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E. Charles Prather: Dr. Crane, it's a pleasure to have you here today.

David Crane: Thank you.

CP: And we're grateful that you would come. The guideline is that I hoped that you would just share with us anything that you want to, and that you want to remember about your great career in public health. I think it'd be useful, for our audience, to tell us a little bit about yourself. How did you get involved in public health?

DC: Well, it's kind of interesting; I started out in private practice in Miami. Doing general practice, and in about two years' time, a had a nice peptic ulcer.

CP: Oh, boy.

DC: And that was not too pleasant; and when I started coughing up and spitting up blood, I decided it was about time to do something a little less stressful. So, at that point in time, with Dr. Cato, who was the director of the Dade County Department of Public Health in Miami, was looking for an M.C.H. Director—

CP: Yes?

DC: And I had done some schoolwork and things like that for the health department.

CP: What's M.C.H.? Forgive me.

DC: Maternal and Child Health, sorry.

CP: Thank you.

DC: And school of health work; and so, Dr. Cato contacted one of the physicians that I was in practice with, and asked if there was anybody out there that might be interested, and so, I went down to change hats, if you will; and you're dealing with the community. And it took me a little bit of—little time, so, when I first started out, I was, as I said, Director of Maternal and Child Health down there; and so, I did a lot of clinic work.

I actually went down and saw the patients in the clinics, and maternity patients, prenatal care, and so on and so forth, and the newborn babies, et cetera, et cetera, and I had a lot of fun doing that; and I also worked in the head of the school health program, and so, we had, of course, immunizations and physical exams going on in the schools, and I kind of supervised that sort of thing with local physicians, primarily.

And it was a very exciting experience, and, as I say, I really began to change and realize that all of the time you might spend in a career as a private practitioner, you would never ever be able to influence the health of as many people as you could if you spent half that time in public health, because it is the total health of the people of the community we're interested in; and so, that was a kind of a physiological, psychological change for me, to switch from the one to the other.

CP: Yeah.

DC: It also healed my ulcer.

CP: Congratulations.

DC: Which was very appreciated. (CP laughs) But, yeah, that was exciting; and then, I had the opportunity, of course, under the old program of the state board of health, giving scholarships to able people, who wanted to progress into the—deeper into public health, to go on and get their degree—their master degree in public health; and so, I had the opportunity to do that with Dr. Sauder and Dr. Cato's approval.

CP: Yes.

DC: And went over to Tulane, and they have a wonderful school of public health over there, and I did tropical medicine and public health. Which, fortunately—

CP: That was appropriate for Miami, was it not?

DC: Yeah, it was, and fortunately, came in, later on, very handily when I went overseas for my foreign mission experiences. So, anyway, I enjoyed that a whole lot, and had a really good experience down there, and spent a year; and when I came back, I felt like, well, I think I really know what this business is all about now.

CP: Good, good.

DC: And so, that, incidentally, was where I first saw the famous—now famous studies on smoking and health—

CP: Yes?

DC: Cancer and all those things, and that's when I stopped smoking.

CP: Congratulations.

DC: And I said, "Okay, that's it." It convinced me. So, came back to Miami; and then, by that time, there was a Dr. Madda who had taken over the M.C.H. department. And Dr. Mathis, I believe it was, had just left and gone up to state board of health for a tour up there. And so, Dr. Cato asked me to be his deputy director, which I did; and I stayed on there then for, well, that was '57, '58, so I stayed a year; and then, incidentally, interestingly enough, a sanitarian, guy named Jack Greenly, had been in Dade County, and he was on my team that inspected nursing homes. Those were back in the days when we first got the nursing home inspection program. And Dade County had a lot of them. I think well over a hundred.

CP: Really?

DC: And some of them were in pretty bad condition; and so, we proceeded to shut down around one-third of that group.

CP: Wow.

DC: Just because they were negligent, and they weren't providing any good care, so forth and so on.

CP: Do you remember the year that law providing for the inspection was passed, approximately, just for the record?

DC: I think it was right around—probably right around, 1950, '51.

CP: Okay.

DC: And it resulted from a big fire in a nursing home in Largo, Florida.

CP: Oh.

DC: Where a number of people died as a result of the fact that there was inadequate personnel to assist these people to get out; the doors were not conveniently arranged so the people could get out, particularly people who had multiple handicaps; and quite a few people died in that fire; and that was when the legislature said, "Okay, we've got to regulate these nursing homes." And, of course, they gave us the job, which was the proper thing to do.

CP: Yes.

DC: And I think, statewide, we did an excellent job of putting the marginal operators out of business.

CP: Good.

DC: And assisting those who were doing a good job. And while, at first, there was a lot of resistance, but, finally, when we really worked through this thing, one of the major people down there, in the nursing home business, Manning Rice, who owned about two or three nursing homes down there, and was doing a good job, finally came to me, after we warred about this for a long time, and he said, "You know," he said, "One of the best things that could ever have happened to our work is that you people got in the business and cleaned out the scumbags that were operating nursing homes simply so they could make dollars off these poor folks."

CP: Oh, great.

DC: And so, we felt very good about that, and that was a good experience.

CP: That was an aside; you were talking about the sanitarian that's part of your team.

DC: Yeah, Jack. In the meantime, after I—when I went away to school, Jack had been contacted; he was a public health service—US Public Health Service Officer. He had been contacted by I.C.A., the International Cooperation Administration, and he was asked to go out to Indonesia; and as the head sanitarian on a team that was being established out there for rural health training; and we were training—the purpose of the program was to train sanitarians; public health nurses, particularly nurse midwives, which in Indonesia, are called "ducums."

Nurse midwives; and what they call "village health workers," which we don't have anything exactly equivalent for that, in this country, but they were kind of jack-of-all-trades people that went out, went around, and they kept track of statistics; who lived, who died, where they were buried, things of that sort, and that type of thing in the villages; and they wanted set up a training school for public health.

And so, Jack was interested enough, and he said, "Well, I know a good public health physician, that just finished his master's degree, that would love to be involved in something like this, I think." (CP laughs) And so, he came back to Miami, and he recruited me. So, my wife and I, and my two youngest babies, my two kids that we had at that time, we made the trip to Indonesia; and it was a wonderful, wonderful experience; I enjoyed it so much; and it was kind of interesting, from the standpoint that there was approximately one physician per hundred and fifty thousand people in Indonesia.

CP: Wow.

DC: And these physicians were trained, but not what you or I would call highly trained. They were there barely adequate; and, of course, you probably know that the University of California set up a medical school in Surabaya, and did much of the preparatory work, and then drew these physicians in for special courses, for training courses, and trained the young people coming up through the collegiate system in medicine at the University of Surabaya. So, anyway, we went into this province, which was just adjacent to Jakarta, the capital of Indonesia; and our school was set up there.

There was an old rice mill that the Japanese had used during their occupation of Indonesia, and the rice mill was, of course, in somewhat deteriorated condition; so, we went in and pulled out everything out of the rice mill, and we built a public health school there, (CP laughs) and we did all right with that. And, as I say, Jack was the chief sanitarian, and he trained the sanitarians in the field, and he did a heck of a good job; went out there and showed them how to put in pumps and how to put in sanitary waste disposal facilities; the common practice, at that time, was that you found a small body of water, whatever size it was, and some were very small, and that's where you did your washing, that's where you bathed yourself, and that's also where you dropped your waste materials, was into the water. In Indonesia, they call them "callies", the waterways; canals, we would call them, in Florida?

CP: Yes?

DC: Indonesia, they call them callies; and the calli was the sort of gathering place for all the people to come together on wash day, on bath day, and also, for their other necessary bodily functions. So, it's kind of interesting; and of course, our—part of our job, through Jack, was to teach people that it's better to put your waste away, in the ground someplace, where it doesn't get in your drinking water, and then you won't have all these diseases that you folks are having all the time.

CP: Yes.

DC: And it worked pretty well.

CP: Good.

DC: In our province, where we were, and we were in Bekasi province, incidentally, which is right next to Jakarta, about thirty miles; and so we went down to Bekasi everyday, and sometimes, we'd stay for two or three days down there. We'd have staff meetings with our people; we had an Indonesian physician; one, two public health nurses, Indonesian public health—they were nurses that we helped to convert. And then a village

sanitarian, a village aid, and that type of person; and we kind of picked the best of the crop, and used them as our training people.

CP: Good. (Affirmative murmur)

DC: And we had a staff of myself; and our public health nurse, Julia Worthington; Jack Greenly was our sanitarian; and we had a man named Calhoun, who was our health educator; and we had that little team; and that team is kind of the basis of public health all over the world. Wherever you go. If you have that team—

CP: Yes, still today it is, is it not?

DC: Yep, if you have that team, you've got the basis for a public health establishment, and you can go from there. So, that's what we did; and I stayed there a little over two years, and we finished our tour; we got the school built, we trained people, we went out into the villages. We had a couple of big epidemics while I was there, primarily as a result of poor drainage; we had some, like, monsoon conditions, where the water was about up to your hips; and so, of course, there was, you know, no sanitation at all, then; and so, we had the usual, you know; and so, we gave immunizations to everybody, and that kind of thing; and it was a very interesting and mind-expanding experience. Subsequently, I went to Libya, which I can't really confess was really pleasant. Not like Indonesia.

CP: But directly from Indonesia, were you moved to Libya?

