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Dr. Ellen Daley: So, good morning Charlie.

Dr. Charles Mahan: Good morning.

ED: Good morning. This the first in a series of oral histories that we're doing with maternal and child health leaders and I want to thank you for coming and talking to us. I'm Ellen Daley. I'm on a faculty of the University of South Florida College of Public Health in the Department of Community and Family Health and you and I go way, way back and I'm honored that you would come and talk to us about this.

CM: Oh I'm honored to be asked.

ED: Thank you. So, the Association of Teachers of Maternal and Child Health or ATMCH, has funded a project to ask maternal and child health leaders if they would be willing to give us some, some time talking about their history in maternal and child health, what their attitudes are about things that are sort of, you know, current issues, future issues. So I wanted to start by asking you if you could tell us a little bit about what you're doing now, how you got involved in MCH, sort of what your history was? Okay?

CM: Well now I am fully retired and really enjoying that. I still serve on some boards related to maternal and child health, notably the Ounce of Prevention Fund in Florida and the Frontier Nursing Service in Kentucky. Frontier Nursing University now, which trains more midwives and nurse practitioners than any place in the world. And but basically I'm retired and the—what were you going to ask?

ED: Well, to say you're retired—you're retired from once of the most amazing careers in maternal and child health. You're trained as an Ob/Gyn and you went to medical school —where?

CM: At Northwestern.

ED: Northwestern, okay.

CM: Which had a great public health department, it had one of the best OB departments in the country at the time. But, most of my obstetrics and gynecology that I took was—we could elect where to go and I always went to Cook County Hospital, which was at the time—I think it's safe to say—just a totally out of control place. Yet during the first year that I took OB there, we had the most deliveries of any hospital in the United States before or since. In one year we had 26,000 deliveries.

ED: Oh my.

CM: And that was the size of my hometown, Morgantown.

ED: (laughs) Right.

CM: And that was an impressive number.

ED: How many of you were—when you say 26,000 how many—how many people were delivering those babies?

CM: Well—

ED: This was your residency?

CM: No this was medical student.

ED: Medical school. Medical student.

CM: Yeah, yeah—well, there about 26,000 people subtract twins and triplets but—

ED: Wow. And how many—so how many doctors and residents—I mean when you saw that as a medical student, some medical students would have, like, run screaming from that and said, "Twenty-six thousand, I never want to go near that again."

CM: Oh now well, it was—compared to medical students today, we got to do a lot of things. You know surgery, that, and so on. Lot of it was unsupervised and we actually were thrilled by it. Now some people just thought it was an adventure but some of the rest of us really took it seriously and tried to really make it a better experience for people.

ED: Right.

CM: And then the senior year, we had one of the last home birth services in the United States and so we spent a month in South Chicago delivering babies in peoples homes, apartments, tenements, and so on.

And that was a real experience. It was crazy. I delivered—well, the woman delivered—I attended a birth at gunpoint. The dad was drunk and said, "This better be a boy," and the nursing student who was helping me—we were both there and the woman was—back then people had six and half babies per family. So some of these folks are having their tenth and twelfth babies and so their labors were pretty fast and so we kept encouraging the guy to drink more. And he did, and he was in pretty bad shape by the time the baby was delivered, which was a girl. We quickly threw a towel over it and said, "It's a boy." (both laugh) Got the placenta delivered and stayed for while and put him to bed—

ED: Go ahead.

CM: And got out of there. And I don't think he remembered any of it but that's the kind of thing that made life exciting. (laughs) And—

ED: And that was just when you were a medical student.

CM: Right. But, I just say that because it really influenced a lot of, you know, what I got interested in later on because, even though it was an exciting experience as a student, it was a terrible maternal experience for most people and you could see that a lot needed to be done.

ED: What years were those?
CM: Early sixties.

ED: Okay.

CM: Yep. And then I finished up a little early and I did an Endocrine Fellowship and the interesting part about that is the pill came in in 1960. And because it was such a high dose there were a lot of complications with it, so the whole field of Sex Endocrinology was sort of starting. And that was really interesting to me. And so, I sort of was trying to make a choice between internal medicine and endocrinology and Ob/Gyn. But I really liked working with women so I decided to go into OB.

ED: Lucky for us.

CM: Well.

ED: Yeah.

CM: And then I went to Minnesota, which is a wonderful place where you go from Chicago, which was out of control, to Minneapolis where people really want to take care of people. And worked in a county hospital that really tried hard, even though they were

busy too, but tried hard to make it—what we would call customer service today where people really got, you know, compassionate care.

ED: Was this in your—so was this in your residency when you went to Minnesota?

CM: Right.

ED: So that's such a great juxtaposition of a medical student in this—I mean it almost sounds like the Wild West.

CM: Oh yeah, it was.

ED: You know, crazy, right. And then going to a place where as a resident you see where, sort of, policies make such a difference, the setting, you know the leadership—

CM: And sort of the culture of, yeah, sort of the—Saint Paul was largely German-Catholic folks, Minneapolis was Scandinavian folks, both of them had a culture of really wanting to take care of the poor. And the only reason they weren't overwhelmed was that most poor people were smart enough not to move there. (laughs) Because they'd freeze to death six months a year so—but I just point that out because having that background—my dad a family doctor in West Virginia and my—our first seven years was in a mining town about 700 people. And, he always said, and I told students this, that 30 percent of his people couldn't pay him, but that was the price you pay for the privilege of practicing medicine. And he really eventually evolved into mostly dealing with OB because he really loved it. So the first birth I ever saw, he dragged me out to the hospital and saw triplets being born.

ED: Oh, no kidding.

CM: And then the other thing was that I used to help him, he was—he started the first blood bank in West Virginia and mainly for Rh disease. And so I used to go out in the middle of the night and help him to exchange transfusions on babies because the pediatricians didn't want to have anything to do with it.

ED: Really?

CM: And so I'd count the amount in, then keep track of the amount out and—

ED: That's fantastic! How old were you?

CM: I was in high school.

ED: Really.

CM: The End(?) College, I went to college there too. But that's one of the things that's been fantastic throughout my lifetime as a—you know, babies dying of Rh disease have pretty much disappeared.

ED: Right, right.

CM: German measles has pretty much disappeared. Polio, things like that. I'm digressing but—

ED: No, that's great. I mean I think that's—that is amazing to see those kinds of transitions over the years—what things have changed. And sometimes I think, and you and I have talked about this before, that technology has been both, sort of, a blessing and a curse, and sort of, scientific advancement has been just amazing in the field of MCH [Maternal and Child Health], especially, when you talk about things like you don't see polio anymore, you don't see Rh issues anymore, but then, now we have all kinds of problems related to technology and science.

CM: Oh yeah, we've sort of overdone our thing, as they used to say in the sixties.

ED: We have. Yeah.

CM: So after that, after my residency, I—the Navy had paid a good part of my way through medical school and then they deferred me through residency because they needed obstetricians and pediatricians. And so I had to serve my three years on active duty and—so that was my first paying job was serving at the Marine base at Quantico during the Vietnam era. And, we didn't have enough OBs and Peds, so we were really busy. Often we were on call every other night, up all night; see 100 patients in the clinic the next day, after doing major surgery. And—but, I think the Marine wives were absolutely wonderful people and I still will communicate with some of them today. But I averaged a birth—attending a birth a day and one major surgery every other day. So by the time I got of the Navy I didn't have much interest—I was planning to go into practice with my Dad, who died while I was medical school and I still was planning to go into private practice, but I was just sick and tired of doing everyday normal stuff. I'd done thousands by that time. I just wanted something different and the different was going into academics instead of—

ED: Really.

