be there when they had their baby.

We wrote a five-year plan for improving pregnancy outcome in Florida. And at the end of five years, we had totally carried out the plan. And I think it is the only five-year plan that has ever been carried out in the state of Florida, probably Russia too, for that matter.

So, I spent my year on sabbatical, and then, I owed the university. You had to go back to the university after you did that, but the university was nice enough to let me stay involved. And so I was appointed director of maternal and child health for the state. And I would devote two days a week to that, and of course, a lot of phone conversations. And generally I would call up on Friday and they would say, "We want you to go to Miami next Monday and Tuesday," and that's how I would spend my time with the state there.

Then, in late 1987, we were having the Institute for Child Health policy that Dr. Freedman runs in Gainesville was having a legislative weekend for legislators interested in child health issues. And they'd invited a lot of legislators: the president of the Florida Medical Association, Jim White, Sec. Greg Koehler of HRS [Health and Rehabilitative Services], and a number of other people were there and the—you had decided to step down, and they were looking for a new person at that time.

And interestingly enough, early in the evening, Dr. White and some of the people from the FMA pulled me aside and said, "Would you like to step into the job of state health officer?" I had just gotten a big grant, $10 million grant from the Robert W. Johnson Foundation[9] to work on infant mortality in the southern states, and I was going back to Gainesville. And I told everybody I couldn't keep coming up two days a week.

8Children's Medical Services (CMS) is a Division of the Florida Department of Health.

9The Robert Wood Johnson Foundation is the United States' largest philanthropy focused solely on health.

So that totally caught me by surprise. And then, later on—entirely separately, and they hadn't talked—Secretary Koehler pulled me aside and said that he and the governor had been talking, and they were looking for a state health officer and would I consider doing it. And that was a pretty amazing coincidence.

First thing I did was talk to my family about it, and they thought I was coming back to Gainesville. And my wife had a good teaching job. And they weren't too thrilled with the idea, but I was starting to get really interested in it. But I figured that the way I would decide whether to do it or not, because I knew that I had worked in most areas of public health, but not all of them, and I didn't know whether I was really qualified to do that. And so I figured that the decision maker was going to be my discussion with you.

And I don't know if you remember that, but I came in and sat down in front of your desk and you said, "What can I do for you?" And I said, well—and I told you about everything that happened. And I think you about fell out of your chair.

CP: I was asleep probably.

CM: No, but you weren't expecting that conversation at all and sort of took you back for a minute. And then, you sat back. And you were real quiet, quietest I have ever heard you for a long, long time, and I just sat there. And finally you said, "You know, it's crazy, but that might work."

CP: Are you quoting or paraphrasing?

CM: I am quoting absolute directly. I will never forget those words. And then you said, "Yeah, you know. Yeah, you know."

CP: Well, this history has shown that it worked very well.

CM: With a lot of help and rehabilitation and so on, you can probably—

CP: Some retraining.

CM: Yeah, right. Because I had obviously worked in MCH [Maternal and Child Health], which is a huge part of public health. We estimated that 60 percent of each day at the local health department spent with Maternal and Child Health.

I had been doing research in Minneapolis with sexually transmitted diseases because the epidemic had started up again. And actually, I was working with the Hormel Company on a syphilis vaccine up there. And we had to recreate all the treatment centers up there, and so we recreated them because they had all closed down.

So the city, the state, and the county got together, and we decided that we needed to do this fast, we needed to do it differently, because we couldn't afford to hire doctors to run all those things.

So what we decided to do was to set up clinics around the city that were run by nurse practitioners and corpsmen. We call them PAs [Physician's Assistant] today, but they were Navy and Army corpsmen back from Vietnam looking for jobs.

We brought in the gay community and talked to them because the president of the University of Minnesota at the time was a gay fellow, Jack Baker. And they were very militant at the time. And we said, We know this is a big problem in the gay community. Will you help us design a clinic? And, of course, they wanted it all focused on gay people and we said, Well, some other people have trouble, too. But that turned out to be a wise move because it really worked well.

CP: Isn't that true in all aspects of public health, involve the community being served?

CM: Yes, but then the most amazing thing that happened is after we designed all this, and this was within a week, we came up with the budget. We got it approved by the city and the state and the county in two days.

CP: You did?

CM: Yeah, because they were ready for a solution but that is also Minnesota. They make up their minds about things pretty fast. So, I worked in MCH and STD and infectious disease, essentially most areas of public health except environmental health. And I didn't know environmental health at all. I knew there was air; I knew there was water, and I used both—

CP: There's dirty air and dirty water.

CM: So, I prayed that after I became state health officer that my first two emergencies or crises would be moms and babies. And, of course, they was lead in the Miami water supply and radon.

CP: Well, you learned environmental health pretty quick.

CM: And I also learned I better go out and hire one of the best people I could find to run environmental health, and that was how Dr. Rick Hunter got up in the state health department from Wichita.

CP: Wise decision. He did very well. Well, how was your experience as a state health officer? That's a very beautiful beginning.

CM: Well, I really loved the job. I mean, it's just full of surprises, as you know. I can't always say that I enjoyed some of the surprises—

CP: You'd be dishonest if you said so.

CM: What I tell people is that you would, being all of us are trained in science, and so you sort of want to plot out what you are going to do that week and that month and that year and sort of work towards fixing some things and some goals and outcomes and so on. So you plan your week, and here is the great accomplishment you were going to make that week. And the phone

would ring about 10 o' clock on Monday morning, and it would be some legislator from heaven knows where in the state saying that, Two cats have died in their community, and they think there is an epidemic of Ebola virus. And can we come out and check that out?

And you know that these cluster investigations are hardly ever, never going to turn up anything, and they are going to cost you money you don't have, but you have to do it. Then you realize at the end of the week you didn't get a thing done that you thought you were going to do to save mankind.

CP: That's right.

CM: Except to give this legislator the bad news, which you gave them on Monday, that that wasn't going to turn up anything.

CP: I gave the conclusion on Monday, and now, here is the data that supports that.

CM: Right. So I always said that I always showed up for work early every morning as state health officer wondering what in the world is going to happen next.

CP: That was some of the fun, going to work every morning wondering what is going to happen today.

CM: I think I always thought back to Sir William Osler[10] and one of the things that he said about staying up all night worrying about a very sick patient. He said, "You should never stay up all night worrying about that particular patient because the next day something entirely different is going to be wrong with them or somebody else is going to be sicker."

But I think I already knew this from the 13 counties I had worked in and from working around the state with the Maternal and Child Health folks, but we just really have a totally selfless group of people working in public health. They are just the most devoted group there is.

CP: I think that is true.

CM: They work under extremely difficult positions. They get the lowest pay of anybody in the healthcare field. One of the problems that they have that is so endearing is that they work hard, they don't toot their own horn, and that is a problem because—

CP: If they were horn tooters, they wouldn't be in public health.

CM: Well, that's right, but, on the other hand, they are going to have to change a little bit because as somebody says, We are the invisible profession. Only if something goes wrong do people know we're out there. And if you just are doing great and nothing ever goes wrong; then, they

10Sir William Osler was a Canadian physician and one of the founding professors of Johns Hopkins Hospital. Osler created the first residency program for specialty training of physicians, and he was the first to bring medical students out of the lecture hall for bedside clinical training.

take your money away because they don't think you are doing anything. It is a constant problem, and it is one we haven't solved.

And I think of something I struggled with the whole, more than seven years that I was up there as state health officer is: how do you get the message to the legislators? And it is something that we are doing a lot better than we did 20 years ago, but we still haven't completely solved it. And it's something we need to work on.