DC: Yeah, (affirmative murmur) That was our next tour.

CP: Okay, (affirmative murmur)

DC: Yep. I went to Washington for a little while, and worked with a man named Walsh, who started the good ship Hope.

CP: Oh, really?

DC: Yeah, and he and I did some of the planning work and stuff while I was in Washington, before I went—before I shipped out to Libya. So, we went to Libya, and there, same kind of situation existed, except there weren't any little ponds; everything

was dry. (CP laughs) So, we didn't have any little ponds to deal with, but we had the same basic team: public health nurse; a nurse midwife was with us, she was a nurse from the Virgin Islands—American Virgin Islands, Iona Armstrong was her name, real nice girl, and she did the education with the mothers and children; and Maggie was the public health nurse, and she helped with the management of things. We set up rural health centers in various areas, in the desert; and, at that time, of course, there were practically no Libyan physicians whatsoever. You know, they had been occupied by the Italian army first, and then the war was fought, pretty much, over their doorstep, out of Benghazi and all those things, you know, during the war. So, they didn't have any really basic core physicians; there were maybe, maybe twenty-five physicians in the whole country.

CP: For the nation.

DC: The whole county. And most of them were in the ministry of health. (CP laughs) But, we did work very closely with them, and we established the programs in and around, outside of Libya, in the field; and, again, we had a very good health team; at that time, malaria control, of course, was the big thing. Of course, that had been a very busy program in Indonesia, as well. Which, incidentally, I think we need to do something about now, because I understand malaria is tremendously on the rise. Since DDT has been practically, for all intends and purposes, taken off the market.

CP: Worldwide, it is coming back.

DC: But anyway, so, we had the same basic team; and we went out and did the same basic kinds of things: educated people about sanitation, about disease control, about taking care of their children properly, proper nutrition, those kinds of things, and, you know, the sorts of things that public health people do; and the physicians that were in the country were mostly on contract. We had two or three German physicians, about a dozen Italian physicians, and we worked with them; and they were mostly hospital situated. The one German physician, very interesting Rommel type; very military, very stern; and—but a nice guy.

And he was in the Ministry of Health; but he was—had worked previously in Egypt, and so, he was kind of—well, let's say he looked down a little bit on the Libyans because they were very backward; in terms of their development, compared to Egypt, which was substantially ahead, even though not anywhere near where they might have been. That was during King Idris' term of office; he was the king, and of course, subsequently, Muammar Gaddafi took it upon himself to depose the king; and that was the end of that. And then, Wheelus Air Force Base, which had been in Libya, in Tripoli, was out; and that—we were all thrown out of the country then, the whole gang, "Get out." So, we all got

out; (CP laughs) came home.[1] But I was ready, it was 1964; I was ready to come back; and my children were getting a little older, I had three by that time. They were getting a little older, and—especially the two older ones. They wanted to get into a stable home environment and school environment, where they knew where they'd be going next year. Which you don't know, in the Foreign Service. So, we decided to come back to Florida. I wrote to Dr. Sauder and said, "I'd like to come back;" told him what I'd been doing; he said, "Well, come on back, because I think we have an opening for you."

CP: Okay, good, good.

DC: So, back I came; and then he appointed me as director of bureau maternal and child health in Jacksonville. And then, I was working with the county health departments, of course. Doing pretty much the same basic kind of thing; going around and helping the Health Officers to understand the needs of, particularly, the maternal and child health population; and, as you know, in the early days, in Florida, you didn't—we didn't have a whole lot.

CP: No, we did not.

DC: Going for us. Although, by '64, when I came back to Maternal and Child Health Bureau at the state level, by that time, we had gotten, as you know, all sixty-seven county health departments—had a health department.

CP: Yes.

DC: And they were, I think, by that time, there were somewhere in the neighborhood of eighty or eighty-five physicians that worked in those health departments.

CP: Employed—yes.

DC: So, every county in the state of Florida had access to a physician. Now, that's not to say that every county had a full-time physician. Because, some of those little health departments like Lafayette, Gilchrist, some of the little small counties; maybe the total population of the whole county was only twelve, thirteen thousand people; and I suspect maybe Gulf county and some of those were even less. So, they really didn't need a full-time health officer. But they did need a health officer who was in charge of their little

1King Idris I of Libya was overthrown in 1969. Wheelus A.F.B. was turned over to the Libyan government on June 11, 1970.

staff. And their little staff were right back to the basics: public health nurse, sanitarian, clerk, and a visiting health officer. So, most of our health departments in the state of Florida, at that time, I think, maybe, we had, what? Twenty, possibly twenty units in the state.

CP: That covered all sixty-seven counties, though.

DC: Yeah, they had the big staff. With, you know, the full-time physicians making—multiple physicians. We had the whole program; but the smaller counties, they did the best they could with what they had; and, at one time, you probably remember, we had Dr. Kroll, who was an Itinerant Health Officer out of Jacksonville, and I think he was really in charge of about twenty small health departments; and Dr. Kroll and religiously visited every one of them, kept track of what was going on, ran some clinics, and took care of the necessary administrative kind of details of work, and kept the ball rolling, and gave advice and things of that sort to nurses—nurses, if there were more than one, in some places, there weren't, and to the sanitarian, and kind of gave them support and assistance, and helped, particularly, I guess, helped to work with the local community leaders.

CP: Yes?

DC: Whether they be mayors or legislators—

CP: Chairman of county commission.

DC: Or Chairman of County Commissioners. Of course, we worked very closely with the commissioners because, of course, they helped to fund the programs that we were operating; and, at that point in time, I think county health—the county boards of county commissions throughout the state of Florida were putting about eight million dollars.

CP: Out of a total budget of what? What proportion was that?

DC: Something—something like twelve.

CP: Oh, three-quarters.

DC: Something like three-quarters were coming from the local.

CP: Speak to that arrangement, Dr. Crane, the public cooperative agreement.

DC: Okay, well, yeah. That should be talked about, because, you'll recall very well, that Chapter 154 of Florida Statutes is the book, as far as public health in the state of Florida is concerned, it says that each county health department in the state of Florida "May;" and I want to emphasize the word "May," it doesn't say anything about, "Gotta," doesn't say anything about "Shall", you better do it; it says "May."

CP: (Affirmative murmur)

DC: And "May," you know, that doesn't mean anything when you come down to spending money. (CP laughs) You know what I mean? "May."

CP: I understand.

DC: Yeah, I "May" have a Cadillac, but I can't afford one, so I don't have one. So, anyhow, that was—that's the most impressive point, to me, is that law, of course, was passed, I guess, 1931 legislature, was put into effect, really, in 1932; we actually had, I think, we had one—we had Taylor County Health Department in 1930, started their own health department on their own, primarily because of communicable disease.

CP: Yes.

DC: We can talk about that a little later. They had a big epidemic there, and the paper mills and their concern, and then the board of county commissioners got involved.

CP: Okay, let us not forget that; we'll come back to that.

DC: And then, there were—then, I think Leon County was next, and maybe Pensacola, Escambia County, might have been next; but between that period; 1930, '32; before the law actually even "You may," some of the boards of county commissioners were interested enough in the health of their peoples to say, "We need something here," and, primarily, that was because of communicable diseases; 'cause, of course, that was the big thing, in those days. The period from, as you well know, from 1889, when the whole thing started, up until the 1930s—

CP: Yes.

DC: Was just a constant series of yellow fever—

CP: Hookworm, malaria—

DC: Hookworm disease, malaria, venereal disease, rampant all over the state of Florida; and then, all kinds of waterborne infections, and so on, and so on, and so on; and there wasn't really anybody organized to do anything about that, and the private physicians in the communities, they did what they could, but they were burdened with taking care of people on a private basis. They didn't have—

CP: One at a time.

DC: No, they really didn't have time to run out and try to take care of the whole community. They worried about it, because that was clear.

CP: Yes, yes, yes.

DC: That was clear when we began to talk these health departments up, the local physicians said, "Yes, we need to do something here. We need somebody here to clean up some of this mess, because it's creating problems for us. As well as for all the people that live in this community. We can't keep track of it." So, that was part of it; and the Florida Medical Association and the local physicians in—practicing physicians throughout the state maybe; surprisingly enough, in a way, but not really; they were very much interested, and they were a lot—they gave a lot of impetus to the development of the public health programs at the local level; and gave us a whole lot of support, and consultation, assistance, and their knowledge of what had been going on in those communities over the years.

CP: Ah, great.

DC: So, that was very helpful. But anyhow, we get the—that law did get passed, and then, the development of the health departments, after that, was fairly rapid and, as I say, we went from, in thirty years, from 1930 to 1960, we went from one health department in

1930 to sixty-seven in 1960. That's thirty years, sixty-seven health departments. So, I think that was a pretty good indication; not only of the support of the boards of county commissioners, who put up that—what in those days was a staggering amount of money, you know?

CP: Yes. Yes.

DC: When you consider the state board was started with fifteen thousand dollars—

CP: Yes.

DC: —Back in 1889. Eight million bucks, by 1965, that was a lot of money for the boards of county commissioners to put up to support these programs. I worked a lot of boards of county commissioners over the years; and the vast majority of them, I would have to admit, didn't really know a whole lot about public health, okay?