CM: You know it wasn't public health yet, it was academics, but it had a lot of public health flavor to it. So I went back to Minnesota for five years on the faculty and saw some private patients—I was at the county hospital and then was the head obstetrician for one of the federal community health centers in an Indian neighborhood and so got to work with Sioux and Chippewa people. We trained the first Indian nurse practitioner and they were just wonderful people to deal with and I still am interested in all things Indian but—

ED: So you got introduced early into this relationship between Ob/Gyns and nurse practitioners and nurse midwives at a—pretty early on. When did that first start with you? Was that Chicago or was that Minnesota?

CM: It was Minnesota because—oh, well no, it was actually doing the home birth thing in Chicago. The first week we were on the home birth service, and some of the students who had taken their OB in private hospitals didn't really get to attend many births. So they had to be watched more carefully then those of us that had had a lot of experience. But at any rate, the first week that we went out to people's homes a British nurse midwife went with us because the U.S. wasn't really training many nurse midwives. And they were just wonderful people and they would show us—I learned so much from them about following a labor and tending a birth. Then if they said we were ok at the end of the first week, then we got to go out with a nursing student on our own—but it was neat because I had a really nice relationship with one British nurse midwife and a couple weeks later she called me up and she asked if I'd come and stand by while she gave birth at home.

ED: Oh, how nice. Really?

CM: And that was neat. She just wanted me there in case trouble developed so I could call the authorities (laughs).

ED: Oh that's kind of an honor isn't it? That's neat.

CM: Oh it was an honor, absolutely.

ED: That's nice.

CM: That's big. So at any rate, I sort of fell in love with midwives at the time. There really weren't nurse practitioners yet, but they were coming and they started as pediatric nurse practitioners. But we thought, "Well, you know if that works for pediatrics why can't we do some of that for women's health."

ED: Right.

CM: And so Sally Bolio, who was a Sioux woman, nurse, we sort of informally trained her and she did a lot of prenatal care after that and she was great. And, so then Bill Spellacy, who was about five years ahead of me, he was an instructor while I was a resident at Minnesota, came to University of Miami and—with—and brought Bill and Donna Buhi with him because they were his research people, and now Eric Buhi is on our faculty. And gonna be a superstar nationally on his own. And the—they were down there about four—the time I was at Minnesota and then Dr. Spellacy was asked to chair the OB department at Florida, in Gainesville, and so he called me. I was his first faculty recruit.

ED: Really?

CM: And he called me—I mean I really loved working in Minnesota—I'll talk about the red door—but he—I'd been reading about this rural health project and since I'd grown up in a rural area, I was really interested rural health—but they had a maternal and infant care project. It was a federal project. It was one of only two of the sixty around the country that were rural. And it served thirteen counties around Gainesville, and they'd written some publications about training family planning nurse practitioners and OB nurse practitioners and sending teams out to the county health departments to take care of moms and babies and family planning. And I really thought that was a neat concept and we were thinking about how to do that around the Twin Cities and he called me said, "You know, the fellow who's running that is leaving, I'd really like you to come down and run that." And, boy I didn't have to be asked twice.

ED: Really.

CM: I went down to do that with—the department was in such, just such a young department that it drove my wife crazy because he couldn't give me an increase in salary, so I went down for the same salary and my wife's going, "We're going to move and you're gonna have the same salary." (both laugh) So I—"But I really want to do this, you know." But going back to Minnesota, one of the things that happened in the late 60s, was never supposed to happen again, and that was an explosion of gonorrhea and syphilis. 'Cause we'd had penicillin and it was never going to be seen again. So they had closed all their VD [venereal disease] clinics, as they called them. And, then all of a sudden, wham. Minneapolis had a big gay population and, of course, with the pill—everybody was thinking the pill protects you from everything. That was big teaching problem.

And, so only in Minnesota could you do this. The head of STDs at the state, Hennepin County, and the city of Minneapolis, we all got together, 'cause we were the county hospital, and said, "We're gonna have to open some new clinics around here. Let's do it differently. Instead of having old burned-out doctors running them, let's run them with nurse practitioners for the women and corpsmen that had come back from Vietnam for the men. And, let's set them up to be gay friendly and let's don't call them VD clinics because a lot of businessmen come in for treatment. Let's name something else." So we called them the Red Door, and it just had a big red door. I don't think it fooled anybody, but that's what it was called. And it was very successful. The first year and the first one we opened we saw 19,000 people and really, it just—my job in overseeing it was, every time we had a new case of primary or secondary syphilis I had to go see it and make sure that that was what that was 'cause that was more serious then the gonorrhea. Herpes came in at that time and we didn't really have much we could do about that.

ED: That's right.

CM: Except get people to use condoms and so on but—so it was—it was very successful and a really good model. And it horrified the medical profession because, you know, here was one doctor and all these other people working and—actually that's been a problem over the years, even in Gainesville. What was I doing supervising six nurse practitioners? How could they possibly function without me standing me standing next to them? So, we

went before the nursing board a couple of time about that and said, “Well, it’s either that or the people don’t get cared for. What do you ra ra ra—”

ED: So the nursing board was critical of that model?

CM: Yes. Nurses are very tough on other nurses.

ED: They are—I know that’s true, you’re right.

CM: Yeah.

ED: So it was more then just the medical board that was critical of that model, the nursing board as well.

CM: Well it was the—it was the medical doctors in Minneapolis didn’t like the model. In Florida, the medical board didn’t have anything to do with it. It was—the supervision of nurses fell entirely to the Board of Nursing. By—well we had a lot of trouble introducing nurse practitioners to the county health departments ‘cause they’d come with us and the public health nurses weren’t nurse practitioners and they weren’t so sure they liked that idea.

ED: Right.

CM: So they’d complain about it a lot. What we finally did was made sure we trained or help train, the county health department nurses to the point that they could easily come back and get a nurse practitioner thing if they wanted, which we encouraged ones in the big counties like Ocala and places like that, to do. Or, they could do prenatal care when we weren’t there and we calculated that over ten years when we weren’t there, the public health nurses probably took care of about 220,000 women and never once made a mistake. They’d call us if—in Gainesville—if they had a concern. We’d either have them send them in or whatever but—we’d write up a plan of care, they would follow it, if somebody had a problem like diabetes or hypertension and—it’s a great model. And, you know, it’s why I really feel with national health—health changing now and more people are going to get care that are uninsured, we’re not going to have enough primary care doctors and it’s a great time for nurses to take over primary care. ‘Cause they do a better job for the most part.

ED: It’s a great model.

CM: But the docs aren’t going to like it. And—but they could step right in and do it. And, so I hope—I hope I know that the nurses and midwives are meeting with Congress this past week trying to convince them that that’s a good model. Out there’s—

ED: You’ve been a great—you’ve been a great champion of that model for a long time. I mean a lot of—that’s actually one of the ways that you and I got to know each other and found out, ironically, that I had been trained—I’m not—I’m not a nurse, I’m not a doctor.