Now, it's easier in Maternal and Child Health, because I could go to the legislature and say give me $8 million, and by this time next year, we will have gotten this many more people into prenatal care, we will have reduced the infant mortality rate by a certain amount. And because pregnancy only lasts nine months we could pretty much show them that we were making progress, and they'd say great. But, you know, with heart disease prevention and toxicological problems and does this contamination cause breast cancer, it takes generations to find the answers to that. Politicians and the public have a very short attention span, and they want answers before the next election.

CP: Yes. And you and I can understand that.

CM: But I think there are ways, and I think we have found some ways to really help remedy that. But I think that was the biggest struggle, was to go to the legislature every year. And I knew that this particular program—let's say the radiation program we had in environmental health—I knew that was an important program, but it was dry and uninteresting to them because no catastrophes had happened in the last couple of years.

CP: And how can I get a vote out of that?

CM: Yeah, I know, right? As the Harris Poll[11] showed a couple years ago, people in the US really respect everything that we're doing, they think it is important, but when you ask them what public health is they have no idea. But if you break it down, do you think it's important to have your water supply monitored? Absolutely.

CP: Who does that? The public health people. And the average Joe public doesn't know that. And they assume it is being done, but don't know where it is coming from. But you're doing something about that as the dean, which I say thank you for.

But I want to go back to your years as state health officer, because you realized some of your early goals in my seat project through the well-baby activities that you did. And the—I don't recall the name—but the early pregnancy guidance. Potential problem pregnancies you identified early and monitored them through. I view that as your baby and now as a full realization of some of your early dreams, talk to us about that some.

CM: I think that really is something that I'm very proud of, but on the other hand let me hasten to say that's how I found out what a wonderful bunch of people there are out there in public

11 The Harris Poll is run by Harris Interactive, a market research firm. The poll covers a wide range of topics to gauge the general public's interests and concerns in multiple countries.

health, because they did all the work. I think it helped a lot that I had worked for years at the MIC project, that I had taken care of a lot of people on referral from around the state, and people generally knew I was a good doctor.

CP: Yes, that helped.

CM: And that bought me a lot of favors, because I really asked people to push the program forward fast. And we decided we need to screen pregnant women and babies. We decided we needed to put that into play early on and very quickly. And that was called the Improved Pregnancy Outcome program[12].

CP: Yes, thank you. The IPO it was called.

CM: And to their credit, that was funded pretty close to what we asked for by the legislature over a couple of years. They could see we were headed in the right direction and they could see the results. And so they dug into the state money enough, not all federal money, and helped fund that. And that was something that didn't occur in many of the other states.

As I said, we carried out the five-year plan. A lot of that included things like the private childbirth education people training public health nurses and other local folks to teach childbirth education to people that were pregnant. And it included the expansion of prenatal care from just the MIC projects, which were in North Florida, Orlando, Palm Beach, Fort Lauderdale, and Miami.

Many counties in the state had no prenatal care at all, and so what the IPO program did was by the time a couple of years were up every county was providing prenatal services. And that probably was on of the biggest, most important steps we took.

The reason the health departments had to do it was because Medicaid wasn't paying very much nor covering very many people. So we had to get the money from the legislature to put into the health departments because the private doctors felt there wasn't enough money for them to be involved. And of course, historically, that is a southern thing.

The northern states in the middle '60s, the private practice community really adopted the Medicaid program and took low-income people into their offices. In the southern states, either because of poor participation, Medicaid, more payment, racism, classism, shortage of doctors, it just didn't happen here. And so, throughout the southern states, the public health department really had to be involved in that. Many northern states never got involved in that at all.

So the health departments played a huge role in turning that around for us. One of the most important things was that we were the worst in the country. We were 50th in getting women in for care.

12The Improved Pregnancy Outcome (IPO) is a program created to reach low-income, medically and socially at-risk pregnant and parenting women, fathers, infants and other stakeholders to provide the necessary resources for a positive outcome.

CP: Terrible statistic.

CM: And obviously, if you don't get people in for care, you can't teach them prevention and you can't—

CP: You can't care for them can you?

CM: So one of the landmark studies that we did was to have Sarah Meechum (sic), who was a social worker on loan from the feds, set up a study around at the major delivery hospitals in the state. And for a month or so, we interviewed every woman who came in with no prenatal care and asked them, "Why? Why didn't you?"

And I think a lot of our folks figured you could put up a clinic right across the street, and some of those women wouldn't walk across the street to get care. And what we found was that the enemy was us. The average woman had tried five different times to get into care. And either couldn't get an appointment for four months, had to go five places in Orlando to get eligible for Medicaid before she ever saw a doctor or a nurse, usually just gave up.

So we right then figured we had a big job to do in reforming the eligibility system and how people got eligible for care. And I think one of the best things HRS as an agency ever did was buy into that and take that on because it had to be done hand in hand with the social service people, because they determine the eligibility. To their credit, they bought into it. And the goal was to get one-stop shopping.

We did another survey and found that for the average poor person—we said, Where is the most likely place for them to go in a year? And we found that the most common stop for 60 percent of low-income people was the health department, not the social service agents here or the welfare office or whatever. So, we said, Let's put the one-stop eligibility in the health departments.

CP: It's where most people go anyway, good point.

CM: And so, then, the eligibility workers had to come to the health departments. And they weren't too thrilled about that, because they were all stuck in these nice, big, high-rise buildings in downtown Orlando or Jacksonville or whatever. Now, they had to travel out to Green Cove Springs or wherever, and they weren't too thrilled about it.

But the interesting thing was that you could imagine these peoples' jobs. They were the gatekeepers, and all the clients hate them. Even if they get eligible, the clients hate them because they had to wait and the kids are squalling and everything. When the eligibility workers got out to the health departments, they could see the connection between what they did and the actual services being provided, which they had never been allowed to see before. And the retention rate for those workers went up enormously, because otherwise the turnover was like a revolving door.

So, that actually worked out really very well. And very quickly then, we started getting people in for care. And now, we are in the top third of all states in getting women in for care.

CP: Grew from bottom to top third in ten years.

CM: Yeah. Now, the other problem we had then was that we couldn't care for everybody at the health departments. We just were overrun and that was with adding a bunch of staff and retraining and everything, so we really needed the private community to help. So all the governors that we've worked under, I've worked under: Graham[13], Martinez[14], and Chiles[15] have all moved us along in this area.

Of course, Governor Chiles came in with this as his reason for living. And even though we had done all this great stuff, he said, "Well, we want to do more." And that is when the Healthy Start[16] program came up, and I was telling somebody in the Bush administration the other day that. They said, There are so many Healthy Starts. We've got federal Healthy Start, projects in Tampa and St. Pete, and we've got Florida Healthy Start all over the state. And we can't keep them straight.

And I said, "Well, I went in to Governor Chiles when we were doing the legislation, and we sat down and I said, 'What do you want to call this? And before we called it Improved Pregnancy Outcome—' and this is a new program. And he said, 'Well, I want it called Healthy Start.' I said, 'Well, President Bush just announced last week he was calling his new program Healthy Start.' And then the governor said, 'I know that, but I thought of it first.' And that's why it's called Healthy Start."

Rather than my usual thing, I should be saying, "Are you nuts, nobody will be able to keep it straight." I didn't say that at the time. I behaved myself. I thought that was very good.

CP: That's unusual. Tell us about the Healthy Start program. This is different from the Improved Pregnancy Outcome, which results in a Healthy Start, but there is more.

CM: And we had taken giant steps with Improved Pregnancy Outcome, but like I said we were overrunning the health departments. We were only paying $300 for total pregnancy care through Medicaid, and you had to be under 30 percent of the poverty level to get on Medicaid. So almost nobody was covered. And yet many people thought they had just covered everybody and we were in great shape.

The first thing Governor Chiles said with his Healthy Start program was that we want to cover as many people as we can, and WIC, the feeding program, goes up to 185 percent of poverty, so let's do that to with pregnant women. Then we needed to pay people more, doctors and

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13Governor Robert "Bob" Graham is an American politician who was the 38th Governor of Florida from 1979 to 1987 and a US Senator from Florida from 1987 to 2005.