CP: (Affirmative murmur)

DC: But that really wasn't important. What they knew a lot about was their community, and they wanted that community taken care of, and they wanted somebody to do it; and the private physicians, they say, were too busy with their own practices to do that, and they realized, the only way to get it done was to get a health department, and that's what they did. So, these men were very much interested in their communities, and I've been to Taylor County, and talked to board of county commissioners, and they weren't the original ones who started the first commission, but they were close to them (DC and CP laugh); and they were mostly farmers, and some of them were in the lumber business and so forth, but good guys. Good guys.

CP: You were talking about the "May" relationship that the law allows; let me redirect your attention to that "May," and how did you stimulate county commissioners to contribute such money? Because, the State Board of Health was getting direct money and had a legal responsibility.

DC: That's true; and, as you know, the State Board of Health had established, I guess they called them district or regional small health offices in various areas, about five or six of them throughout the state.

CP: Okay.

DC: And one of those regional health officers, in the early days, was a man named Dr. George Dane; a man that you and I love and respect very highly. And Dr. Dane was a very diligent worker. He went out there, and he worked with those guys on a personal basis; and he got in there, and explained to them about all these diseases, and what they could do about it. He wasn't the only the one, there were others around the state, but he's the outstanding one, in my mind; because, of course, he later went on and became the director of the Bureau of Local Health Services. He was the man who, initially, I talked to after Dr. Sauder, when I was hired, and so, I respect Dr. Dane very highly for the work he did, and for years, he was with the State Board of Health, and worked diligently to get the county health departments established and developed and to encourage and work with these people, and that's what it was: it was personal persuasion. That's the only way I can put it.

CP: Power of personality.

DC: Getting out there and talking to these men, and explaining the values of a health department, what the health department could do for their community; to reduce the morbidity and mortality, to cut down the people who were too sick to work, and had to be put on welfare or whatever, to assist them with their hospital expenses, and so forth; a lot of hospitals, in those days where there were hospitals, of course, you know, several counties didn't have any; a lot of the hospitals in the counties were supported, a lot, to a large extent, by the boards of county commissioners. They put money in there; take care of uninsured patients; and, along with that, went the many physicians all over the state of Florida who gave of their own time and efforts and never saved a dollar; taking care of patients who couldn't afford to pay; couldn't afford to pay the doctor or the hospital or anything else.

CP: But they were ill and needing care.

DC: Yeah, they needed care, sure.

CP: (Affirmative murmur)

DC: Subsequent to that, of course, you know, the state entered into a program which we participate in, in what was called the "Hospitalization Program for the Indigent", and we helped to pay their hospital bills, which helped to relieve some of the expenses on the counties, which they appreciated. That came a little later on, but it did come down the

road. But anyway, the physicians who were in those district offices, Dr. Dane and others, plus Dr. Sauder, working—and other Health Officers—State Health Officers; Dr. Henry Hanson and others who were very well respected by the medical communities where they were, and in the Florida Medical Association. They worked with the physicians, and got them to encourage the boards of county commissioners to do these things. So, it wasn't just public health. It was private practice; it was working with the boards of county commissioners; it was worth—working through PTAs, through the schools, the school wanted school health programs. The children came to school not—maybe not sick enough to stay in bed, but not well enough to learn what was being taught.

CP: Ah, yes.

DC: They had hookworm disease; they had all kinds of problems. They were anemic, et cetera, et cetera; and so, the kids really couldn't do very good—very well in school; as a consequence, school boards got involved. So, they helped with the pressure. The local PTA groups, local teacher associations, the State Education Association of Florida, all these groups got together; and not only them, but then the private health agencies; E.B. Association, you know, Cancer Society, Heart Association, et cetera, et cetera, et cetera. All the groups that were out there that are interested in the health of people were working on these things, you know; just kinda' keep the pot boiling constantly, and encouraging and working with commissioners and letting them know that they expected the commissioners to do something about health conditions in their community, and that, you know, ultimately, they had to get reelected (CP laughs), and the way to get reelected is to keep everybody happy; and the way to keep everybody happy is to help your health problems.

CP: Yes.

DC: That's one way. (CP laughs) So, anyhow, that's kind of the way it went; and gradually, worked at it and worked at it over the years, and we built the County Health Unit system.

CP: About 1960, it was in place and going.

DC: It was in place and under full steam; and, I don't know, I think St. Augustine up there, I think they kind of enjoyed keeping us on the hot seat for a few years there before they finally decided to have their health department in 1960; I think they kind of enjoyed the fact that St. Johns County didn't have a health department.

CP: It was the only hold out?

DC: Everybody else had one, you know? They were the last ones, you know?

CP: Do you recall the sixty-sixth came in? What was the interval between the sixty-sixth and the sixth-seventh?

DC: Well, I just happen to have a piece of paper here that'll tell us that.

CP: I'm curious.

DC: I don't remember exactly, but I can tell you very quickly.

CP: Oh, look at all this data you have here!

DC: Here they are. Here they all are. Well, it was quite a while. Collier County was the next to the last.

CP: Yes?

DC: And Collier County started its health department in 1950.

CP: Oh.

DC: So, it was ten years before St. Johns finally got off their high horse and said, "Okay, fellas, we need a health department."

CP: And join—(CP and DC laugh)

DC: And Dr. Sauder; when he used to have a meeting with health officers every year, as you remember.

CP: Yes.

DC: He used to call that the state of the state meeting.

CP: Yes.

DC: And every year, prior to 1960, every year, Dr. Sauder would get up and say, “Well, there’s only county in the state of Florida that doesn’t have an organized county health unit, and that’s St. Johns County; and I want you people to remember that, and you all go back and talk to your people, and tell them, ‘What’s wrong with St. Johns County, out there? You know they need a health department.’” (CP and DC laugh) So, finally—

CP: What finally convinced them?

DC: They finally got convinced, yep, and I don’t think that there was any big epidemic or anything like that in St. Johns County; that I ever heard of, at least. I was in the state, working, at that time, so, I don’t think I ever heard of that; but anyway, they decided that it was time, and so, they came into the program, and I think Dr. Mason Morris was the first County Health Director there. And a nice guy, he was. He was a navy retiree. And quite a few of our physicians came out of the military; not surprisingly, really; because, in the military, not only do you have individual health programs for people, on the military bases, the military people themselves, but also their families and so on, you know, that kind of thing; but, in addition to that, you have to have camp sanitation, you have to have food control, clean food in those mess halls, et cetera, et cetera, et cetera. You have dispose of human waste—

CP: Arthropod control. Yeah, sewage disposal.

DC: —And get rid of that. You got mosquitoes out there; you know that’s not good, so you gotta get rid of them. So, you got a health department operating on a military base; and a lot of our Health Officers were former military, because they saw, on those military bases where they were, both in this country and abroad, that they needed—

CP: They need the public health action.

DC: They needed a public health action; and when they came back from the war, they said to themselves, “Heck, I know about this stuff now. I’m gonna’ go ahead out there,

and get a job in public health, and I'm going to do something for these communities." And that's what they did.

CP: Great.

DC: There was a bunch of them. We had quite a few of them. I can't name them all, of course, 'cause, you know, the old memory doesn't do all that well; but there were a lot of them, and it was a joy working with them, 'cause you didn't have to educate 'em first.

CP: Ah, yes. Did you have a special orientations/educational program for new physicians coming into the system?

DC: They had several educational efforts, actually. Many of the physicians that came to us came from out of state.

CP: Yes.

DC: As you know. And the first thing they had to do was get a license, because we didn't employ physicians in Public Health as County Health Directors without a license in the state of Florida.

CP: I like that.

DC: So, most of those guys had to get a license. So, that was one of the big courses we had, was a class on getting your Florida license. (CP laughs) Because you and I remember well, those Florida license exams were tough.

CP: I remember 'em too well.

DC: Yeah, yeah. I could spend an hour on that, but I'm not going to. Anyway—

CP: Yeah, thank you. That's—(CP laughs)

DC: We had—we ran courses for them. There were several people involved in that; and I was one of them, later on, when I came up to Bureau of Local Health Services; because that was one of the other courses we ran, was a course in public health.

CP: Oh.

DC: Yeah. And some of the new guys that came in—of course, that had been going on before I got there. Every year, we had a seminar; two or three day seminar, I think; and the new men who came—new people who came in, and were either awaiting an assignment to a health department or who had already been assigned to a health department were invited—

CP: Yes. Most of them came, I suspect?

DC: I think all of them came; it was a little more than an invitation. Dr. Sauder said, "Come on up and sit in on this class." But in any event, we tried to really just kind of summarize; and we had public health nursing come in, had environmental health come in, we had sanitary engineering come in, we had your shop come in—people in disease control come in, had all the specialists that we had at State of Board of Health came in; and spoke to them briefly about their particular programmatic activities, what was going on, what the problems were, especially if they were already assigned to a county, what the problems were in their particular county, to give them a little bit of background on that;

And then, we talked a little bit about just public health teamwork in total to them; and I think most of them felt that it was a very worthwhile effort, and that it was helpful to them when they went back to their local communities; and much of what we talked about, actually, or, at least, as much as—far as I was concerned, much of what I talked about to them was how to get along with that medical society in their county, and how to get along with that Board of County Commissioners; because if you did not get along with your medical society, you might as well go on back to wherever you came from, 'cause you're not going to get anything done; and if you didn't get along with your board of county commissioners, the next year, when your budget came up for your county commissioners to look up—look over and decide how much money you were gonna' get, you were in serious trouble. So, you had to get along with those groups; not to mention the other health-related organizations in your community, depending on the size and content of that county. Some counties were richly filled with all kinds of people in the health field. Other counties had very, very little, and the health department did it all.