I came up through the women's health movement. And we—that was that same model that you used nurse practitioners and midwives in clinics to provide primary health care and reproductive health care and I had been to the Red Door. And when you were the Dean here, and I was just getting my PhD., that's how we made that connection, that we actually, probably had passed each other when you were at the Red Door. But that model of using nurse practitioners and nurse midwives to provide care has been so successful but—and you been recognized by so many organizations as a proponent of that. And it's really tough; I mean it's never been an easy sell anywhere. I mean it's—and yet it seems like such an obvious solution to so many of our problems.

CM: Well, I think like everything in America unfortunately, it threatens people's income. It all boils down to that. I know when I was working with state, you know, we—and having seen my father die at age fifty-four just working himself to death because there wasn't enough help, he probably wouldn't have wanted to use nurse practitioners.

ED: Really?

CM: And—now he was really into, you know, sort of the—wanting his patients to fall in love with him, I think. And, there are a lot of people who go into OB that do that. But you know back at that time OB was only 5 percent women.

ED: That's right.

CM: And now it's, what, 70 or 80 percent?

ED: That's right.

CM: But, seeing him work himself to death when I was training—helping train the residents up in Gainesville—we'd introduce them to the nurse practitioner model, which they worked with. They'd go out to the clinics with us. Midwives helped train them, showing them, you know, "Here's how to take—you know how to take care of a high risk patient. But here's how women want to be taken care of if they are not high risk." And so, we'd sit down them and say, you know—I'd tell them about, just about getting trampled in the Navy and say, "Why would you want to go out there with just two or three OBs and get up all night for a routine births and see people for routine pap smears, when you could have a really well-trained assistant do that and you can see the interesting stuff, and maybe get some sleep." (ED laughs) And, a number of our residents did go out in, with that model of practice, you know, two OBs, four midwives, something like that. Some of them didn't, but we tried to say, you know, "Here's a great model, but you can live a long life. You'll make plenty of money and so will the midwives and the nurses. But, instead of making 5 million dollars a year, you may make 800,000 a year, but —" I don't know, some people just have the doctor trumpet.

ED: They do, they do. So, let me go back a little bit to when you came down to Gainesville with Bill Spellacy.

CM: Right.

ED: And—so you were at UF? Right?

CM: Yes.

ED: For—and how long did you do that? With the rural program and—

CM: Well, actually I was in charge of it for fourteen years, but, as we will talk, the last four years of that I was really working heavily in Tallahassee, going back and forth. I had a big private practice, too. I specialized in referral from all over the state and people who had a baby die.

ED: Oh, I didn't know that.

CM: Then, Ken Kellner, my colleague, was—built a lot of his research in bereavement, you know, the proper way to take care of somebody. We worked—we had a great team that worked on that in Gainesville as a sort of a model of the rest of the country. But, sort of out of that—you know, that wasn't all that I did, but I mean, that was sort of my niche area was that—got to be known for that. And then, the other thing that we—our group, practice group was really the first one in the south to allow fathers in labor and delivery. And, so we actually, because nobody else was doing, we'd have people travel a couple hundred from Valdosta, Orlando, and so on, to have their babies in Gainesville because—so their husband or their significant other could be with them.

ED: What years were—

CM: Oh, that was in the mid to late 70s.

ED: Seventies, right?

CM: Yeah.

ED: That was a huge change in—

CM: Yeah.

ED: Practice wasn't it?

CM: Oh yeah. And again, it was sort of that thing—I probably was a little harsh saying that about my father, but there was a lot of that going around, was that, you know, get your patients to fall in love with the wonderful Dr. Jones and whatever. And, so the docs really had to step back and say, "We're going make this a family business and I'm gonna stay in the background unless needed." Which was very hard for some people to do. But, I thought it made it a lot more fun.

ED: Did you?

CM: Oh yeah. I just thought, you know, it was fun to see—get the fathers involved. You know, sometimes there was disaster, you know, we didn't have ultrasound then and you—the father would be there, you'd deliver a baby, there was terrible abnormalities and we'd all sort of have to suck it in and deal with that all together. And, right away, and in some ways I think, in the long run, that made it easier then the father sitting out there, somebody mysteriously saying, "Oh, what's happening?" "Well, the baby delivered." "Well, how's the baby?" "Well—" You know?

ED: Yeah.

CM: So—and then the other reason people came a long ways for a while was that all of us were really—had been trained to do vaginal birth after cesarean. And, that was not offered hardly anywhere. And people would come from all over the state for that, you know, live in Gainesville the last couple of weeks in a hotel.

ED: Did they really?

CM: Course these were people who could afford to do it.

ED: Yeah, right.

CM: But then that was offered also to our low-income clients that we dealt with out in the counties. So, they all got the same level of care.

ED: So all this—this change from how labor and delivery was practiced and moving towards natural childbirth, and then getting the family involved, all those changes that come both from changes in practice, but also in policy. I mean you—you know, letting other people into the room, for instance. You know, that's a big change in, you know, getting hospitals to agree to that sort of thing. So, you went through all that. Talk a little bit about—because you are such a champion of this now, of what technology has got us to now in maternal and child health that we flipped back over to this very high tech approach and we have some problems now with things like C-section rates and—. What do you think of—its' amazing to me to think of all the changes you've seen and what you've been a part of and here we are and now we have sort of a new set of issues that we need to deal with because of technology and—

CM: Well, when you dig into any of those things it all goes back to money. And you know, it—making money drives people to do some pretty stupid things. Taking the various technologies, let's start with epidural. Back before the war, most babies were born at home. After the war they moved into hospitals and women were often put to sleep, which is dangerous for the mother and baby. Then Lamaze, the idea of being awake and aware came in and my father was very interested in that, and was one of the first people to refuse to put people asleep.

He learned to do caudal anesthesia, which is a difficult technique. Epidurals hadn't really come in at the time. The other thing that he used was saddle-block anesthesia, which is a low spinal, and that's what the services used, so—in the Navy, in the Air Force, in the Army—you'd go all the way through labor, maybe get some, a little bit of IV pain killer, and then only for delivery, you'd be sat up while you're ready to deliver, needle be put in your back and you'd, called saddle-block because you'd be numb around the perineum. And—but the OBs did all the anesthesia. When I was a resident in Minnesota, whenever—we had a very low cesarean rate it was 4 percent and it was too low because we would drag babies out that shouldn't have been born that way. When we had to do a cesarean, it was very difficult to get the anesthesia department to come, especially if a woman needed to be put to sleep, we couldn't do that. And they'd come and they'd complain and they'd gripe and moan and—you know, they had no interest in doing OB anesthesia.

ED: Really?

CM: But then, somebody came up with the idea of the epidural, and I think it was a Cleveland Clinic. And this was something that was technically a little difficult to do and the anesthesia people were doing it. And then came the idea if we did this in enough volume, we could make a lot of money. And then, as I joke, we went from never getting an anesthesia around the OB unit to actually having them hang out in the OB offices waiting to give an epidural at the first prenatal visit, you know. But—so that's how that evolved and then they infiltrated childbirth child education classes and just sorta said, "This is what everybody does, you don't want have pain," and this and that. And women bought into it. The other big change, well a couple—ultrasound came along, which I think is the most wonderful technology that we had because we didn't miss twins anymore, which, for like people who are overweight is easy to do.