14Governor Robert "Bob" Martinez is an American politician who was the mayor of Tampa, Florida, from 1979 to 1986 and the 40th Governor of Florida from 1987 to 1991.

15Governor Lawton Mainor Chiles, Jr. was an American politician who was a member of the Florida House of Representatives from 1958 to 1966, a US Senator from Florida from 1971 to 1989, and the 41st Governor of Florida from 1991 to 1998.

16Florida's Healthy Start was formed in 1992 by Governor Chiles. This program was formed to ensure that mothers and babies were getting the prenatal and infant care needed.

midwives, so more will participate in the program. So we raised the payment from $300 to $1,500—actually, $1,000 for a normal birth.

That's a big jump though, $300 to $1,000. And that is prenatal care, delivery, and postpartum care, and then $1,500 for a high-risk birth for children's medical services. And that made a big difference. That really got lots of people involved in helping care for them.

Then we also expanded children's medical services so that the regional perinatal centers would not just sit there and wait for people to come in, but they would send teams out into the smaller communities so that really high-risk mothers and babies didn't have to travel. And that was very successful. And just in the pilot project in Tampa, where people from Collier County, Naples, used to have to travel all the way up to Tampa General to be seen. In one year, they reduced the number of admissions to Tampa General by 90 percent.

CP: Wow.

CM: So, obviously, it paid for itself very quickly.

CP: In the first year.

CM: One of the most interesting things that we did that is still very unique about Florida's Healthy Start program was the establishment of the community coalitions.

CP: All right, tell us about that.

CM: Well, I wrote an article about that for one of the public health journals. It's called, "Surrendering Control to the Locals." And what it deals with is the issue that, you know, Charlie didn't go up to state government to turn it all back to other Charlies to run down there. He went up to state government because he wanted the power and influence to make changes in other parts of the state.

And that is why a lot of good people come from public health nursing and other areas to state government, because they want a little broader influence in policy making especially. Well, we found that one of the problems in getting some of our programs working well in the local community was that the local community really felt like they were being handed down from on high and, in a sense, they were. I mean, that's the way we do things.

CP: They had no trouble accepting the money from on high, did they?

CM: No, but what we were finding was that there was enough antipathy to that coming down that many of the counties were saying, Well, if they are going to send us down this money and tell us how to behave everyday. We're going to take county money out of the health departments. And that was really starting to hurt us.

And so, very quickly, we got the message that we had to do a better job of incorporating their ideas into the whole thing. And we thought we were doing that. I think we would try to develop programs with a lot of input from the communities, but we weren't doing it well enough.
{{{0:49:10.5}}}
So, we established coalitions. When you are ready to do it, here are the guidelines: you have to do needs assessment in your community, you have to give us a plan, tell us what you are going to do, how are you going to leverage the money we give you with community money. When you are ready we will give you $150,000 to staff this, so you can hire help.

We will also give you the right to make local decisions over all the unobligated federal and state money that comes down, which should be about 30 percent of the Maternal and Child Health money is not earmarked. Now, if you want to spend that a different way in this community then the next community is that is your decision. That was probably the key to holding these things together.

And now, ten years later, we have 30 coalitions throughout the state, covering the whole state. The majority of them do a fantastic job and really watch over moms and babies in the area. And the interesting thing is, the most recent one I've been to is Osceola County, and they probably have 10 or 12 programs going that they thought up themselves that they have gotten local money for that are just wonderful ideas.

And so each year we have a conference and we had a sort of a competition for people to bring those ideas. We call it sharing solutions and best practices. And they come back and they present it to people from around the state. And hopefully, that spreads the wealth around.

CP: Yes, it would, it should.

CM: But it wasn't without its problems because a lot of my wonderful colleagues at the state, a lot of the county health departments didn't like the idea of giving off this kind of decision making to community people, and they had to get used to it. But most of them have and most of it is working out really very well and probably the fact that they were starting to get used to that.

Then when we came along with the idea of having a partnership with Kiwanis Clubs[17] to increase our immunization of two-year-olds, because we had been stuck at 62 percent. Kiwanis came forward and said, We're interested in that, and we will devote the rest of this decade—this was in '92—to that being our major project.

And that really got a lot of the folks at the state and at the local level concerned because they had not worked with a private group like that. And the Kiwanians came in like gangbusters, Where are your computers? How are you following up these kids? Oh, we don't have any. We'll buy them for you! Well, we don't have anybody to run them. We'll teach you how to run them. How do you do it out in the rural areas? Well, people have to come in. Well, let's buy you a van."

17Kiwanis International was founded in Michigan in 1915. It's an international, volunteer-led service club that raises more than $100 million a year to strengthen communities and serve children.

So, I'd start going around the state for these van dedications and things. And I would get up, and I would thank the Kiwanians for what they did. And they would come up to me afterwards and they said, No, we thank you, because if the state hadn't gotten us involved in this program our club would have died, and this is the best thing that has ever happened to us. And it really worked both ways. Now, we're up close to 90 percent.

CP: Yes. Yes, you are.

CM: Which will be the goal for the year 2000, so we might make it. But I think one of the things schools of public health need to do is look at how much private partnership you can have in public health. I strongly believe that we've had many failed experiments in the past century, where private industry has tried taking over the milk stations or other things and found that it was too big for them to handle, just like if they were trying to take over the military. And so there are certain things that government is going to have to be involved in in public health that really nobody else can do, certainly the law and the regulatory activities can't be done—

CP: Our police power, we can't delegate.

CM: The quarantine power and so on. Probably some of the best ideas would be public-private partnerships.

CP: Oh yes, in specific areas.

CM: Yeah, yeah.

CP: Like your marriage with the Kiwanians. You know, I think every volunteer association and fraternity out there has an unspoken mission statement that challenges folks in your position, in the county health departments to make the match. And some free money to the county health department, as you did with your MCH policy would provide the nest egg to do that with.

CM: No, I think that is absolutely true. And I think another good example is Rotary [International] with PolioPlus[18]. And I remember in our Rotary Club in Tallahassee, the goal was to pitch in and raise $150 million that year around the US for PolioPlus. Well, by six months they had overshot the goal to $250 million. And now they have put $600 million into this worldwide program, and polio has been wiped out in the Western Hemisphere, and there are only two or three countries left.

CP: And the Kiwanians are on it. And they are on it now; it is still their lead program.
Pause in Recording

CP: Back to Tallahassee though, was not the primary care initiative and to change the law for county health departments to provide primary care, did that come under your administration while you were there?

CM: No, that came under—do you mean implementing it?

18PolioPlus was a campaign to eradicate polio that was launched by Rotary International in 1985.

CP: Yes.

CM: That came under Dr. Howell[19] and then I think you had to be a little involved in moving that along. I think the funding for that came in 1986, $28 million, because I was working at MCH when that came.

It was ’85 or ’86. And that was phased in over three years with a third of the counties coming in. At the time—that’s interesting to look back on that. It points out another tremendous partnership we’ve had over the years with the Florida Medical Association and the Nursing Association. They have been wonderful partners long before you and I ever got there. In other states, they never speak to each other, you know?

CP: And I don’t understand that—

CM: I don’t either.

CP: —because we’re not separable.

CM: No. I’ve often had conversations depending on what tangent they were going off on to say, “We can’t really support that particular issue. But if you support some of our issues, it’ll be looked on as while you’re having issues on your part, and I think you will gain from doing that.” But we would agree to disagree on certain things, but not very often, not very often.

CP: As long as we are open with our disagreement, don’t go back of my back.

CM: That’s right. And we would work all that out when we were planning for legislative session and so on.

CP: We got so much in common that we can work on together without letting our differences interfere with our common denominators or commonalities.