CP: You know, I carry the memory that the county commissioner really was involved with the employment of the local Health Officer.

DC: Yes, they were. Yes, they were.

CP: Speak to that.

DC: Yes, they were. Legally, as far as the law is concerned, the County Health Officer in each county is appointed by the Board of County Commissioners.

CP: Oh.

DC: Yes, is appointed by the Board of County Commissioners; he's their man, but he has to be approved by the State Health Office.

CP: Oh, okay.

DC: So, Dr. Sauder had to give a letter of approval—stamp of approval for each Health Officer that was employed. Now, I'm not gonna' say that weren't times when we recommended Health Officers to various counties in the state.

CP: Yes.

DC: Someone had died, someone had left, someone had retired, whatever.

CP: Yes.

DC: And we had a good person, who was maybe in a smaller health department or something, and we felt that they were capable of taking on larger responsibilities and that sort of thing; and we would recommend people to boards of county commissioners.

CP: That seems appropriate. You were the recruiting agency, really.

DC: Oh, yeah, yeah.

CP: You could recruit—

DC: The Bureau of Local Health Services, we handled; I don't know how many thousand, I wish I knew—could remember; we handled thousands of letters every year, written to physicians all over the United States of America and some abroad.

CP: There's your recruiting effort.

DC: Who wanted to come to Florida.

CP: Oh.

DC: Yeah. They wanted to come down here to this beautiful land we live in, and they wanted to know what the opportunities were in public health.

CP: Yes.

DC: Some of them had been Health Officers where they were, and, of course, we loved that.

CP: Yes.

DC: Others of them had worked in totally different environments. They were either in private practice, and they were kind of; you know, private practice could beat you to death, back in those days; and they were kind of really tired of private practice, wanted to get into something that just took just a little less energy; and a lot of them came down thinking public health took a little less energy, and then found out it didn't.

CP: But your stresses were different.

DC: But anyway, that's the important thing—Oh, we stressed the sunshine, and the fishing, and all those good things, you know. We didn't talk about hurricanes or anything else.

CP: Or the fourteen hour days.

DC: No, we didn't mention those. But anyway, yes, we did a lot of recruiting, and I would say that ninety-five percent of the County Health Directors in the state of Florida were recruited through the Bureau of Local Health Service.

CP: Yeah. I'm also recalling, seems to me that the Alachua County Health Department had a special grant to provide a special orientation to physicians who were employed, but had never had public health experience. Do you recall anything about that?

DC: You're right about that, and also, Dr. Hall—

CP: Yes?

DC: Down there—who was County Health Director down there for years, and years, and years—

CP: Yes?

DC: Dr. Hall also ran an excellent program down there for county sanitarians.

CP: Oh, same thing?

DC: Yeah. Same thing.

CP: Same process?

DC: And you know that the county sanitarians, in the early days, they were simply men who had graduated from college.

CP: Yes.

DC: Some of them had been in the service.

CP: I doubt there was any specialized training in environmental health available to them, was there?

DC: No, and there wasn't any specialized training required. The requirements for sanitarians were they graduated college, period.

CP: Okay, they could read and write.

DC: Period. So, you could graduate as a—in—

CP: Business major?

DC: In world literature.

CP: Oh.

DC: See? But you had a degree, and then you could go out and get a job with it, see?

CP: As a sanitarian.

DC: And, of course, there wasn't a lot of call for people interested in world literature at that point in time. So, you went to work as a county sanitarian. (CP laughs) Well, we'd take those fellas; ship 'em up to Dr. Hall, up in Gainesville; and he would put them through the works for about two weeks; and I mean he would give them a workout. They'd be down there, sticking their head in the sewers and everything else, to find out just how these things worked; and, of course, those little communities around Gainesville were beautiful training areas for sanitarians, because there must have been two or three thousand outhouses in the area; all of them had to be inspected to see what was going on, and whether they were good or not, whether they were doing their job, and most of them weren't.

And so, these guys had to get out there, and they had to find out what an outhouse was; and a lot of them came from metropolitan communities where they didn't know what an outhouse was. (CP laughs) Well, we had plenty of them in Florida, back in those days,

and pig farms, and lots of other interesting things; but anyway, yeah, Dr. Hall did a great job up there, and ran that health unit. They also had a training program for public health nurses; I believe it was down in Green Cove Springs; and as I recall it, in the back of my memory, Merty McClare—

CP: Was the director there.

DC: Was the director of that program, and she was one grand old public health nurse; and she put those gals through their paces, too—

CP: And I love her to death.

DC: She put them through their paces. They learned what public health nursing was about. And, of course, a lot of them came out of hospital exposure and things like that, and they didn't know anything about that kind of stuff.

CP: About the community as a patient.

DC: Yeah, yeah.

CP: And Dr. Hall taught physicians also, I want to remember.

DC: Yes, he did.

CP: That, to make—help them make that psychologic[al] transition that you spoke to.

DC: Yes, he did.

CP: And the schools of public health were not up and running, and we couldn't afford to send them at the time, so this was our public health training sites, yeah.

DC: Sure it was, yeah. And those physicians, also, during that three day tour when they came up to state board of health, they also went to each of the divisions, and sat down with the division director, whoever it was, the bureau within divisions at the State Board

of Health, and had a nice little chat about what was going on in those programs, in addition to their little formal presentation.

CP: That was part of training, too, was it not?

DC: Yeah, they made the rounds; they went through the state lab up there in Jacksonville, and they saw what was going on up there. They saw what all the work that Dr. Hardy and all the followers were doing up there, and that helped them get a better feel, a better grip on the kinds of things they needed to keep their eyes on when they got back to the local level, again, working in the community with their programs and all that down there.

CP: How do you view this excessive—how did health—these new persons—new physicians to public health, how did that work out? How did they do?

DC: By and large, they worked out beautifully.

CP: Great.

DC: By and large, they worked out beautifully, and I think that there were several reasons; first of all, they fell in love with the community where they went, that was the first thing.

CP: Very important.

DC: That was very important, ‘cause they really realized the tremendous need there was in that community for health service activities, and they became torch bearers with their county commissioners, with their city people, with their legislators, with whoever they could get their hands on, they became—

CP: And the State Board of Health, I suspect.

DC: Yeah, they became the torch bearers to say, “We’ve gotta’ have so and so in this county.” And that’s where some of that eight million bucks came from; was those guys out there, working in the field, going to those commissioners on a regular basis, see, they saw them every week. Had to. They had to go to county commission meetings, and mostly, they were every week; now, some small communities only met once or twice a

month; but, for the most part, every week. And they were down there, and they were telling the commissioners, “This is what’s going on out here: these pig farms, these chicken ranches, all this stuff; this is terrible! We’re spreading flies, we’re creating a terrible problem, and you’ve gotta’ help us do something about this.” And they did. That’s where the money came from. (CP laughs) So; and of course, you know; the state put up few dollars, but the state didn’t get into it like the counties.

CP: That’s my impression.

DC: Yeah, let me tell you a little bit here, quickly.

CP: Please do.

DC: Nineteen thirty-five. Local money: twenty-four thousand, three hundred and eighty-three dollars.

CP: Oh. (CP laughs)

DC: Local money. 1935. State money: three thousand, eight hundred and sixteen dollars.

CP: Really?

DC: So, the counties were putting up, what, eight times—

CP: Eight times.

DC: Eight times as much money as the state, at one time; and then, as I said, by 1965, it was eight million dollars from the counties, and a little less than twelve million total; and of course, there was federal, the state money in that was two million seven. Sixty-five, compared to county money of eight million. So, you see, counties got into this thing in a big way.

CP: Yeah, big way.

DC: And they wanted things done, and the only way to get it done was put up the money; and then, of course, you'll recall, I'm sure, over the legislator's sessions, over the years, that the legislature had a very, very clever way of passing little laws, and saying, "The county will take care of this."

CP: Uh-oh.

DC: He passed a whole lot of those things, you know?

CP: Uh-oh, yes.

DC: "The county will do this." And so, no money went with the law—

CP: State didn't appropriate money?

DC: No money went with the law. The law was passed, the county was responsible, and there wasn't anything to do it with. So, the county had to put up the money to do it.

CP: How did they react to this?

DC: And they didn't like that one little bit. They used to really fuss about that; all these county things that are—I mean, these state things that are being put on us to carry out at the local level. Then it was the job, of course, of the diplomat, the County Health Director, to get in there and explain to those guys, "We understand what you're talking about, because we're asked every day to do stuff we can't do, because we don't have any staff. You give us the staff, we'll go out and take care of that stuff for you, so you won't have to worry about it, see?"

CP: Yes.

DC: So, we sold the programs that way; but that happened a lot in Florida, and it still does happen in Florida a whole lot; but anyway, (CP laughs) that was a building block, even though you could say, "Well, you know, that's not very nice to do things like that." That was a building block for public health in the state of Florida.

CP: Yes, it was.

DC: Cause if they hadn't passed those laws in the first place, it wouldn't have happened. The commissioners at the local level probably either wouldn't have thought of it or would have said, "Well, if we pass this law, it's gonna' cost us a bundle of bucks."

CP: "We're gonna' have to pay for it."