And—but that's been overused, too. I mean, there have been some people who use it as do an ultrasound every office visit and then they make money off that and we've had to stop some doctors here in Tampa, through the Healthy Start Coalition, because they were using up all the woman's Medicaid visits just doing ultrasounds, so—we had to turn them in to get them to stop. One of the ones that bugs me the most is the electronic fetal monitor. That came in, while I was resident back in the 60s, and—. That was invented by Dr. Edward Hon at Yale[1] and Corometrics was the company that put that out. And they would run ads in *Redbook* and *Cosmopolitan*, which were the big women's magazines at the time, and they'd show a picture of a monitor and they'd say at the bottom, all they'd say is, "You want your baby to be normal, don't you?"

ED: Wow!

CM: So, women started thinking—oh, asking their doctors, you know, am I gonna be monitored and so pretty soon it became the big thing. Everybody bought up monitors, 5,000 dollars a piece. Enormous medical costs ruined a lot of labors because the early monitors were very insensitive and if a woman moved a hair, it would lose the baby's heartbeat. Kept people in bed, so they couldn't get up and walk. Really—and then, Dr.

1Dr. Hon invented the Doppler fetal monitor in 1958.

Thacker and Banta did a huge epidemiologic study after the monitors had been out about fifteen years. I can't remember, I think there are 20 or 30,000 people in the study that showed that the monitor had absolutely no value. And, Dr. Thacker was here five or six years ago to do a dean's lecture. It was twenty years later, and he said, "It really makes you feel good that you do a landmark study and nobody pays a bit of attention to it." So monitors are still being used unnecessarily. It's a huge industry, costs the country billions of dollars, and people argue, "Well, if we didn't do it, we be threatened with lawsuit" and the other argument is, "If you do do it and people still don't know how to interpret it, it can be used against you in court, so why bother doing it when it doesn't work?"

So those are examples of technology gone crazy and then, that sort of helped lead into a lot of unnecessary cesareans. And then, the thing that the Chiles Center is working on now with the Florida Perinatal Quality Collaborative is working with the March of Dimes and the state Ob/Gyn Society, which now has come to realize that the cesarean rate at 36 percent is way too high. It should be 20 percent or below. That's costing the state hundreds of millions of dollars, and the country billions. These are things that need be dealt with with health care reform, and it's been very hard, but I think we're making inroads into that by showing that it actually—the high rates are actually harming babies and harming mothers and, you know, educating doctors and nurses and families that, you know, boutique cesareans or scheduling your cesarean at your first prenatal visit, it not a healthy way to go. Some women have chronic abdominal pain from the surgery that they can't get rid of. There's just a lot of bad stuff. It's unnecessary abdominal surgery. It's a big deal and, you know—

ED: It is a—it's a huge deal and I don't know how we're going to solve that because when you talk to the docs they say we're forced into this because of the technology. Like the stuff that you're talking about is, you know, you use that monitor and you start this cascade of if something goes wrong and there's absolutely no way that their going to stop that and say, you know, "No we won't—we won't do that, we'll wait a little longer and see if we can, sort of self-correct." So the docs are saying that women are asking for it and they are also forced into a corner because of technology. And then, when you talk to women—some of the things that your hear from women are they're encouraged to have it done and so those days of childbirth education classes when the whole—I mean, I think back on when Patrick was born, it was all about empowering you to have as natural a childbirth as you can and I feel like there's been almost like this sea change in what's happened with obstetrics and women's health. It's really disturbing. I don't know how we're gonna back out of that.

CM: Well, I think we are backing out of it. I think, you know, one of the things that happened was that hospitals co-opted the childbirth classes with the epidurals, et cetera, and then later with how great it is to have a cesarean. But, the terrible thing about it is that people are doing this—a lot of the doctors—well, one of the changes I've seen is that we worked really closely with the pediatricians, you know, we'd have one or two that we would always have the babies that we cared for go to and they would always let us know if something bad was happening with the baby or the child. And, you know, that was both outside the hospital and in the hospital. Dr. Nelson, who's here, and I worked together

closely for years and I always knew if a baby was having trouble in the nursery and I'd go to the nursery every morning before I made rounds to make sure the babies were okay, so I didn't walk into a room and have a mother crying and finding that her baby had turned blue overnight and they were doing all sorts of stuff to it.

That's just not happening today. The doc—the OBs are not talking to the pediatricians, so they don't know some the bad things that are happening because of epidurals, because cesareans. They don't know that the baby's having seizures because of fever after the epidural and that's a bad disconnect. So, one of the things your dealing with is—and also some of the docs aren't keeping with the literature about the bad effects of this. If you look at a lot of continuing educating programs, it's about how to use a new technique or a new surgical procedure. It's not about what's happening to your babies. And—but the big thing is that the parents aren't getting informed consent. And I think The Childbirth Connection and other national groups are really trying to show parents that there are some really bad things that can happen for unnecessary surgery, to you and the baby. And they're not being told about that.

ED: How would you—how would you correct that in terms of training or policy? You know when you talk about—the thing is, you can have a huge impact, I think, in medical training and in residency. I mean, that's one point of contact where you can make a big difference. 'Cause once the docs are out in practice, it's tough to turn that stuff around because they're in pract—I mean, you can do some stuff with continuing education, but —

CM: But medical training wasn't doing their job either. Some of, some of them are leading people into the idea of cesareans for fluffy reasons, you know? But it is turning around. I have to say that over the past five years I've been, I never thought it would happen, but I've been very gratified. I talked to Jennifer House, the President of March of Dimes when she was here for an event about five years ago, and the cesarean rate was up and up and up, and I said, "Jennifer, I know the March of Dimes doesn't like to touch this, but you're going to have to take on the doctors, and you're going to have to take on medical practice because this is bad practice."

Oooooh. But they did, they absolutely did. So a lot of what we're using now as our training modules for docs and it's really, I'd say it's really working well in the northern part of Florida. Tampa General and the hospitals in Tampa have really bought into it and the cesarean rate is going down. I think in southeastern Florida, Miami, it's a tougher sell, but the joint commission is going to start looking at it for accrediting hospitals. A lot of things are coming down that are maybe going turn around, maybe for the wrong reason. People are going to do it 'cause they're going to be affected economically if they don't, but, I think it is gonna turn around. It's just—but women really have to be involved, and when, you know, as—couple of former students in the room here, they've had that hammered into them that this is their job now.

ED: It is.

CM: And you gotta convince women that this is bad stuff, and that it's, you know, going through a normal birth with a lot of good support, with your partner there, is one of the most wonderful things that can happen to you, and your baby.

ED: Well, let's talk about that some more in a minute when we switch to the next sixty minutes.

Part 1 ends; part 2 begins.

ED: So, we've talked about how you got involved in the field of MCH and some really fantastic stories about—almost seeing the worst of MC—sort of the chaos and how people are treated badly and bad practices and then some really nice models that have evolved. And, certainly some of them you've provided the leadership for but you've also had this opportunity to get involved in some things because of other—both the times were right and the people were right. So, if you were to talk about, kind of what were the opportunities or what do you think about for emerging MCH professionals and emerging leaders. What kinds of elements do you think are important to help the field move along? I mean, there are so many challenges to us to help women and children and families. If you were going to talk to students and new professional, what kind of things would you like to see us put together in terms of skills and policies? I know that's a broad question but looking at your career, what helped the most? What would you like to see other people get?