CM: Well, the primary care program was really the brainchild of the Florida Medical Association. And their concern was that the hospitals, especially the rural hospitals, were losing their shirt by doing primary care in the emergency room. And nobody was paying for it and that it was a real drain. And, of course, the docs were involved because they kept getting called in at all hours of the night to see somebody with a runny nose, and they were getting tired of that.

So their idea was that if we could provide primary care in the health departments, we could relieve that pressure in the emergency room. So they helped us lobby for, I think it was $28 million was the initial amount. It was very difficult to set up because the health departments, most of them did not have primary care doctors or nurses available to do that.

19Doctor James T. Howell is an accomplished public health physician in Florida, serving in various positions throughout the Florida public health system, including that of State Health Officer and Secretary of the Florida Department of Health. An interview with Dr. Howell is available in Digital Initiatives and Services’ USF College of Public Health Oral History Project.

And so they would bring people on board to do that. Which was very hard to recruit people at that time into public health. Many of them found some very good people to do it, and they eventually got it up and going. It's now being defunded, and that's creating problems here 13 or 14 years later. We're sort of being asked to get out of the business.

And the problem is that I see, and that was a problem right from the beginning, was that we had to recruit doctors and nurses into that that really were there to see patients but had absolutely no feel for public health. And that created real conflicts with our preventative programs because—

CP: With the larger mission.

CM: —people would say, "Gosh, we need more money to see patients. Let's cut out the immunization program," or "Let's cut out the environmental health program. Let's do this or that."

So, it was very difficult because often the doctor that was brought in was valued because he brought in Medicaid money, and that was big dollar signs in the eyes of the administrators of the health departments. On the other hand, that doctor then gained a lot of power through that ability, and sometimes it was able to take money from Peter to pay Paul and some of the prevention programs really suffered.

CP: What is the present status? Are they recovering? Where are we?

CM: I think it is being phased out. My personal viewpoint, and I know a lot of my colleagues in the health departments don't agree with me, but I don't think in that particular area, in personal health services, that the health department should be doing that. I think if the private sector can do it, let the private sector do that. But give us enough money and well-trained people to put the prevention programs in.

CP: I'd like to say, who else is committed to preventive medicine? There's only one organization in all of America interested in preventive medicine. Is a lot of folks who are interested in curative medicine? Let's help them do their thing.

CM: That's exactly the way I feel about it.

CP: If you are to summarize your experience in Tallahassee, do you have two or three highlights that are highlights to your career in Tallahassee? Is that a fair question to ask you?

CM: Yeah, that's a hard question. I think, as I said earlier, I really absolutely love the job. As I always tell everybody I loved it except during March and April. I really—

CP: For our audience, be sure they understand what March and April is.

CM: That's usually when the legislative session is, and I really just about perforated ulcers during legislative sessions. I could never get used to the sort of mad tea party aspect of it. You

know, I'd go over it with a carefully thought out, well rehearsed educational plan because we weren't allowed to lobby.

And you get up there and you present it, and if somebody was generally against it they could come up with some of the most off the wall questions, "What were the tides last week in Sumatra? "Well, I don't know." You come here not knowing, not prepared?" Most people weren't like that, but—

CP: There was one on every committee though.

CM: Oh, I know.

CP: There was one on every committee.

CM: I just always felt that the important thing was to—dealing with the legislature—always base your presentation on good science, always be well prepared, and always be willing to say when you don't know something.

CP: Yes, yes, yes. Good pearls.

CM: And I think the other thing that I think that we are working hard with our students now is to try to get people to use data better than they have in the past. And of course our resources are so much better than they were.

CP: I've been impressed over the years, too, that from a day of professional opinion, because you're an MD before the legislature, you didn't have to use data. Your opinion was respected, but that is no longer so. Your opinion is valueless without hard data to back it up. Excuse me.

CM: No, no. That's fine.

CP: I think that is a hard question from the standpoint that a lot of really good things happened while I was there. I think, of course, from my personal interests it continues on. I like the fact that I was able to have a lot more time and support to put into advancing maternal and child health. I mean, if I had stopped where I was originally going to in 1988 and just done the southern thing with Johnson Foundation, I wouldn't have been in a position to carry on things the way that we did.

And then, of course, having Governor Chiles come in there and say, "What do you want? We will give you anything you want." I mean, that is—people in other states really envied us when we had that going.

I would say another highlight was that we were able to recruit a lot of really good people up into the state health office, and we tried to recruit from local health departments. And I think that made a big difference in people not looking internally at the view from Mount Olympus, but bringing us down to Earth every now and then.

CP: It brought real life experience to your level.

CM: And also as we figured out it was more important to do grassroots planning, those folks were very helpful too. I'd say one of the things that absolutely stands out in my mind—I ran into a bunch of folks that were from the National Guard and the Army and so on a few weeks ago in Atlanta, was Hurricane Andrew[20]. That was, fortunately, something that we were pretty well prepared for. And it was almost by accident that a good friend of mine, after Hurricane Hugo[21] had hit, I was very close friends with the health officer in South Carolina, who actually was dying at the time of a brain tumor, a wonderful man.

And so, I called up to see if we could help them in anyway, and we did send some people up to help. He said, "Well, you know, what you might want to do along with that is to send some people up here and some people down to Puerto Rico to learn from the recovery in case this ever happens to you, because it is going to happen to you someday."

And luckily, we made the decision to spend the money to send the people there to learn from them. And, of course, a couple years later, Andrew hits. And we had built on the experience of Hugo, set up a disaster management team, and, of course, the state was working on that too through other departments.

But I think that when Andrew hit we were pretty ready to go. And even though it was totally unpredictable and lot of our good planning didn't work—for instance, we bought all the nurses in a lot of the coastal areas cell phones, which were sort of new at the time. And, of course, they had a lot of use for them beyond disasters, but we figured, Boy, this is going to be great. It's going to be hard to communicate. Well, all the cell phone towers were knocked down and none of those worked.

CP: It isn't funny, sorry.

CM: We were inundated with people from out of state; the doctors and nurses came in looking for all the bodies. Well, nobody died as a result of the storm, which is amazing. And nobody got sick afterwards because the environmental health folks were well prepared. And they did a great job because all the plumbing was knocked out for Florida City and Homestead. And they got right on top of it and monitored things beautifully.

We found the thing that we hadn't planned for, but our nurses adapted very quickly, was that nobody was hurt. The first few days everybody has got a lot of energy, once everybody—we can get through this. Two weeks later, the folks realize that they're not going to get back in those homes until a year or year and a half and severe depression sets in. So our biggest problem was mental health problems.

And Kathy Mason and the nurses quickly got together with people here at Florida Mental Health and the college, put together teams that went out to help with counseling and helping people. A

20Hurricane Andrew was a category five hurricane that caused major damage to the Bahamas, Louisiana, and South Florida in August 1992. The hurricane was the fifth most destructive hurricane in US history.

21Hurricane Hugo was a category five hurricane that caused major damage in the US in September 1989.

lot of good improvising went on by some really good people. Our public health people came from all over the state and showed talents that we didn't even know they had. And people who had been in the military before in other disasters that never told us about it came through, and they were fantastic.

You look back and it really makes you feel good. I remember the first day we were down there, which was the day after the storm, a couple of public health nursing students were helping out and they came to the control center, and they said, We don't know where to deliver these things. The street signs are all down, and nobody can tell which street they live on anymore. Nobody can give us directions, and our phones don't work. This is really a mess.

And somebody behind me, I think Nick Chapman, stepped forward and said, "That's why they call them disasters." And I think we had to spend about three months down there to really get—at least I did, on and off. We kept relieving the local folks for a long time afterwards. But it was quite an experience.