DC: Yeah, "We got to pay for this. So, you know, let's just let that sleeping dog lie." And then the state legislature comes along, passes the law, "Uh, okay, we gotta' do it." So, begrudgingly, they did it; but eight million bucks worth by 1965, I'd like to know what the figures were in 1975, when things kind of came to a screeching halt; you know, before they divided everything up, said, "You'll take care of these things, and we'll take care of these things, all that stuff." I don't know how much went in there, cause I don't have the access to the figures.

CP: I'm very impressed with the figures you got. I hope you're going to leave a part of that as your figures as a part of your taping today. Can we make a photocopy of that?

DC: Well, you can if you want to; it's all in the seventy-five-year history; you know, this all came out of the seventy-five-year history. So, if you have the monograph, *Seventy-Five Years of Public Health*, you'll find it.

CP: Oh.

DC: Sixty-six through seventy-one.

CP: Okay, and for the records, *Millstones and Milestones*.

DC: *Millstones and Milestones*.

CP: Published by Pynchon and Hardy.

DC: Yep, yep, Dr. Albert Hardy and May Pynchon, yep.

CP: That's very good. For the record, we need to note that. Thank you.

DC: That's an excellent book; anybody who really wants to know a whole lot about health, especially about the early years, what I call the infectious disease years.

CP: Yes.

DC: You know, prior to 1930, when they had all yellow fever and all the rest of the stuff, and when Dr. Sauder was called down from the state to go to Pensacola and wipe out the red light district, and all the interesting things that happened, you know, we have venereal disease all over the place, and we had soldiers and sailors and marines training in the state of Florida, and they were all having bar girls and so on (CP laughs), and they were all polluted, I mean it was something else; and not only that, not only that, but interestingly enough, and that comes out in here, I believe on the VD section—the call section.

CP: Yes, yes.

DC: I wish I had brought the figures with me, but I didn't; but anyway, just accept this as very rough figures.

CP: Okay.

DC: One-third of all the young men who are brought up through the draft system—

CP: For World War II or I?

DC: For induction—World War II.

CP: Okay.

DC: For induction into the army, in 19—around—no, I guess it was World War I. I guess it was World War I, come to think of it; I had to look that up, but I guess you're right, World War I; one-third of all the young men were infected with syphilis.

CP: Really?

DC: In the state of Florida.

CP: Really?

DC: Yes. All the guys who were brought up; and they had to be put into those rapid treatment centers and so forth, to try to get them cured, and that was—the cure was almost as bad as the disease. Not quite, the long term effects, but immediately, it was worse.

CP: Yes.

DC: Cause once the sore heals, you know, you don't know you got anything until you start going nuts or whatever.

CP: Until you end up in Chattahoochee.

DC: Yeah, right. But that rapid treatment thing was something, you know? You use the fever therapy, and they used neoarsphenamine,[2] and they used all that stuff, and, my gosh, that was horrendous.

CP: Yeah, the fever—

DC: That was torture.

CP: Just for the record, you mentioned it, the fever ship that was in Jacksonville for a period of a time, just to give fevers for the treatment of syphilis. That was before your time.

DC: Yeah, yeah.

2A yellow powder containing arsenic that was formerly used to treat syphilis and yaws.

CP: But it was there, and it's useful to have that it on the record that it was there.

DC: And it was still a problem, even World War II, do you remember? Because we didn't have penicillin.

CP: Yes, that's right.

DC: Penicillin didn't come out until after the war was well into its second or third year. So, in the early forties—

CP: We the public didn't get it. We got penicillin in late '45.

DC: Yeah, I know; and in the early forties, when these people were being brought up for the draft and stuff, gonorrhea and syphilis were still serious problems. Even that late.

CP: That's shocking. Can you address what local health departments did, in reaction to that? How did we, Florida, from a local health unit point of view, what did we do about it?

DC: Well, you know, to tell the truth, venereal disease had been a serious problem in the state of Florida from practically year one; you know, you know about the Bible, it's in the Bible, you know that; but anyway. We won't go into that (CP laughs)—the first profession? (CP laughs) Anyhow, the State of Florida has always had a relatively obnoxious history, as far venereal disease is concerned.

CP: Yes.

DC: And so, one of the early things that health departments had to do was to do venereal disease control.

CP: Oh.

DC: It was right up there with TB control, and all these other programs, you know? For communicable disease control, even environmental health wasn't quite as bad as the VD

situation; so especially in the major centers of population: Miami, Tampa, Jacksonville, Pensacola, you know, the big cites, Orlando, the big, urban populations. Place was rampant, and still is—it's still there unfortunately.

CP: And synonymous with venereal disease.

DC: But anyway—

CP: That's where our AIDS is too, by the way.

DC: So, in the early days, of course, we didn't have a really strong—although, Dr. Sauder, that was one of his first assignments in Florida, as you know, was to wipe out the red light district and clean up venereal disease in Pensacola, which he did.

CP: First part of the Second World War.

DC: Yeah, he lived through it, too.

CP: Yes, he did.

DC: He wasn't sure there, for a while, but he did live through it. He started closing down the houses, that's when he started running into some problems. But he survived it, anyhow. The public health service was our—US Public Health Service was our strong supporter in that area, because this isn't just Florida, you know, it's all over the United States; Florida just happens to be a bad place for it, but it's all over the country; and there are other states, I'm sure, that were worse off than we were. I just didn't work there, so I didn't know about it. But, in any event, the Public Health Service gave us Public Health Service Officers, both at the state level and to go out into the community to, particularly, these major centers, and do venereal disease control; and we ran VD clinics, and we drew I don't know how many thousand samples—blood samples every year for VD control, but I know we kept the laboratory busy. Right on, just with that alone.

CP: Case finding. You did serologic surveys for case finding.

DC: Maybe three or four hundred vials and samples a year, just on that alone. So, that's pretty big.

CP: You're in maternal and child health, speaking of that, neonatal syphilis, can I just kind of stimulate you a minute? What'd you do about that?

DC: Well, we had it—

CP: Uh, what was your focus?

DC: We had it, believe me, we did. I started out, as you know, in Dade County, and Dade County was one of the places where we had plenty of syphilis, and all the other VD, but particularly syphilis, of course, that's the one so damaging to newborns and kills many of them; and, course, what we did was we got almost all of the indigent women, because, you know, the indigent women who wanted a midwife delivery had to come to the health department clinic. They could not obtain a midwife delivery unless they came through the health department clinic.

CP: Did local health concerns govern-regulated midwifery?

DC: Oh yes. Oh, yeah, yeah, yeah. It was a law passed, I would say, in the forties.

CP: All right.

DC: Can't tell you the exact time, but in the forties; and there were, at one time, you know, there were about three thousand midwives in the state of Florida busily engaged in their practice.

CP: I remember.

DC: Some were very good. Some weren't. When I went into Dade County, we had, I would say, we had somewhere in the neighborhood of thirty.

CP: Just working in Dade County?

DC: In Dade County. Just in Dade County alone. And they were granny midwives; none of them had ever been to school anyplace to get any special training.

CP: They weren't nurses.

DC: No, they weren't nurses. No.

CP: Okay.

DC: And they worked with an older midwife, who either was a granny—a grandmother, who had trained these young girls in midwifery, or they worked with a neighbor or friend or somebody; they got interested in that kind of work, they went out and they learned their trade, and then they were regulated by the health department.

CP: Okay.

DC: In that county and in every other county in the state of Florida, we had to inspect them; I did the physical examinations on all the midwives that we had, and we did—fortunately, I had a certified nurse midwife working in the health department.

CP: Very good.

DC: She was their supervisor. She actually went out on deliveries. Selected various midwives, and she would go out on five or six deliveries a month, and sit with them and see what they were doing.

CP: Excellent. Excellent.

DC: Make sure that it was being done right; and that happened pretty much throughout the state, especially in the urban areas, where you could have that kind of a staff onboard in your health department.

CP: Yeah. I remember the state board employed a nurse midwife that did just that for the smaller counties.

DC: Yes, indeed. Yes, indeed.

CP: One of those was Velma—Alma Voss. Miss Voss. Do you remember her?

DC: Yep. Yeah, I do.

CP: That's beside, but this is important local health—

DC: I remember her; I was trying to think who the—

CP: Alma Voss.

DC: Who the main, main one was, though. I was at her party when she retired, and I can't remember her name, but she was a nice lady too.

CP: Yeah.

DC: Yes, they did do that. And I can—

CP: We were talking about neonatal syphilis, and I got you off, I'm sorry.

DC: And so that, we had control of the patients that they delivered, cause they couldn't deliver, so we got all those patients first. We did physical examinations on all of them before the midwife oversaw them. Did all that. Did all their blood work and so forth; if anybody had syphilis, they were yanked out immediately and treated. See, by that time, course, that was '53, when I went down there, you know? So, by that time, we had penicillin, we could treat them in a hurry and get 'em cured; before they ever got to the point where it was dangerous for the baby; and if you can treat them in the first trimester of pregnancy, particularly, you're all right.

CP: Yes.

DC: After that, then you've got some possible problems. The abnormal teeth, you know, some of that stuff, even if you treat them. But anyway, so, we did all that. Then, in addition to that, of course, and this is not just in Dade County; it's just that I'm more familiar with Dade County and Sarasota than anyplace else, cause I was there six years.

CP: That's where you were working.

DC: Yeah.

CP: I understand that.