CM: Well, I had, after I'd been in Gainesville about ten years, I was approached to take a sabbatical and go up to the state health department and write. 'Cause, we already had a really good program throughout the state to take care of sick babies, the Children's Medical Services Program and then that started including high-risk mothers. But we had —most of the counties had no basic prenatal care, except the counties under the MIC project, which were Miami, Fort Lauderdale, Palm Beach, Orlando, and then the Gainesville area. That was—those are the only places basically where poor people got comprehensive prenatal care in this big state. So the pediatricians actually, after a number of years at the CMS program said, "We got to stop the influx, we're getting overwhelmed." You know, it's the thing about stop throwing bodies in the river, and so they said, "We got to get somebody up here to deal with the pregnancy problems."

And so I was invited up and I spent a year in Tallahassee, bunch of us around the state, we wrote a five-year plan, and it was mostly policy. Here's what we need to do. Poor people need childbirth education. So, we started an outreach childbirth education program. We need far more comprehensive family planning available then we have. Every county needs to be able to—and the only model we could come up with was to have the county health department provide the prenatal care, which was the model we were using around Gainesville. Let's do that in all the counties. To do that we needed money 'cause the Gainesville project was federally funded. So we had to come up with this plan, present it to legislature, and get it funded, and they funded it. But the—one of the ways that we convinced them to fund it is I made a slide to show to them saying that, if you'll fund this to the tune of about 8 million dollars, in five years we will reduce the

low birth-weight rate by 50 percent. Fortunately, most legislatures have very short attention spans. We didn't make a dent in the low birth-weight rate, but on the other hand, everybody started getting prenatal care. So, the other thing from policy standpoint that we did is we had all this data sitting up there and nobody was using it. MCH has the best data of any part of public health.

ED: Absolutely.

CM: You know, pregnancy lasts nine months and then you see what happened. So, we all started—you know, actually Dr. Sappenfield who was at CDC, helped us figure out how to start using our data effectively. Before that we just sorta made stuff up. And, you know, our data was better then theirs because they didn't have anything. But from a policy standpoint, using data effectively is amazingly important. Even though we have some anti-scientific politicians, most of them will ask you, "Show me." And then, the other very effective part of the data is the health management part of it. What are you gonna save 'em? 'Cause, you know, some politicians will help you out because it's the right thing to do. Some will help you out because it's going save a bunch of money. I'd say the best are right in the middle somewhere. But you got to deal with both issues.

And so, we're very effective at doing that and I mean "we" in the big way because the—we established the Florida Healthy Mothers, Healthy Babies Coalition which was interested people from around the state, not necessarily professionals, many of them were. And, we selected people from various groups, like the Ob/Gyn society. Instead of calling them up and saying, "Send us somebody," 'cause I've been on their committees before, and there are professional committee goers. We'd say, "Send us Dr. Jones from Ocala because we really know he'd be interested in this." And, Dr. Jones would come and he'd be engaged and he was with it. And, so those people really made a big difference when we went to the legislature and the governor because they were all behind it.

ED: Right.

CM: So, it's very hard for one person to make policy change. You need a group of people. The other thing that you need is, if you're going to do something really big time, it may take you two or three years to get something big through, and you can't give up. You just gotta be persistent. And then, people need—another skill people need to learn is presentation skills. You know, how do you present something in three minutes? Like they say the elevator speech. People should be trained in, if they're going to be running an agency or helping run an agency, in ambush interviews.

ED: Describe that.

CM: How do you deal—yeah, you're walking out of a committee meeting or somebody and the press jumps in front of you and says, "You know, you said this in there, prove that that's for real." And you all—well, you know. So, I think those are all great skills to have for people that aren't—that want to be leaders in MCH, I think you have learn to be better public speakers. You know, there are things like Toastmasters and other clubs you can

belong where you can improve your skills. You know, I—my kids used to make fun of me, and I'm catching myself doing it here, is that I would say "uh" every other word. And, they just start making fun of me about that. So that, I didn't kill any of them, but I did try very hard not to keep doing that. (laughs)

ED: You're pretty good at not doing that.

CM: Um. (laughs) Let's see—

ED: What do you think—think of someone you really respected in the field of MCH and what do you think those elements are that make a respected leader, or—

CM: Well, there are a lot of people. I think of my contemporaries, I really—I think Dean Peterson is a good example of somebody who's a consummate MCH leader in the modern era. She, you know, is well trained, well read. She really does a good job of engaging people. She deals with issues head on. She's very straightforward; I don't think I've ever heard her give anybody a bunch of blarney about anything. And I think those are all—she's just a really good example for students to emulate. But, I also think that it's good to—when you're in training, not necessarily stay in one place. When I was going to medical school, I was in Morgantown, West Virginia; it had a two-year medical school for seventy-five years. The dean was a friend of our family. I was accepted. I went to—he called me in for an interview. He said, "I really want you to come here, but you should not do that." He said, "You should get out of Morgantown. You've been here all your life. Go to different places. Everything's done differently around the country."
ED: Great advice.

CM: Oh yeah. And it absolutely was. So, I've been all over the place, and it helps you deal with Florida, because Florida's all over place.

ED: Florida's a challenge.

CM: The state is like five different countries. But at each place, when students are talking to me about going to a place like—what's her name that went up to study with Gene Declercg.

ED: Jordy went up right.

CM: Jordana.

ED: Right, right.

CM: I really wanted her stay here, but then I thought, "Well, you've been here."

ED: I felt the same way.

CM: Yeah.

ED: I did.

CM: And, Gene's just such a gem to deal with. Well, he's a great leader, I mean, and you can learn so many things from him as to how to convince people to change policy. Those things that we see in class of his presentations are masterful as far as using data in an effective way to change policy. And, I think—the other thing that made a big difference was working with Governor Chiles as a—learning from him as to how you get other people to do things, is almost becoming a lost art, and that is, you try to be as friendly as you can to the opposition. You try to make friends with them and—so that they know you as a person and not as an opponent.

ED: Right.

CM: And, he was very good at that, and people nowadays are getting so polarized. They don't think they can do that. But actually, Benjamin Franklin in his autobiography, which I think everyone who wants to be a leader should read, how to win an argument and it's not by calling the other person a jerk. The other thing I learned from Governor Chiles and other people in politics is never go into an important meeting about policy without knowing how it's going to come out. Which means if you're going to in try to convince six committee members to do a change that you want done you should have met with all six of them before the meeting and tried to convince them to be on your side. And then, if there still are a couple that aren't in the committee meeting, the ones that are on your side can help convince them, so it's not you doing it.

ED: Charlie, talk a little bit about working with Governor Chiles in a—that time that—so you were at UF and you did that sabbatical up in Tallahassee and that led to, sort of, the next phase of your career. Talk a little bit about being in Tallahassee.

CM: Yeah, actually the—when I started working that in 1982, we were at the bottom of all states in infant mortality, and so that was the big challenge, and we did the five year plan. That involved a lot of stuff, including the coalition, and so they asked me after my sabbatical was over to be the MCH Director for the state. So, I had a busy life. I'd lived in Gainesville, I'd drive the three hours up to Tallahassee, or wherever they wanted me to go that week: Miami or Key West or whatever. And, tried to keep my practice going on Fridays, and that went on until 1988 when Governor Martinez was elected governor and the Florida Medical Association and Governor Martinez asked me if I'd direct the state health department. And, I had—all my life I've fallen into these things. I had no—this was not pre-planned (laughs). So, I talked to my family, and agreed to do that.