Of course, if it had hit 20 miles further north, it would have wiped out Miami, and it still wouldn't have recovered. People say we would be in a serious depression now by losing a major city. So we were very, very lucky, but I think also pretty ready for it.

CP: I am glad to hear that.

CM: I remember the wonderful statement a year later by Governor Chiles, who had given us high marks for the health care response but had gotten some criticism for some of the other things, probably more comfort things than anything else, that people were upset about. And a year later, he went back and looked at Cutler Ridge and Homestead and the whole area.

The reporters asked him what was different now, what he noticed, versus the year before. And he said, "Well, there's a lot of lobbyist stuff, but the first thing I would start with is that—as I was touring around this time, people down there were waving at me with their whole hand compared to a year ago."

CP: Fascinating. He was never without a little quip.

CM: I know, I know. It was wonderful.

CP: Well, those are the highlights. Can I ask you about your low lights? What are some of your disappointments of your service in the state health department system?

CM: I got to do one other highlight, I think.

CP: Oh, please do.

CM: As I tell people now, I think part of the luck that we ran into then was sort of the start of the rebirth of public health around the country. And we started riding that wave, which helped a lot. But as I tell our students, in my opinion, the things that have made this happen and come forward

were first, the setting of goals for the nation, which we just never did up to the ’80s. And that keeps everybody focused. It’s interesting, keeps them focused, we can see how we did, hard to escape if you’re a legislator that we’re not doing well in certain areas.

Next, was the development of the leadership programs nationally. I have often said that, we have some wonderful leaders in public health, Everett Koop[22] and lots of people we can name, but we just don’t have enough of them. And so nationally and statewide we are heavily into training leadership, and that has made a huge difference.

The third thing was the whole idea of improving quality. And we were the first state during that time, again under the nurses, Kathy Mason, we converted public health nursing to public health nursing and quality improvement. We were the first state to do quality improvement in public health. And that had some remarkable results.

Many health departments that were really struggling bought into that and absolutely turned around. Our goal was that every health department should be a place that myself or any of my family would love to go to for services. And there are a number of places—counties around the state now that do better than any health-care group you will see anywhere, because of that. They are fantastic.

CP: How marvelous.

CM: The down part is that there are some that aren’t. And again, I think that’s a leadership issue. I think it is not a financial issue. It doesn’t cost a lot of money to improve your quality. It doesn’t cost a lot of money to improve your customer service. It is an attitude and it is a leadership issue, and we really need to solve those problems.

You know, I can—now, I won’t do it—but I can name one big county health department and probably five medium and small health departments that really didn’t improve under my watch, where as everything around them did. And sometimes even being at the state and everybody is a state employee it is hard to change the leadership in a health department if they have a lot of local support and so on.

CP: And attitudes are very difficult things.

CM: Yes, right. Although we saw—there were places. If you had asked me to write down the five that would be the most successful and the five that would not, I would have been totally wrong. So, somehow we got to some people. Somehow, for most people, they were waiting for this to come along and happen.

And, of course, the way we did it—and we learned even more as we went along. I think it sort of started out as a gotcha thing as we call it, but then we learned that you really emphasize the positive things. And instead of saying you failed in these areas as we started out saying, we’d say

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22C. Everett Koop (October 14, 1916 – February 25, 2013) was an American pediatric surgeon and public health administrator. He served as the Surgeon General of the United States from January 1982 to October 1989 under the Ronald Reagan administration.

here are some issues we all need to work on. And we need to work on them and you need to work on them. You tell us how would you want us to do it.
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CP: Your ideas for how we can do that.

CM: I think another failure—

CP: I'm not calling them failures, disappointments.

CM: —disappointments or issues we need to work on—

CP: Yes.

CM: —was losing the food service program.

CP: Oh yes, to [the Florida Department of] Agriculture [and Consumer Services].

CM: Well, and to business regulation. That was the worst part of it. I strongly feel that public health—and that has been underscored even more in the last four or five years with all the concern about food safety—that should be totally under public health. That was a situation where under some politicians that I work with in a very friendly manner over the years, they decided that regulatory things needed to be taken out of Health and Rehabilitative Services to make it smaller, and somehow they picked on that particular program.

And I think they had a lot of pressure from the restaurant industry to do that, because some of it was our fault because we would—we didn't have uniform standards from county to county. So, a guy that might own a Wendy's in Columbia, Alachua, and Bradford County would have three different sets of rules he went by.

For the most part, I think the problem was we were probably doing our job too well and the industry didn't like it. But it's still out of our area, and I really think we are going to work hard to try to get it back.

CP: I agree that's a health issue. Okay, any other disappointments?

CM: No, just—actually, for the most part, I think we made progress on almost every area.

CP: I think history shows that.

CM: And again, it was a good time to be there for the most part. Well, I think we previously talked about the primary care program. I think in retrospect—and I was quite excited about it when it started—but in retrospect, I think that was a wrong turn to take back in the '80s.

CP: For public health?

CM: Yeah. I don't know what the alternative would have been because there wasn't much money being offered up to help the private sector, but nowadays if that issue came up we would say, Well, increase payments in the Medicaid program, or something along that line. But we wouldn't say jump in and say public health should do it.

CP: Say, we'll do it. I don't think public health said that, it was kind of said for you by others.

CM: Oh no, I agree.

CP: Well, after all that fun and excitement, I have been curious, did you leave something to move to Tampa, or did you come to something in Tampa, if you get my difference, get my drift? Did you resign from Tallahassee or accept the position as dean in Tampa? Let me rephrase the question.

CM: No, no. I was just trying to figure out. At the time I left the state health department—

CP: You were riding a high.

CM: Yes. I loved the job and—

CP: And not a single legislation committee was investigating you.

CM: —as a matter of fact, I got into a little trouble. Now, I've known President Castor for a long time. And when she was commissioner, we worked together. Remember, we had joint agreements between education and health for the first time. We would work on school health and AIDS and teen pregnancy and so on, and it was an exciting collaborative. And then Sam Bell, whom she married around that time, was the godfather of our college here and—

CP: He was a legislator at the time.

CM: —was up for speaker of the house, but got defeated in the next election and never assumed that position. So he's been a good friend for a long time. We're both West Virginians and had that in common.

So, they both sort of got on me when the previous dean resigned to come down here and take us over. And that was the furthest thing from my mind. I had never wanted to be a department chair, and I never had aspirations, certainly, to be a dean.

But they kept on me about it and went through the national search and so on. Then, when I came down to visit the college—and, of course, I had been here for meetings and so on before—and got to meet the faculty and see all the things that were going on. But especially, as I had said before, I got to meet the students.

And the students are what really sold me on coming because I think where I was at the state health office was knowing that Governor Chiles was going to be through because of term limits in '98, that I was planning on going back to Gainesville at the University of Florida, and I

actually started working on the Chiles Center[23] at Gainesville. And the governor and I had been planning that for years. And he was a graduate of Gainesville and loved the idea of it going up there.

CP: That's a fit.

CM: That's what I had planned to do, and my family was looking forward to that and everything. And that is where we were going to end up, so this was a real sidetrack issue. But the other thing that came up at that time was that I was president of the Association of State and Territorial Health officials. And in '93 and '94, I was actively working with Ira Magaziner[24] and the people in the Clinton administration on Clinton's health care plan.

The first thing we noticed was that the various public health groups were all explaining public health differently. So one thing we did was get all the national groups together and say, We've got to tell everybody what public health is, but it's got to be the same story. And then the second thing that we noticed was we had a terrible lack of leadership. A lot of those national groups had people that would never speak up and would often not show up, and that we were just killing ourselves.

So that was about the time that CDC[25] put money into the national leadership program and that got started. That was having so much success after a couple of classes. And we were nominating Floridians to go to that, so we had people there. I think Mark Magenheim was the first person to go from Sarasota County.