DC: But anyway, all the counties, the indigent patients were taken care of through the health departments.

CP: Yes.

DC: There wasn't any other source, really.

CP: Of maternal care.

DC: Now, the private physicians in the communities, for the most part, were willing to deliver these girls free of charge; didn't charge a nickel for it, and they were willing to deliver; and that was a tremendous help, because, of course, we didn't have people who were trained to deliver babies. You know, you need to be an obstetrician.

CP: Yes.

DC: We didn't have people trained like that; we had a few around the state, but very few. Anyhow, but they didn't want to provide the prenatal care. Because, you know, that's a regular thing; it's every month; and then, after you reach a certain point, it's every two weeks; and then, after you reach a certain point, it's every week; you had to be seen, and examined, and so forth; and you have to have, nowadays, sonograms, and in those days, we didn't have sonograms; nowadays, you listen with a little meter that you put on their tummy, you know? Now—those days, we had to put on the delee forceps, you know—I mean, headset, and listen with the stethoscope to hear the baby's heartbeat and all those

things. Anyway, we took care of those girls; and, in fact, there's some babies in Dade County that are named after me.

CP: (CP laughs) Congratulations.

DC: I didn't deliver 'em, but I took care of their mamas. (CP laughs) Several times. Repeatedly.

CP: Yeah, I think of the eye infection secondary to gonorrhea, and eye prophylaxis. Give us a paragraph on the early days of eye prophylaxis.

DC: Okay. We had a lot of problems with the gonorrhea infection of the eyes, gonorrhea otitis; I guess you'd call it.

CP: Ophthalmia neonatorum.

DC: Yeah, and some of those babies were blind.

CP: Oh, really?

DC: In the early days, yeah; but, early on, and, again, I can't bring into focus when it was, it was long before I came into public health; a law was passed in the state of Florida that said that every child, every newborn, had to have treatment.

CP: Ah, for their eyes, for gonorrhea.

DC: Immediately after the birth, had to have treatment for the eyes, for gonorrhea. Specifically. Because there was so much of that. And we, of course, we kept track of the midwives, and they had to write their little report on every birth they did, and they had to specify that they had put the drops into the babies' eyes, and that was all provided by the state board of health; and then, of course, later on, they went to addition of tetracycline and some other things that they were using, but, in the early days, it was silver nitrate. Everybody got silver nitrate, and people used to wonder why the white kids had little black spots on the corners of their eyes; because silver nitrate does that, it turns your skin black; but that's okay.

CP: Better than being blind.

DC: You bet, you bet; and, of course, the seventy-five percent of the patients we saw, the indigent patients were black anyway, so they didn't have to worry about black spots on their faces, because they had 'em. (DC and CP laugh) So, it was no problem. But anyway, yes, that saved a lot of children from blindness, a whole lot of children from blindness; and prenatal testing, the measurements that we did, the examinations that we did, and giving them treatment for the various kinds of illnesses that they had; you know, there were women in our program who had had six, seven, eight babies, and we were giving them treatment for that, we were on top of all those problems, and we kept the—we got the maternal and infant mortality rate down pretty low. When I first went to Dade County, Dr. John Milton, you probably remember Dr. John Milton, he was the director of Bureau of Internal and Child Health, for a while.

CP: Also, a member of the State Board of Health.

DC: And he was chairman of the State Board of Health for a while, I think just before Dr. Eugene Peak, who I remember with great fondness, because he was there the whole time I was up there; a great guy. Dr. John Milton sat with me on the committee of the health department—of the medical society; Dade County medical society on Maternal and Child health in Dade County, believe it or not; and this was, you know, we're talking 1950s.

CP: Yes.

DC: You'd say, "Well, by that time, my gosh, that stuff should all have been taken care of." Well, it wasn't. We were still losing about ten mothers per thousand live births.

CP: Oh, boy.

DC: That's high. That's high.

CP: That is high.

DC: Now, I don't know what the most recent statistics are, but I'm guessing we're down to somewhere around one mother per twenty thousand live births.

CP: If that frequent.

DC: If it's that—

CP: It's very rare today.

DC: Exactly, yeah; and our infant mortality rates, you know, Florida was very high; in fact, we were once castigated by the American Public Health Association for being something like twenty-seventh in the nation, some such thing as that. The highest mortality rates amongst infants were way up in the thirties, thirty per thousand; and I think that's down somewhere now, I think, around six, six-and-a-half, seven, somewhere in that area.

CP: That's correct.

DC: In that ballpark.

CP: Yeah.

DC: So, a lot's been done, and I can't say that Public Health is to blame for all of it. We're not, obviously.

CP: But you were part of the picture.

DC: Yeah. The practice of medicine has changed tremendously in the state of Florida, over the years; and now, fewer and fewer and fewer women are being treated through health departments. More and more and more, we have worked out relationships with the local physicians, obstetricians in the community; and with the availability of funds, specifically, some state money that's being made available through Medicaid and so forth to pay for these deliveries and that type of thing, plus physicians willingness to accept less for an indigent patient than they would for their own private practice.

CP: Ah, of course.

DC: Much less.

CP: So, the quality of service is improved—

DC: So, the quality of service has gone up tremendously

CP: And it's shown in the statistics.

DC: Most of these—Most of the patients, I would say, at least in the urban areas in Florida, most of the patients are being delivered by private practicing physicians in the community, who are doing that and getting paid through Medicaid or other sources; the health department, also, in some instances. For instance, in Orlando, the Orange County health department pays physicians when the patient is not eligible for Medicaid. They pay the physicians for deliveries.

CP: Really?

DC: And that's being done a lot more, now.

CP: Yeah, that's great. You mentioned Sarasota; were you in Sarasota?

DC: Yeah, I was there six years. One of the more enjoyable tours that I had—

CP: As the local Health Officer.

DC: Beautiful place.

CP: Director of Local Health, right?

DC: Oh, yeah. Beautiful, wonderful place to work.

CP: When did you get there? You were director of local health services, for a season, with the state board of health.

DC: Yeah, yeah, I was.

CP: And you was director of Maternal and Child Health.

DC: Yeah, I was. I was in maternal and child health from ‘64 to ‘66, and then I went down to Sarasota; there was a little brouhaha about the health officer down there (CP laughs), and he bought some furniture for the health department from his wife.

CP: Oh. (CP laughs)

DC: And that is not acceptable in Florida.

CP: Oh, that was—that looked bad.

DC: Yeah. You buy from the lowest bidder, in the state of Florida; you don’t buy from your family.

CP: Okay. (laughs)

DC: If you’re a Health Officer, unless you don’t want your job anymore.

CP: And that’s what happened there.

DC: Yeah. That’s what happened.

CP: He was tired of his job.

DC: He was tired of his job, yep. So, I went down to Sarasota, and, really, I had a wonderful experience down there; I enjoyed it, no end at all; and it was really great.

CP: As director of the health department, you're now accountable for all those programs and their integration.

DC: Yeah, right; and we had our own sanitary engineer; and we had, of course, the Environmental Health Program, it was quite big, extensive; we had, I don't know, maybe twenty-five public health nurses; and we did a lot of work in school health, and that sort of thing, down there; and health educator, full-time on the staff; nutritionist, full-time on the staff—

CP: So, you didn't know what to do with such a variety of staff, coming from Indonesia to that, that's some gap.

DC: But all those things are very, very important to a total public health program in a community; because there's so much—so many things to be thought about, besides just polluted water and stuff like that, which we have plenty of; but there's so many other things to be thought about; and—for instance, your nutritionist works with all of the nursing homes in the community, gives them guidance on proper food for those people that live in those homes; they're entitled to a decent, adequate diet; and that's one place where nursing home directors, operators, like to cut corners; is to feed cheap. If you can feed cheap, you make more money for yourself.

CP: I can understand that.

DC: So, we didn't let them feed cheap (CP laughs), we made 'em feed right.

CP: Good.

DC: And there's a difference.

CP: Yes.

DC: And health education, 'course, was desperately needed. You probably remember the program that we worked all over the state for several years, teaching teachers in the school system to understand health, cause most of them didn't.

CP: Yes, that's correct.

DC: And health educators worked heavily on that. Elizabeth Reed started that program when she was State Health Educator, you remember that, probably; and that was a very important program every summer; teachers from all over the state used to enroll in that program.

CP: Called *The Teacher's Summer Workshop in Health*.

DC: Yeah, right, right, and it was excellent; and those people went back into their schools, and became real sparkplugs for improving the health, and they were able to observe the kids in their classrooms, and pick out children that had health problems after that.

CP: Yes, yes.

DC: I mean, they weren't doctors, they weren't nurses, but if they saw a kid back there with his head on the desk all the time, it wasn't because he stayed up 'til two o' clock in the morning, it was because he wasn't getting fed right, or something was going on in his system.

CP: Yes.

DC: And they picked those kids out, and they'd get those kids into the health department to be seen and find out why, so—

CP: Excellent program.

DC: That was an important program, that was one of the big ones.

CP: Yeah, I thank you for mentioning that. Do you know when that started? An Approximate?

DC: Early fifties.

CP: That was going when you came?

DC: Early fifties. It was going—

CP: And it was a dominant part of your program in Sarasota?

DC: Yeah.

CP: Yeah, what was the highlight of your service as a local health officer? And what's the downside to—

DC: Okay, I'll tell you a couple of highlights.

CP: Okay.