So, about two years into that Governor Martinez was not re-elected. One of the main reasons was because he tried to torpedo the state abortion laws. Eighty-five percent of Floridians didn't want them touched, but he's still a good friend. And Governor Chiles was elected. Now, I'd worked with Governor Chiles for a number of years when he was in the Senate 'cause he established the National Commission on Prevention of Infant Mortality and I went around the country with him doing hearings on infant mortality.

Mostly throughout—I went with him throughout the South. And, in the couple years when he dropped out of the Senate, he was coming to see me all the time because he just wanted something to do. So, we got him involved up in Quincy, because the infant mortality rate was so bad up there in the black community, and he—then after working up there, ‘cause he and Mrs. Chiles were so interested in pregnancy and children, he just got antsy and decided to run for governor. And so, we were all happy about that. And of course he got elected and I was already working there and running the state health department and he asked me to stay on. When new person comes in, everybody is asked to resign, and then they pluck back whoever they want. So, we already had a nice close relationship, but we were all making—already making a lot of progress in infant mortality. We’d gone from last to thirtieth, or something like that. And, ‘cause we were doing a whole bunch of things we hadn’t done before, and so—

ED: What kinds of things?

CM: Well, you know, we’d expanded the WIC Program to all counties, we—family planning, training more midwives when we had a doctor crisis. The coalition was one of the biggest. Prenatal care in all the counties that we hadn’t had before. So, huge change, and I was feeling pretty good about where things were. Governor Chiles says, “No, we need to do more than this.” And, that’s where the Florida Healthy Start came in, and that expanded children’s medical services. We now have high-risk screening for all mothers and babies. We’re the only state that does that. And, a couple of other things—oh, it increased payment to doctor and midwives, so more of them would participate.

ED: Right.

CM: But, the biggest thing I did was establish the coalitions around the state. And that was Governor Chiles idea. He said, “You know, Bob and Adele Graham were interested in seniors. They did so much for seniors around the state. Governor Graham leaves office and all those programs go away.” He said “I don’t want these programs to go away and I think the way we can keep them going is with local coalitions.” And, you know, my friends around the country said, “That never works, don’t even bother with it.” And, I said, “Well, governor wants it done.” So, USF and Dee [Dolores] Jeffers and Doris Barnette really went around the state helping the coalitions get established. They had to learn how to use data and how to talk to politicians and so on, and the March of Dimes was a big help. To this day, they’re very strong and, considering some of the administrations we’ve had since, we’re still in a hole but we wouldn’t be in as deep a hole if the coalitions weren’t there protecting us, ‘cause they go to the local politicians and say, “Don’t you touch our money ‘cause here’s what we’re doing in this community.” And one of the best is here in Hillsborough. It’s really fantastic.

So I think, that’s one of the biggest things—well another good example was—one of the biggest things we did was to get the county health departments, who in this state are state run, to actually get out there and let the community be involved. And at first, many of them hated the Healthy Start coalitions because they felt they’re nosing into their business, which they were. It’s another group to be accountable to. We’re doing just fine,

well, maybe not, and here come these uppity women, and whoever else is on the coalition demanding us be accountable. And another good example of teaching the health departments that they had to work with the community was back in, you know, Governor Chiles asked early on, “Why is our childhood immunization rate for two year olds stuck at 63 percent for the last ten years?”

And we had good people at the state in immunization, but we just weren’t getting the job done and Dr. [Wilbur] Blechman, an internist at Miami that I had met, had just stepped down as president of International Kiwanis, and we knew that they were interested in children’s health issues. So, I called Will up and he met with Governor Chiles and I and I said, “Is there anyway you can help—think you can help—Kiwanis can help us with this?” And he went back to them and he came back and said, “We’re going to take this on as our main project for the next ten years.” And, it was amazing what they did. Well again, some of our folks at the state and at the counties, here are these businessmen coming in the county health department poking around saying, “How do you keep track of how many kids you’ve immunized?” “Well, we don’t have any way to do that,” or “We have a card file.” And they’d say, “Why don’t you use computers.” “Well, we don’t have any.” “Well, we’ll buy them for you.” “Well, we’re in this—Polk County, it’s a big county, it’s hard to get out to all the rural areas.” “We’ll buy you a van.”

ED: Is that how you get involved with Kiwanis?

CM: Yeah, I am in Rotary, but—

ED: Oh, that’s right, you’re in—that’s right.

CM: Yeah.

ED: I didn’t know that.

CM: But we knew Kiwanis—you know, Rotary works worldwide to eliminate polio, so I’ve worked on that. But Kiwanis works with children’s issues, and so they took this on, and—but it really made a lot of our folks nervous and I just said, “Governor Chiles wants Kiwanis to work with us, we are going to work with Kiwanis.” And the—within two years we were up to almost 90 percent.

They did all sorts of things. They’d—the ones in Miami said, “We got all these undocumented people down here and all these recent immigrants. We’ve got outbreaks in the Haitian community of diphtheria. Let’s get all these kids immunized.” “Well how do we do that?” Well somebody thought most of them are Catholic. Lets get the churches involved and a lot of the illegal folks—or undocumented folks, are afraid to come to the health department because they’re afraid they’ll be turned in to immigration. So let’s—they’ll come to church and if the priest says, “This is okay,” they’ll get immunized, and they did. And so they just thought of all sorts of ways our folks hadn’t thought of, but then they learned these are good ideas.

And it was really interesting because I'd—it's very hard to get younger people to join service clubs today 'cause they're too busy. And the whole idea of service clubs is to promote business in the community and provide service in the community by doing that. Our Kiwanis Club in Temple Terrace just closed down because they couldn't get enough members. I would go, after we worked with Kiwanis for a year or so, they'd invite me to Union County or someplace like that to dedicate a van and they just wanted me to be there. So I'd go down, and I'd say some good words thanking them for raising all the money for the van. And invariably they would come up to me afterwards and say, "No, we thank you guys because if we didn't have this project we would have folded by now. This was our reason for living."

ED: Really?

CM: Yep.

ED: Oh, that's great.

CM: So, you know, I hadn't even thought about that one, but it worked both ways.

ED: Sure.

CM: So, anything—so when I arrived here as dean in 1995, this college wasn't engaged with the community, I mean in any meaningful way. And now we—and the community told us that, "Hey, your professors come out here to do studies here in East Tampa and they don't ask us what we want studied. We go along with it, but then they never come back and tell us what the results were. So, we're not going to do it anymore."

ED: That's right.

CM: So, it took a number of years to rebuild that trust and being on the boards of the coalition, other community boards. It's just like in the last ten or fifteen years that public health schools have learned the thing about community based research. And it's been a tough sell to the faculty. One of the reasons is that we don't—we had not had very many practitioners on the faculty that ever been to a health department and so why shouldn't—what would doctors and nurses be like if they didn't work in hospitals as students? Well, our students now go out and work in health departments, and that's the way it ought to be.

ED: What do you think, from you perspective, starting in the hospitals in Chicago and Minnesota to Florida to UF, up to Tallahassee, and then you were the dean here of the college and then on the faculty here and teaching and involved in so many of these coalitions. And so you have these perspective across these decades. And now we're looking at the Affordable Care Act and what that may mean to Americans and what that may mean in terms of public health at MCH? What do you think the future of MCH is? And what the next set of issues are that we need to deal with?