That the health plan went down in flames. We had been promised in all these meetings with these high level officials that public health was right in there, and when we read the final thing we couldn't find it. And so we realized that we had been had. And we talked a lot about it back here in the state and nationally about why we weren't at the table. And they played like we were, but we really weren't.

And so, I came down and met the students. And after all those discussions I really thought, I am getting to the end of my time up at the state if parties change—although I had been there through the Republicans and the Democrats—and that I couldn't probably affect a whole lot more myself by being at the state, but I sure could maybe have an influence on the younger generations coming along with leadership. And that if I could get the faculty to agree to focus on leadership, which they did before I came, then I'd consider it. So that's how it happened.

23The Lawton Chiles Legal Information Center is part of University of Florida, serving as a law library for the Levin College of Law in Gainesville, Florida. The center was renamed after Lawton Chiles, former governor of the state of Florida and alumnus of University of Florida.

24Ira Magaziner was the senior advisor for healthcare policy during the Clinton Presidency. He now serves in a leadership position in the Clinton Foundation.

25The Centers for Disease Control or the CDC is the leading national public health institute of the United States. The goal of the CDC is to protect public health and safety through the control and prevention of disease, injury, and disability. The CDC focuses national attention on developing and applying disease control and prevention.

Now, as far as whether it was time for me to leave, let's see, there was a fundraiser, it was, I guess, '94 that I decided to do that. And there was a fundraiser for Governor Chiles' election campaign, and we were out in a cow pasture somewhere. And he and Mrs. Chiles came up to my wife and I—and I had never talked to him about this, because I worked under a secretary.

I mean, I get to talk to him whenever the infant mortality statistics went down even further each year; he'd get all excited. I told the secretary, but I didn't see that I should go meet with the governor about this. Well, he was not happy about that. And it was the first time I'd ever seen him irritated at me. He just came up and he said, "I hear you're leaving." And I said, "Yeah, I going to go down and be dean." And he said, "Well, thanks for asking me."

CP: Really?

CM: Yes. And I said, (makes noise).

CP: Intriguing. That is surprising of an underling to a department secretary.

CM: He felt very, very close to people that worked with him. So here's a part of the team leaving, and he didn't think that that was such a good idea. And so that lead to a funny thing, just a few days before I was going to leave. I went over and sat down and talked to him for a while because we were working on the Chiles Center. That made him feel better.

And I talked to President Lombardy, and it was okay to move the idea to Tampa. And it was actually better off in a school of public health than it would have been in a medical school anyway. So, he was real happy about the way things were going with that. And so we were sort of reviewing what went on and he said, "Well, just tell me, is there anything up here that you would've liked to have changed and so on?"

And he had called me on vacation the summer before, because Jim Toowey (sic) wanted to take Ed Fever, my deputy, away to be the deputy secretary for HRS and I said, "No." And then I get this other page out in the woods where it is from Governor Chiles. He said, "You've got to really do this, he needs the help." So, I had to give Ed up.

So when I'm having this final interview with Governor Chiles, I complained about the fact that he took Ed away from me, and that's sort of the way I said it. And he reared back and he said, "You don't come into the home of a man who has been hanged and talk about rope." I didn't know what in the world he was talking about. Then, I went out and Buddy McKay explained to me, how could I complain since I was leaving him? He sure had a funny—that was a Lakeland way of putting it, a Polk County-ism.

CP: I like that. If you were to go back, what would you do differently, if you were to go back to the state health officer position?

CM: I would start out doing a lot more, trying to encourage the health departments to do more in the community. I mean, they all think they're doing that anyway, but the idea of having training programs to learn how to do direct community development, how to find leaders in a community

and go out and really get buy-in from community members about the programs we are putting out there, because we've dumped a lot of money into communities that have failed.

And I think we have a lot of people in public health, both there and in our college, that are a little afraid of the community, really. It's messy, it's really hard to work with, and there are some upset people out there. But I do think that both research here in the college and programs at the state and local level need to figure out a way to really get folks involved that are going to receive the services. Some of that may be finding out that they don't want your services, or they want something entirely different than you thought about—

CP: Well, I would come back to data.

CM: Huh?

CP: I would come back to data.

CM: Oh yes.

CP: Come back to data.

CM: And I think with Healthy Start coalitions and the immunization coalitions, we have found ways to teach those groups of local people how to use data. And that's been one of the hardest things to do, but it's paid off more than almost anything else we've done. I think getting the local public health units far more involved with their local private care groups is very important too. And that is something, again, that old timers aren't used to.

But the times are changing, you know, and it is really important for people to figure out. When we started talking about accreditation earlier this year and have started moving that along, it was interesting that because local health departments are different in every state. Some of them are paid for locally or some of them are city, and some of them are state.

We figured we couldn't really evaluate them all the same way. So, what we decided to do was that when a county health department or county health services get evaluated, the health department will be evaluated for whatever they do in that community. And it's quite different from place to place.

And the whole community will be—everybody who provides public health. A lot of which, in the future, isn't going to be the health department. So we will give a whole county, for instance, a score on—so we will accredit a county's health system.

CP: I love it.

CM: Yeah, it is going to be hard to figure out how to do it, but people say it's not fair just to lay all this on the local health department.

CP: I agree. I agree.

CM: Some of them do full service, others do 20 percent of what that other one did. And yet they may all be doing a good job, but they're not going to look too good if you stack them up against each other. So I think figuring out that and to do that, we are going to have to make that involvement occur with the private community.

CP: And as dean, you are working on that, I pray?

CM: Yes.

CP: That's one of your disappointments from there.

CM: And I think Dr. Brooks, the new health officer, understands that. And so, between the two of us, I think we can have a lot of influence on that. I think those are big things.

CP: Those two things you would've done differently, but one is a sub to the other, that you would've attacked the community health attitude earlier in your administration. You got around to it before you quit though, that I'm aware, and you're much more now.

And you probably couldn't have more influence from this position than you could from that position, in causing philosophic changes in how you do things. And how do you approach that? The same way you lead an old cow into the barn, catch her calf, your students. Excuse me, I'm putting words in your mouth, which I meant to.

CM: No. I think the other thing that's actually gotten a lot better since I left, that if you had asked me this right after I left, I'd say, "We really needed to beef up our epidemiology capabilities." I'm not just saying that for your benefit, but a lot of the time I was up there, we had one state epidemiologist.

And if we were lucky we would get an EIS[26] [Epidemic Intelligence Service] officer from CDC. Now, thanks to a lot of our graduates, thanks to the recognition by the larger health departments that they all need their own epidemiology, there are probably 25 or 30 epidemiologists around the state, whereas before there were two or three. I mean, people that were full-fledged PhD epidemiologists, you know?

CP: No wonder we are in such the doldrums. If you don't have the basic science you need to run a health department—

CM: Absolutely. I think the Orange County Health Department is a wonderful example. They've got two or three epidemiologists there. They've got a whole lot of studies and community involvement going that they didn't five years ago.

And they want to be an academic health department, which is a new idea that—they'll link up heavily with us, as we are with Hillsborough County. Maybe hire one of their epidemiologists half time here and half time there, and do a lot more of that. And keep that a much more

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26Epidemic Intelligence Service is a facet of the CDC. Those who work in EIS are known as officers and come from medical backgrounds. They primarily use epidemiology to solve public health concerns in the US and abroad.

academic component to what we are doing, which would make it much more interesting to practice, and it would help solve some of our problems by people closer to the community.

CP: And provides a laboratory for your students.

CM: Yes, absolutely. Oh yes.

CP: And it will ease—I like that, I like that. Well, so you arrived at the College of Public Health in Tampa after a great career in Tallahassee as far as the record shows, and I believe it. And you are now in the process of putting together, in an active way, the philosophy that you really developed in Tallahassee over need, your assessment of need. You now feel like you're in a position to do something about that. Talk to that point a little bit.