DC: Not as local health officer, though.

CP: Oh.

DC: But as M.C.H. director.[3]

CP: All right.

DC: The highlight there was—that was in 1963, '64.

CP: Yes.

DC: Okay? And you'll remember we lost a president about that year, the year before, '62, '63, somewhere along in there.

CP: Sixty-two, I think.

3Miami Children's Hospital

DC: We had a president assassinated, and his family was very, very much interested in mental retardation.

CP: Yes.

DC: By virtue of the fact that one of the members of the family was mentally retarded.[4]

CP: Yes.

DC: And they put a lot of pressure on, up at the federal level, and grants became available for mental retardation programs, and we helped to get the program started out of Dade County called the Mental Retardation—it's now the Mormon Mental Retardation Center, I believe, out of the University of Miami School of Medicine.

CP: Okay.

DC: But in those days, it was called the Developmental Evaluation Clinic.

CP: Ah, yes, okay.

DC: Carol Shear and a guy named Smith, Dr. Smith, one of the Smith boys, they ran that clinic, and they had five or six members on their staff, and they did a terrific job. Not only in Dade County, but we got an itinerary worked up for them where they went to the smaller counties that couldn't afford to have that kind of a staff, particularly south of the lake; south Florida; and they held clinics in those counties, evaluated these children and so forth. They were tremendous help. That, I thought, was a very outstanding program that got started.

CP: That's kind of the forerunner of the state level organization for mental retardation. Was that kind of the daddy of the state function?

4DC is referring to President John F. Kennedy's sister, Rosemary Kennedy (1918-2005). Considered to be psychologically unstable by her family, she underwent a prefrontal lobotomy at age 23, which left her permanently incapacitated.

DC: Yeah, sort of. There was, at that same period of time, there was a committee appointed state wide, and I sat on that committee. Franklin Fort, crippled children's commission, he sat on the committee, and maybe fifteen or twenty other people. We had a nurse from over in Gainesville, at the Gainesville Sunland Center, sat on that committee, and others; and parents of mentally retarded children were also involved. And we did a lot of the planning for mental retardation activities in the whole state of Florida; we assisted the McDonald Training Center over in—right here, in Tampa, we developed their program a little bit, got help to get them some federal dollars to build their program up, and they have a sheltered workshop over—I guess it's still in operation, I don't know.

CP: I think it is.

DC: And, yeah, that was a rich period for that sort of thing. The other program that I liked very much was our activity of when I was down at the Bureau of Local Health Services; we got together with people over at the University of Florida, in Gainesville; there was a guy over there—I'll never be able to remember his name, but it doesn't matter, at this stage of the game, who was very much interested—he had once been a Health Officer in the state of Florida, and he was in the medical school over at the University of Florida; he later became dean, but I can't remember his name. Anyway, he was very much interested in doing something in those communities immediately surrounding Gainesville; because, A: they needed more material for the students, the medical school was growing.

They needed more material for their students, they needed more material for their residents, and they couldn't get enough into Gainesville, because most of these people simply couldn't travel forty, fifty, sixty, seventy miles around there. So, what we did was, we started a thirteen county M.I.C. Project, Maternal and Infant Care Project, around the University of Florida, using that center as the nidus for all this development; we had Gilchrist, and Lafayette, and Levy, and all those counties around there—in there, in that program, and they got maternity and infant from specialists, and residents, and interns, at the—plus, their nursing staff went out to these clinics, and actually ran them on site, and they did a tremendous job; and one guy that you do know real well, ran that program about—

CP: He was the original director of it, I think.

DC: For about five or six years, he ran that program, and his name is Charles Mahan.

CP: Who's the current dean of our School of Public Health.

DC: He's now the Dean of the School of Public Health. He ran that program magnificently.

CP: It's a small world, isn't it?

DC: And as a result of that, probably, he was nominated to be the State Health Officer, which he was, as you know, for a while; and then, subsequently, came here as the dean of this school, which I'm very glad of.

CP: Yes.

DC: Cause Charlie's a great guy.

CP: Those are two outstanding highlights that had mentioned to us.

DC: Those things, I really think, meant something in the health of people to the state of Florida.

CP: Not to be—to embarrass you or make your face red, can you underlight? What are some underlights, in contrast to the highlights of your career in local health services?

DC: Well, I really, I really don't have any adverse—

CP: Any underlights?

DC: No, not really, not in public health. I had a wonderful time in public health; it's a wonderful profession, and I think it's done a tremendous, tremendous amount of good; saved unnumbered lives in the state of Florida, and all over the country. The only concern I have now; and I realize now we have a new "regime" in the state of Florida, quote, unquote, hopefully it'll mean something in the future; but, after 1975, when the legislature, in its wisdom, decided to do away with the State Board of Health, and to have a division of health in with a big social service agency, you know, that's known as HRS.;[5] and, since that time, in my humble opinion, public health has gone downhill.

5Health and Rehabilitative Services

CP: Yeah, keep talking.

DC: Substantially.

CP: Yeah. That was a lowlight, in your career, then. You would have been—

DC: Yes, that was the lowlight.

CP: (Affirmative murmur)

DC: That was when I began to think about getting out of public health, was back then. Took me, what, thirteen years, to getting around to do it, finally left in ‘88, but anyway, that’s neither here nor there. The big thing I saw wrong with it was that the first and biggest step, that I could see, was not that there wasn’t money there, but there was not a desire there to see the public health of the people adequately protected. The desire wasn’t there. And the reason that was, I believe is, because the majority of the people who were in seats of power, in the department, were social scientists.

CP: This is the department of health and rehabilitation services?

DC: Department of health and rehabilitation services.

CP: And the leadership was social scientists, okay.

DC: And their primary thrust was to do something about welfare in the state of Florida; and welfare, don’t get me wrong, is tremendously important, no question about that; but healthfare is even more important.

CP: Yes.

DC: And if you ain’t got healthfare, you ain’t got welfare. I don’t care what you do.

CP: Yeah, you worry about the priorities.

DC: Yeah, the priority turned around; and, you may remember, you may not, one of the state—one of the meetings at—in Jacksonville, a very well known state legislator got up before the health officers assembled, and he said, “Physicians are a dime a dozen. We don’t need doctors running health departments; we need doctors taking care of patients.”

CP: I remember that.

DC: I’m not gonna’ say who that was, cause I don’t want to embarrass anybody, even if he is still alive, and I don’t know if he is, and I don’t really care. (CP laughs) But that was a statement that really spelled, for me, what was going to happen to public health; because it wasn’t long after that before physicians were downplaced in public health; they became clinicians, not public health physicians.

CP: That’s correct. To take care of the ill, they became technicians for the treatment of illness—

DC: Illness care.

CP: Yeah.

DC: And that’s one of the things that has really reduced the efficiency and function of public health in the state of Florida; and part and parcel to that is that Florida’s public health departments have more and more gone into clinical medicine, and got out of the old fashioned home care that we delivered. Our nurses went out into the homes; they knew Grandpa had tuberculosis, they knew this child wasn’t quite right upstairs, they saw these things on a day to day basis, out in the homes; and as the clinics got bigger, and the money got smaller, and they said, We don’t want doctors anymore, we want you people to take care of sick people, the nurses couldn’t go in the homes anymore, they didn’t have the time to go into homes anymore—

CP: No, they were busy in the clinics.

DC: They were spending all their time in the clinics, and had nothing—no time to spend out there doing that health education, that nutrition education with that mother, that looking after the other family members, that really helping families to get—to stay together and to pull together, that’s lost.

CP: Focusing on early intervention and prevention.

DC: Right, exactly. That was lost.

CP: Yeah, you'll remember that the legislature did pass the Indigent Health Care Act, in which the health departments were admonished and charged, and their budget was duly done in order to—for them to become sickcare clinics.

DC: And not just admonished, if you recall, but really pressured.

CP: Oh, forced through budget.

DC: By people saying—by people saying to them, "This is where your source of money is, from now on. If you don't get on the car and ride with us, you're gonna' be out there trying to thumb with somebody that isn't gonna' pick you up."

CP: That's right. We do what the money is.

DC: And that's what pushed us—that's what pushed us into the corner of getting into clinic care.

CP: Do you think that public health leadership somehow failed to properly inform, properly motivate, educate the legislative process?

DC: I think, by the time that came along, the water was already over the dam. I really do. Cause that was really came after reorganization, and after the division was set up, and the department was dispersed.

CP: Well, just to remind you, part of that '76 act you're speaking to, it was declared by a secretary of the department that a library was not pertinent to the current charge of this.

DC: I remember well.

CP: That a health education was no longer pertinent; and by the flip of a pen, I'll remind you that the Public Health Library, and its film library, and its entire health education function were abolished.

DC: Which was tremendously assistive to the County Health Department.

CP: Yeah, in that, I'm recalling—I don't want to put words in your mouth, but I want to continue to address that our charge is not that preventive medicine, we have so many sick people here that need care; so, from now on, that shall be your charge, you are the doctors and nurses of this umbrella agency; and doctors and nurses are supposed to take of sick people, so I declare that's what thou shalt do. Now, you were around when all verbiage was taking place.

DC: Oh, yeah, I was around, yeah. You remember, we went over to Tallahassee and we tried to do something about that, but nobody was listening, because somebody over there had made a decision that this is the way things were going to be in the future, and this is the way they are.

CP: Yep.