CM: Well, I think it's huge. If that hadn't passed—five years ago, just looking at these issues we've talked about in healthcare practice, just in Ob/Gyn, I said things were—in the practice community were worse than I had ever seen them in forty years.

ED: Really?

CM: It was really bad. You know, very money driven, a lot of crummy patient care, people ripping off the Medicaid and Medicare system and going to jail or running to another country. Doctors have dropped in esteem from the top down to the bottom. They're just above politicians. But I think there is just a lot of hope now. I think—I was President of the Association of State and Territorial Health Officers when the Clintons were trying to get health reform going and they involved us a lot. We went to a lot of meetings with Ira Magaziner and other misdirected people. They were very brilliant, but not so smart. And, you know, public health by the time they had spent a year or so working on it was just out of it, you couldn't even find it. And we'd complain and they'd say, "Oh, we have public health nurse working in a room right down there." But the prevention wasn't in that. So it was a good thing it failed, I think. It was way overblown.

But I think there's a lot more public health built into—and prevention built into what's coming, and I think that's really exciting. I just wish I was thirty years younger. The—the opportunity for prevention is going to be huge. I think if I was in health policy and management now I just be salivating because the only way we're going to be able to pull it off is for HPM [Health Policy and Management] specialists to show how much money we're wasting, where the graft and corruption is, and getting these bad practices under control. So—and I just—on NPR coming in here I heard about the, you know, they're clamping down on hospital re-admissions. You now get penalized if you have too many hospital re-admissions. This is a boon for the pharmacy industry, for the pharmacists, and Walgreens is jumping in to this whole thing about, "We will—you send those patients to us right when you send them home. We will sort their meds and make sure they understand these new meds they're on for heart failure, or whatever." And that's a great place for Walgreens to hire health educators.

ED: No kidding.

CM: They're already hiring nurse practitioners. Wal-Mart, Walgreens, all these places could have health educators in there and the hospitals could help pay for them to prevent re-admissions because a lot of re-admissions are medication errors or things along that line. So you can look all over the landscape and see huge opportunities for public health. In MCH, you could use that as a microcosm of a lot of that. In, you know, cancer prevention and prevention of overuse of technology, it's—and I must say the American College of Ob/Gyn, I was really hard on them five or six years ago. They're coming around. They see the handwriting on the wall and they're coming around to say, "Yeah, we—we are doing too many cesareans, we are." And they're putting that in their education. But—so I think for the MCH students coming out, health care reform is really going to need people that are good at developing programs, implementing programs, doing community-based prevention research to show how much money could be saved

because Americans are bad preventers. And that's going to have be built into the whole new system that, you know, if you don't want a big co-pay you're going to have to stop smoking.

CM: And I just think—I can't think of an area—you know, I'm glad we're restarting our nutrition program here because there is so much we don't know about nutrition. Alternative medicines are being used by so many people. Some of them are good. Some of them are dangerous. We don't know which, and that's really population-based research to find out anything about whether a supplement, such as CoQ10 or anything like that, really works. We think it does. Seems like it ought to, but that kind of research is very complicated, but we need to figure it out 'cause, that's going to be—pharmaceuticals are a giant, are probably our biggest expenditure in health care, and that's part of what public health needs to be doing is big epi[demiology] studies on drugs. You know, maybe reforming prenatal care—we've talked about that before. We tried that a little bit. Does somebody with modern—somebody who lives in rural area, do they need to travel to have a prenatal visit or could that be done on Skype? It's easy for people to take their own blood pressure. They could even be given a Doppler monitor to listen to heart rate. Of course, even that's superfluous 'cause if the baby is moving you don't need to listen to the heart tones. There's just so many things we could do to cut the cost of care, get people more involved in their care.

And maybe people that are generally healthy could have two actual face-to-face prenatal visits before their birth. You know, some people would like that other people would want to come in and see a person, but that would be their choice. You know, places where people—I mean I'm always thinking about rural health 'cause that's the hardest part of public health is how do you take care of people in rural areas. Somebody once said, "That if you elect to live in a rural area you elect to not have a whole lot of services that you would otherwise get." With modern technology, I know Dr. Kern and I have talked about this. The military seems to be able to handle a lot of these things from a distance. If you're in stationed in Antarctica you can get care long distance, why don't we do that for other people. The—there's just a million things you can think of that we could improve care.

ED: I know, I know.

CM: The—you know, all that good stuff we did in Florida is sort of leveling out because what we didn't build into that was an inflation rate. By that I mean population inflation. When I left office we had a 186,000 births a year and now I think Florida has 225,000. Well, we still have the same level of services we had back then, and that's cramping the system. Still trying to think of MCH things.

ED: I like—I like how you've put together, and it really might almost be a vision both for the college and then for the field because what you've talked about are all base—all the core elements of what we do in public health. But I don't think people look at MCH that globally. Because when you talk about, you know, you're talking about MCH Epi[demiology] for instance, we need the data. But you also need the HPM [Health

Policy and Management] people to say, “How do you use those data and then the economic data?” and put that together and say, “This is what’s going to save us money or here is the most cost effective way of doing that.” And a lot of what your talking about too is we really need to do things smarter because our resources are going to stretch. I mean, in this economy they’re going to stretch, and so how are we going to use the Affordable Care Act, you know, some of those prevention issues.

You need all those elements in public health and in MCH and the bottom line, and I think that’s the theme that you’ve talked about the whole day, is that you gotta put people in the same room to do it. You’ve gotta build coalitions and you’ve gotta get people—you need to know who to talk to—you know you’ve talked about the influence of policy. You can’t do any of this without policy, so really you’re talking about all those elements together instead of training MCH professionals to be health educators or epidemiologists or economists or public health nurses, MCH nurses. That’s a group that you really want together talking about how you do that in a global way. I think that’s sort of public health in a nutshell. That’s—I, you know, I always hear people say that, you know this better than I do, MCH—like public health is MCH. MCH crosses so many elements of delivering public health, and what you’re talking about is that, that it’s really a very global approach.

CM: Yeah, 60 percent of what the average public health department does everyday relates to MCH. And in some schools it’s hardly even there. It really is, I think the heart of public health, and we haven’t even touch on the environmental issues like the Love Canal kinds of things, with abnormalities, the fact international health that there’s no potable water for 70 percent of the world’s pregnant population. You know, I mean its—all those things are really important, but the—I think the hardest thing that we’re—I think we’re solving, certainly in this college, is reaching out to other disciplines. You know, MCH and public health can’t do it all alone. There’s, you know—why did it take us so long—I’m so glad that Dr. Petrila’s head of Health Policy and Management—why did it take us so long to integrate mental health in this? Mental health is a huge part of MCH. Look at depression especially.

ED: Right.

CM: But, you know, so the MPH really needs to have a big mental health component in it ‘cause community mental is another really tough issue. The—one of the ways we got some unique things done in Gainesville, even though I don’t have an MPH, I did not have formal public health training, but I almost always worked in all the different areas except environmental health. And so I was, in a way, self-taught, and, but in—at the medical school in Gainesville we did not have a public health group there, but we worked closely with all the health departments, obviously. We brought in anthropology, health anthropology, the psychology department. It was unusual for the medical school to have anything to do with the undergraduate campus—with the non-medical campus—its’ not undergraduate. But, with physical education, I mean, we found so many people to partner with, and then when we got a provost there who was an expert in AIDS, he brought all the colleges together on campus and said, “You know we have AIDS epidemic and

there's something that every one of you can do to help solve that." Fine arts, engineering, and—made them really nervous—history, "Talking about AIDS! Oh my God!" But, I—it was Andy Sorensen. And he eventually became the Dean and eventually President of the University of South Carolina, but a great public health mind from Johns Hopkins. And boy, that was the ultimate is to take a whole big university, sit them down in one room and tell them, "You're all going to work on the AIDS issue." And some of them really didn't like it, but it was brilliant, you know. And that's the way we got to be thinking.