CM: Well, it was a hard transition to get used to. As I remind everybody, I went from a $1.2 billion budget to a $4 million budget, and that was a little hard to get used to because I was going to spend all this stuff and get all this stuff done. That was an interesting transition.

The other one that was really interesting was that I loved being state health officer, and I loved being involved in a lot of problems that we had. And I got down here and something would happen at the state, and I had to keep being reminded that I wasn't the state health officer anymore.

I'd pick up the phone and say, "Hey, can we help you do that?" And they said, No, we have got it handled. We are doing fine. I was really disappointed, so that was funny, you know. I got over it. By the next legislative session, I realized that I was in a really nice place. I think that my two goals coming in—I haven't asked anybody, but I'm pretty sure I wasn't their first choice down here.

CP: You don't ask that question. Some questions are best unasked.

CM: I think they really wanted somebody a lot more academic than I had been. So they really put me through the ringer, the students and the faculty and everybody. They really asked a lot of questions, you know.

And I was sort of—I liked where I was. I was sort of testing them too, if I didn't get this job I didn't care. But as we got into it, I started to care more and more. So I said, "If I came, the two major things I wanted to do were to implement the leadership program for Florida, and the other was to—since we were the only school of public health in the state, and it's a huge state—broadcast the NPH [National Public Health] around the state to public health workers because they couldn't give up their jobs to come to Tampa for a year in a half."

So the faculty bought into that, and I think that, plus the students, as I mentioned, really made me feel like I really wanted to come here. And we started right out implementing both of those things and got them up in running with a lot of effort. And now we are, last December, we were the first place in the world where people have gotten their NPH over the airwaves.

CP: Never having set foot on campus.

CM: That's right. Well, we had them come get their degree and do—

CP: —do an orientation.

CM: —come and meet people and so on.

CP: That is marvelous.

CM: Yeah, it was a lot of work, and I didn't do any of it. I am technically challenged, but Dr. Phil Marty and a lot of our staff, a lot of help from the state health office, it has been neat. And it is especially nice since I have always had a fondness for rural areas.

Then I went out into Hardee County and places like that. And people out there said, "Boy, nobody has ever thought about us for things like this in the past," and that's really neat. And there would only be three people out there, but they were learning public health.

CP: That's okay. They need it as bad as the nine people in Palm Beach.

CM: Oh yeah. And the other interesting thing that happened was that when we started that up, even though when I was being interviewed the faculty all said, "Yes. Sure, we'll do that." There were a number of faculty that, when they saw the technological complexity to doing it, and they have to learn to teach again, said, "Nah, maybe we don't want to do that."

And so what we said was, Well, who does want to do it? And we will work with the ones that do. And interestingly enough, our best teachers stepped forward. And that's what really made the program because they got—and we really have some superb teachers, and they really—people thought it was all the distance learning, but it was actually the wonderful professors that we have that were teaching. And so that really made it fly too.

Pause in Recording

CM: And the interesting thing is that we found out—and I had been involved with the CDC for a long time—that the majority of people up there don't have any formal public health training. And that was a shocker to me.

CP: That was a shocker to me too. And it has been so historically.

CM: Yeah, I didn't realize that.

CP: That's not new.

CM: So he said, "Well, we have these capabilities, are you interested?" And, you know, Emory [University] is connected to them, the school of public health, and they had been going over to Emory for courses, but we were far less expensive even with out-of-state tuition than Emory. We are about half the cost.

And so they did a need survey up there and plenty of people showed up. And our folks went up and 90 people showed up that were interested. And so, we are the program of choice into the CDC now. And at Atlanta and Cincinnati, and either Colorado or Fort Collins or Morgantown, I can't remember which, with the NIOSH [National Institute for Occupational Safety and Health] centers, you know.

And I go up there for meetings, for the advisor committee meetings, and these students will seek me out. And they'll come up to me, and they will say, "Oh, we really think your professors are great." And, "We had taken a couple of courses at Emory, and your professors are a lot better than the ones at Emory."

That's pretty good. They can buy whomever they want up there. That has worked out really well. And now, just two weeks ago, we ventured into Venezuela. We have a bilingual program, and Belize is signed up to start in the spring and five other countries are interested.

CP: Marvelous, and you are beaming down?

CM: Yes.

CP: That is outstanding.

CM: I think so. And we have had eight years of summer programs in epidemiology for people from South America. This year there were 80 people from 27 countries here for a month getting a certificate in epi [epidemiology]. And those are all people now that feel like they're colleagues of ours. And USF really wants the whole university to focus on Caribbean, Central and South America. And it is really happening fast.

CP: Are other colleges participating? Health is in the leadership?

CM: You mean here at the university?

CP: Yeah.

CM: Business has some things going on. I don't think they are doing it the way we are and engineering has some. But when we interviewed people to direct the international program a couple years ago, of the five finalists, we were all in a crowd interviewing, so they didn't really know who we were, and I was the one from public health there. And when we would ask them what the top three problems in that area in the world were, all five of them said public health was the number one problem.

CP: Really?

CM: Yes. So that's how we started thinking about it.

CP: Did it mean some extra money for you, extra adrenaline on the part of the administration's attitude towards the college of public health?

CM: Oh yeah, but the administration has always been totally supportive of us. So we—

CP: No problem there.

CM: Right.

CP: You're living a cherished life.

CM: Charmed, you were about to say.

CP: Charmed, that's the word. Charmed life. Now, where do you see your international component going? I see a lot of good stuff out of there for your students, larger students to the future. With that question, but where does the Pan American Health Organization[27] sit with all of this? Have you incorporated them in any way?

CM: Oh yes. They sponsor that summer program I was telling you about, so they pay for that.

CP: Oh, they do?

CM: And with the Lawton and Rhea Chiles Center[28], we have established a joint professorship, bringing up the person from Central and South America doing the best research and population based maternal and child health. And we started that this last spring, and José Belizon came from Uruguay. Very few people that aren't in MCH know this, but some of the finest work in the world is done south of the border here and has been for the last 30 years.

CP: No, I didn't know that, but I am not in MCH.

CM: But this is a co-sponsorship of National Institutes of Health and our college. So the person appointed the Chiles lecturer goes up for a day on the NIH campus, and then next day is down here. And this fellow, that Dr. Belizon, directs MCH for PAHO [Pan American Health Organization] down there, so that was a nice first. So you are getting a lot of linkages with PAHO that way.

CP: That networking can only be advantageous for the community of public health.

CM: Well, we are in a global community as people are fond of saying. And from a public health standpoint, here in the Tampa lab, we have folks working on dengue and malaria and things that people say, "Oh well, it will never hit us." We've got all the right mosquitos in—

27The Pan American Health Organization (PAHO) is an international public health agency working to improve health and living standards of the people of the Americas. It is a part of the United Nations system.

28The Lawton and Rhea Chiles Center for Health Mothers and Babies is a subsidiary of the USF College of Public Health in Tampa, Florida. The center specializes in the public health needs of mothers, babies, and families in the community.

CP: You let your guard down one minute, and it will eat you up.

CM: Absolutely.

CP: So this networking with below the border is very useful to that in your planning for these as laboratory for your own students, and I am thinking of coercive tropical medicine in the larger sense. What are your thoughts? Have you given any thoughts to a focus in tropical medicine?

CM: Well, we haven't. Getting involved in some of these things has been problematic. Public health has about 90 areas of research and interest. It's a giant—

CP: You're talking about the core group?

CM: Yeah, right. Those are the ones we know about. And it's a problem for a small college. We have 50 or 60 faculty, and that is the size of a department at Hopkins or Harvard, and we are talking the whole college here. Now, interestingly enough, we have one of the largest student bodies of any in the country. We're in the top ten, as far as numbers of students. We have over 600 graduate students at any one time, 75 of them working on their doctorate.