ED: Yup. 'Cause you could certainly do the same thing with MCH.

CM: Absolutely. You could go—you could think of every college on this campus. And the neat thing, you know there aren't many universities in the country where health is on the same campus with everybody else, and it's usually wasted. And I think Dean Klasko's idea of pushing medicine, nursing, public health, physical therapy, pharmacy, to all learn to live together and love each other is just, you know, wonderful. But then we all need to take that and get out to the rest of campus, too 'cause we have a great psychology department in this campus and engineering and lots of other things we could be working on.

ED: Business—

CM: Yep. Oh yeah

ED: All of that, all those things.

CM: Yep. Yeah, business could really help us work with Health Policy and Management on, you know, how do you keep a hospital and health departments in the black, but still not do things that are unnecessary, you know.

ED: Right. Well do you have any other thoughts? I think this has been—you know, as we're talking I can really see sort of pieces of this being edited so you would look at sort of elements of MCH and how that can all fit together. And then I see this whole other piece, a real theme with you working through this, is this idea of coalitions. That probably one of the strongest things we could do in the field of MCH is to start thinking—and I think we do intuitively 'cause you wouldn't be in it if you didn't think that way. But you know, one of the stories that you tell is you go out and you find those people. It's not like—it's not like it suddenly pops up from the ground all of the sudden. You go and you identify the folks that are already engaged, and in the college when you became the dean, you're right, you have to go out to the community and say, "How are we meaningful to you?"

You know one of the best stories I remember, with that East Tampa Initiative, is Kay Perrin came back from doing a focus group in East Tampa, and she said, "Nobody's gettin' this." One of the things that somebody said in East Tampa, but it made so much sense to me intuitively, is they asked these folks—you know that East Tampa was a desert. There's no public transportation, no pharmacies, no grocery stores, no anything.

So to do anything, you have to travel forever to get there and try to get back. So, public health goes in and says, “What would you like in East Tampa?” And somebody said, “A Starbucks.” And Kay, you know, who is public health absolutely got that instantly and what she told me later was how many people thought that was the dumbest comment they ever heard, but I think that makes all the sense in the world because if you had a Starbucks in East Tampa, that means East Tampa would be like every other place, you know.

CM: Yeah.

ED: I think that makes a lot of sense. And the thing—the thing is with us reaching out and saying, “Who are the folks that want to be engaged?” And then more importantly, the community needs to tell us what they want. So instead of going top down, tell us that you want a Starbucks. I mean, I thought that was a great story. So, I can really see part of this interview being editing those pieces of what you’ve done where it’s always we. We did this, we figured out, you know, here’s the problem now, who needs to help us solve this. I think that’s gonna have to be our future.

CM: And its really hard with—one of the reasons people don’t do it is its hard.

ED: It is hard.

CM: And it’s scary. And if you’re an academic and you’ve never done that and you go out and they’ll eat you up, you know? And I—when I was at the community health center in Minneapolis, it was primarily an Indian community, but there were some black families that lived there and a few Hispanic families and others, and we had a—you know, they’re all obligated to have a community advisory board of honest to God people from the community not, you know—

ED: Right, pretend.

CM: But, once a month we’d have a community advisory board meeting in the evening and you know we’d have food for everybody and everything. The staff was asked to come to those, and I might have been up all night before and worked really hard that whole day seeing patients, and then we’d have the community advisory board meeting. And you know, it’s really hard because people come in, and if you want to give people the chance to air themselves, sometimes you’ll get people that are community activists—and this is back in the 60s and 70s, where people were raising hell about a lot of stuff—and you might be there till two in the morning with somebody just blathering on. Well, I call blathering, but they felt it was important to—but I’m thinking, “Oh God, I want to go home and go to bed.” And yet, that was really important for building trust. We would change the way we ran things, we’d have to fire people at the front desk ‘cause they were mean to people and often they were meanest to people in their own family (laughs). And so it’s messy when you get out in the community.

ED: It is.

CM: It's hard but if we're really going to make serious change, public health has to do a lot better job of that. I think we're gradually waking up to that, you know. Our college recently was honored for having a great distance-learning program. We started that back in 1996. We were the first one in the country and all the other schools, all the other deans said, "That is really stupid," "That's not going to work," and now every one of them does it.

And you know, that's another way to reach out to the community. And I would hope, I don't know if we're ready to do this yet, but MIT put every one of their courses, all their lectures, all their presentations out there for the world. Anybody can take any MIT course they want. Now if you want credit for it you gotta pay. But the knowledge is out there and I think schools of public health ought to do that too and just put it out there on public TV or the open channel, and just say, "If you'd like to take a bio-statistics course (makes noise)," that'd be a thriller. (both laugh) But I think we need to be open in sharing with the community and just much more community involvement.

You know Bob Jackson, I think his name is? He's a black banker here in town. He moved here—he had prostate cancer and he came to me. I was just starting as dean and he said, "I really want to work with men in the black community 'cause prostate cancer is a big deal." And he said, "Do you have any faculty that can work with me and students?" And I couldn't find anybody. There weren't any faculty interested in that. I said our students, at the time, were almost all people that worked. You know, now it's quite different. And I said, "They're just no available to come and volunteer for a lot of stuff 'cause their working all day and they're coming to class all night." He got a little upset with me, and I said, "Well the one things we can do is let you use the college. So anything you want to have we'll host it here."

ED: Right.

CM: So he sort of advertised around the community, the black community in East Tampa primarily, that he was going to have an educational thing for black men as to what they ought to do to prevent prostate cancer. We opened up our auditorium on a Saturday; he had 700 people come the first time he did it. Well what a shame that, you know, we couldn't have had somebody loosen up some time to deal with that because obviously he knew the community—he knew the needs was out there.

And there're things like that happen that you realize we're only touching the tip of the iceberg. We could be doing so much more and we need to constantly, and I know we are, constantly change the way we're teaching and training people to do new things. And that's why I've always said I thought social marketing was one of the biggest breakthroughs in public health. 'Cause we actually ask people what they thought would work.

ED: Yeah. That and things like, you know, you're talking about what Eric's doing, for instance, using technology and social media and the Internet. I mean that's another area,

and I think we've been very good in the college about staying up with those sorts of techniques. 'Cause that's the other thing is that you have to—it has to be meaningful. Now we have this new generation.

CM: Oh yeah.

ED: That's a group you have to reach as well. So—

CM: I look at how President Obama used that.

ED: That's right. That's right. So, I don't know how to thank you enough for coming in and doing this. I think this is just going to be invaluable. And the thing about this being an oral history is you're going to talk about it, Donna's going to talk about it, Howard will come in. It will live out—we'll put those threads together and it will be exactly what like what you're talking about. Then we're going to put it out there and anybody can listen to what you have to say and I appreciate you doing this Charlie.

CM: And that's great.

End of interview