So those are busy faculty. If you got 90 areas of study and 60 faculty, they have to be able to teach those 90 areas with some degree of skill, we hope, but they can't do research in all those areas. So we get criticized from time to time that we're not strong on AIDS. Although in the behavioral aspects we had a lot of good stuff going. But we don't do lab research on AIDS, because Miami does a great job with that and we would be duplicating them.

CP: Why duplicate?

CM: We don't. Doctor [Boo H.] Kwa and Dr. [Ann] DeBaldo have worked with parasitic diseases a lot in the past, and they are very good. And they have got some great things going, Doctor Kwa over in Malaysia, and that's open to the students. But Tulane [University] has one of the strongest programs in that, and we have a joint program in bioterrorism for the Western Hemisphere with Tulane.

So we are developing a lot of partnerships with other universities so that where we may not be totally heavy and to the laboratory research in an up-front area in parasitology, we can call up Tulane and say, Could Mary come over there for three months and work in your lab? And, Sure, that's great.

CP: That's marvelous. Marvelous. Well, with bioterrorism and I think Tulane is still, in our country, the hold out for tropical medicine. There is not a really another good place in the US to get first class, tropical medicine. It is my impression that Tulane is losing its faculty too. And from a larger philosophical view, it just worries me to see America lose its capabilities in tropical medicine.

CM: Well, we've certainly got the interest there. As a matter of fact, we've got a bigger core of interest in that particular area among our small faculty than we do with a lot of other things. Plus, the partnership with the Tampa Branch Lab that we'll be building on campus will focus in a lot of those areas, because there are a couple of people there now, with our students, working on dengue. So, I think once the new lab gets built on campus we will start training laboratorians, which we don't now, which very few places in the country do, and that will just automatically bring more research money in and more—

CP: For our audience, give us a little bit of background to this co-operative effort between you and the state for the laboratory.

CM: Well, I discovered going through—this college is only 15 years old, but that's a 14-year-old project.

CP: Oh really?

CM: Yeah. Actually, when the college started, it was taking up residence with the Florida Mental Health Institute next door. And I found in the files a whole set of drawings and everything that the deal was that the Tampa Branch Lab was going to be built on campus, a new one, and our laboratories were going to be combined with that; and then, up against that, would be office space, and that would be the College of Public Health.

CP: Oh really?

CM: Yeah. I can't quite find the history of how that got separated, but it did. And we ended up with this building being built here and repeated attempts to bring back the other idea, which had failed.

Senator Myers, who has always been one of our angels up in the legislature, constantly kept pushing it. But it wasn't until we went to Governor Chiles and said, "We really need a building for the Chiles Center, and we really need to bring this cooperative thing between the Department of Health and the college together." And he said, "Why don't we put them all together in a package to the legislature, and I'll help get it through," and Senator Myers helped get it through too.

It just breezed right on through after years of stalling out somewhere along the line. And so it helped the Chiles Center and it helped the Department of Health building. And so it will be a wonderful partnership, I think.

And we're planning it all together, about 20-some percent of the building will be conference areas and labs for us. But for the most part, we are going to share labs and leave some offices for our folks. As I say our students and faculty are already over there, working in the crummy old lab that exists in the W.T. Edwards Building now.

CP: Yeah, the state public health lab.

CM: We've got a lot of good stuff. And so, I think this is an exciting partnership, and one that I think UCLA did, but I don't think that many other schools have done that.

CP: You mean UCA [University of Central Arkansas]—that one that you've mentioned is outstanding in many regards.

CM: We brought them in as consultants to help us plan our attack on this one.

CP: And it's about to come to fruition. When will the lab be up and running?

CM: About a year from now.

CP: These are exciting times for the College of Public Health. I like to think you have brought this enthusiasm to the college, and I am beginning to feel it here. But how do you sit where you are right now? You've been here how long?

CM: About four-and-a-half years.

CP: Four-and-a-half years, that's a good gubernatorial term. Where are we now?

CM: It's longer than most deans last and health officers too, by the way. By the time I left the state health office, I was the second longest sitting health officer in the country.

CP: I read somewhere recently that still the average sitting time of a state health officer is two years, seven months.

CM: Yeah, it's terrible.

CP: They turn over kind of fast. But tell me about the College of Public Health, and where you are right now.

CM: Well, we have talked about our two new programs, leadership and distance learning, and they are going great. I think there are a lot of other programs starting in the state, and we welcome that, really, because it is a big state. We'd like to have lots more people with public health training out there backing up what we do.

I told you about our student numbers and so on. And there's tremendous interest in public health. And remember these are fat times; this is when people usually don't take time out to go to college. One of the biggest, most exciting things that have happened has been the jump in our research efforts. We've worked hard on that. And we have gone from about $9 million last year in external research money to $21 million this year with—

CP: Almost a threefold increase.

CM: Yeah. It makes us the second largest research program on campus after the medical school.

CP: Really?

CM: And we're about half of what their program is, and so our faculty has done a wonderful job. The enthusiasm is everybody, but it's primarily our students. About this time of the day, things start buzzing out there, and that's great for the future of public health.

CP: Yes, it is. You have bragged a lot on your student group. And not all of our viewers will be students, active students. What advice do you have for—as a matter of fact, what advice do you have for a young person just starting out? What do I want to do with my life?

CM: Well, I think young people nowadays are understanding that we live in a global village. They're understanding that their future is not in their town, and they're also understanding what the futurists are saying, and that you may hold six different jobs in your lifetime. And so we are really reaching down in the high schools now to get people to know that there is more to health care than nursing and medicine.

And even if you want to go into nursing and medicine, also go into public health. And beyond healthcare, you can be a teacher in elementary school and come back and go into public health, and we can sure use you.

CP: Yes, you can. What advice do you have for your public health students of tomorrow? They've got your message in here. Dean, give us your advice.

CM: Well, first, we tell them that—when I orient them, I read the newspaper to them. And any given day, I can find 20 articles on public health, including the comic strips, so that they realize how many opportunities there are for such a broad area of interest. And then we try to tell them to get as broad of an education as they can. To dip into lots of areas other than the track they're on, because one of the problems with public health is that environmental health people, even the ones trained in the past, don't know anything about maternal and child health.

And so it's a fight nationally with the deans. And we are pushing it more and more to try to get people a broader and broader and broader education, because things change fast out there now and they need to be ready for it.

CP: Well, we are a team, and it is useful for us to have a common vocabulary, where we can be helpful to each other, it seems to me.

CM: But we haven't been teaching people as a team in the past. When employers come on campus now, the folks across campus say that the two questions they ask are: can they work as a team, and have they had some experience out in the community? Those are the two big questions from Xerox, Kodak, and IBM, and everybody now. But just think, those ought to be the two major questions for public health too.

CP: Is there another question for public health?

CM: Is there another question?

CP: I don’t think so.

CM: I don’t think so, either.

CP: I don’t think so. Couple with that the technical stuff that you give me in my technical language to let me carry. But I can’t function without the team in a community setting.

CM: Well, there is another question that they often ask for public health is, when are they going to pay us as much as neurosurgeons, because we save a lot more peoples lives.

CP: Yes, they do. Well, and I would ask, “When are you ready to pay the liability insurance premium of a neurosurgeon?”

CM: Yeah, that’s a good comeback.

CP: Dean Mahan, this has been just a delightful time with you today. And we are complimented that you would take the time, we recognize how busy you are, that you would take the time to come and sit and share just an exciting piece of professional history that you have.

CM: I really want to thank you for the enormous amount of time that you are spending to do our Oral History Program, and this is just part of that.

CP: Let me tell you on behalf of the University of South Florida—and I usually say, and on behalf of the College of Public Health—I thank you sincerely for coming by and sitting with us. And then I say, “I am Skeeter Prather.” And we’re done.

End of Interview