DC: So, I'm hoping—

CP: And they were the bosses, were they not?

DC: Oh, yeah, they sure were. (DC and CP laugh) But I'm hopeful, now, that we have a department and we have a physician—trained physician, as head of that department; and we have this good school here—

CP: With a properly trained dean.

DC: You said it. You bet. And Dr. Mahan's special knowledge, because he had an opportunity to see himself, out in those twenty-one counties—

CP: In the Starks, in the Greencoast Greens, yes.

DC: This is exactly how that the conditions were really hurt. And he found out quickly that public health was very important; and maybe he already knew that, I don't know; but I remember when I graduated from medical school, I didn't know anything about public health at all. We had public health for one week, and three and a half days of that was spent in venereal disease clinic, cause that was public health. The other day and a half was in TB control, because that was public health. (CP laughs) That's about how much we knew about it, you know? Back in those days, VD control and TB control were important. Still are.

CP: Yes, yes, they are.

DC: 'Cause TB is going up. VD ain't never gone down. Well, it went down for a short period, but we have people working on it like mad all over the state of Florida; and when the money drained, the program more or less collapsed. So, VD is very much back again, in a big way.

CP: I can see some relationships between the dissolvent of the venereal disease staffing core which occurred, and the rise of the incidents. There's a direct relationship.

DC: Oh, yes, there's no question about it. Every health department in the state—

CP: Refocus of attention.

DC: Either had their own VD man on staff that was large enough; for instance, I did in Sarasota, and we do that in several of them in Dade. Every health department that was large enough had their own VD control man, but health departments that didn't were able to draw on the regional VD control people; and they go into health departments, they hold clinics, they go out and they do investigations, they go out and find these people in the barrooms, in the halls, in the tenements, in the alleyways, wherever they have to find them; they corral 'em, and they say, "Come on in and get treated." And they get a list of who their contacts are; 'course a lot of them don't know, "It was just Betty, that's all I know. It was Betty."

CP: But a little point for the VD investigators, "Well, where did you meet Betty?" And those investigators would find Betty.

DC: They're sharp. They're sharp.

CP: They are sharp.

DC: Yeah, they got out there; in many cases, they did find Betty. Screaming and wailing, she didn't want to come in, but she came, 'cause Betty didn't know she had anything wrong with her.

CP: You mentioned '76 as a highlight in the—in public health history in Florida, won't you address that further? The '76 nidus; what else went wrong then, Dr. Crane?

DC: Well, it seems to me, that besides this total change in attitude, about what Public Health ought to be doing, which is not preventive medicine by any stretch of imagination, but by treating people and so forth; and getting rid of the library, getting rid of public health education and a lot of other things, I'm sure, went with it.

CP: You're aware, in retrospection; most of the environmental health stuff is now in other departments now, too.

DC: That went the way of all flesh, yeah, that went to another department, which has never done it as well as we did it. It was done well when we were doing it. Those people are too associated with the restaurant business themselves to ever, really—I mean, that's like, you know, putting a fox to guard the henhouse. Anyhow, so many things of that type, but, to me, it was the attitude.

CP: Of the leadership?

DC: The attitude and the leadership in the state of Florida simply said, "We don't really need these people anymore; and, particularly, we don't need doctors." And think how many doctors have gone out of public health in the last—

CP: Yes, ten years.

DC: In the five years immediately after 1975, just think about the number of doctors that went out. A lot. A lot of them.

CP: Oh, lots.

DC: Right after that. Because we all saw the handwriting on the wall: they don't want physicians running health departments anymore; they want physicians to treat patients.

CP: Yes.

DC: And, theoretically, that's what we're supposed to be doing; but when the community is your patient, you're just as important and just as busily engaged as the guy who's looking out there, looking at kids' tonsils.

CP: Yes.

DC: And it's just as important.

CP: Uh, I like to think it's a little more important, cause we can prevent—

DC: You know it is. You know it is.

CP: Yeah.

DC: And I know it is. Yeah, kids need their tonsils looked at, sure; you know, I'm not saying anything against private medicine; they've been tremendous support—tremendously supportive of public health; and they were—I have many friends in the business.

CP: Yes.

DC: But, and if we had public health established like we used to have in the old time, in the old days, I could get a lot of those guys out of private practice, 'cause they hate it. (CP laughs) They don't like it anymore, with Medicare and all the rest of it, they're eaten alive by paperwork; they're going nuts. They say, "We spend more time doing paperwork than we do doing patient care."

CP: And their liability.

DC: And it's disgusting, and they're unhappy.

CP: The question of frivolous lawsuits.

DC: I could recruit more than one health officer for every county in the state of Florida in no time at all.

CP: Yes.

DC: 'Cause they want out.

CP: Yes.

DC: And I can understand that. I can understand it fully.

CP: That's too bad.

DC: But the attitude has changed. There's no longer a desire at the uppermost levels, at least, there hasn't been; maybe now, there will be again.

CP: I see it coming back. I see it coming back.

DC: But up to now, there has not been a desire, at that level of government, to make public the most important activity of the counties in the state of Florida. It hasn't, no. Welfare and treatment of patients; that's the two most important things.

CP: Okay. What do you see as a solution? You want to talk about the future a little bit? What would you like to see to come back, from your experience, in those early days when Florida public health was really at its—at the pinnacle, and I recall, was accoladed [sic] by the Public Health Service and the World Health Organization as the place to see, if you want to develop a local health service, go to Florida; I remember many foreign health officials—

DC: Plenty of them. Plenty of them. Yeah.

CP: I could name some specifics that came here; sent by the World Health Organization to learn, in Florida, as to how to establish a public health service; and that was the focus on local health services, always. And you were there, David.

DC: Well, I will say, categorically, and I don't think Dr. Sauder, or you, or anybody else that knows anything about public health would dispute this; we had, in the state of Florida, in 1975, one of the finest public health organizations in the United States of America or anywhere in the world. One of the finest.

CP: I believe that, and I think the record supports you.

DC: Absolutely, I believe it; and we were—our folks were out there doing the work. They were out there, where the rubber meets the road. Now, you said, "What would I like to see for the future?" You can't go back; that I've learned over a long life; you can't go back. I'd love to see us go back to State Board of Health, but you can't do that, okay? So, what I would like to see is a really strong department of public health, in the state of Florida, that really was going to work on providing public health services to the people of state at the local level; through the County Health Unit System, with physicians in charge, and multiples of that basic staff, and multiples of that basic staff we've already talked about, to get out there and do the job where it needs to be done. That's what I'd like to see.

CP: Yeah, you used the word strong. "The strong state health department." Define strong for me, here. Or talk about that a little bit. What would—how would you—

DC: By strong, I mean, a strong leadership.

CP: Strong—oh, so important.

DC: Somebody that's up there that can talk to these guys at the legislature and make them listen. Strong leadership. Secondly, you've got to have funding; you've got to have money. You can't run anything these days without money.

CP: 'Cause money is staff.

DC: Money is staff. Money is program. You haven't got money, you've got nothing; you might as well wrap it up and go home.

CP: Yes, yes, yes.

DC: And, a real, basic understanding on the part of our legislators, not only at the state level, but the local level: county commissioners, mayors, city commission, so on and so forth, all the way down the line, okay? A real, basic understanding of what is this stuff called public health; we don't know what that means.

CP: Yeah.

DC: What is it?

CP: Haven't we confused with our use of the word healthcare? That's one of my favorite sermons: separate healthcare from medical care. Those are two separate things. Excuse me, go ahead.

DC: Sure, yep, that's it.

CP: This is not my preaching day, I'm sorry.

DC: No, but you're right, and that needs to be preached; and that's where we need—we need the grass level—grassroots support, which only comes from understanding and education, we gotta' have that. We've gotta' have an understanding at the point where the money is handled; that means the legislature and boards of county commissioners, they've got to really believe, in their heart, that this is important; 'cause if they don't, than it's not important.

CP: That's true.

DC: And we've got to have the leadership to make them believe that.

CP: All right. Those are good pearls.

DC: We may have to take off the glove and put on some brass knuckles, because there's some hard heads, like the one that came to our meeting and said, "We don't need doctors in public health. We need doctors out there taking care of patients." That's when it all started going downhill. Right there.

CP: It's interesting that you're—that that is a highlight in your memory; and I remember that, too.

DC: I'll never forget that. The part that almost killed me was he was standing in front of sixty-seven health officers, saying that. You know?

CP: Well, he was chair of a rather dominant committee; he controlled the money, what can we say to him?

DC: He sure did.

CP: Do you remember?

DC: Yeah.

CP: Yeah, what can you say? He's got the first paints.

DC: Yeah, too bad we weren't in Russia; we'd all have jumped up and (imitates gunshots). (CP laughs)

CP: Now, the Russians don't do that anymore.

DC: No, I know they don't. They never really did. (DC and CP laugh)

CP: Well, any summarizing points that you want the record to reflect?

DC: Well, the only summarizing point I have is that public health is a great profession; it's a wonderful program; a wonderful effort that we made do to something really, really worthwhile for the people that live in the state of Florida. And we did a lot worthwhile, because, at one point in time, this state was regarded as one of the very most dangerous places in the world to be; because of mosquitoes, because of disease, because of all the other things; and even the hurricanes, nobody worried too much about, and I lived through a lot of them down in South Florida, and I didn't worry about them either. They're not dangerous. It's the people that are dangerous. But yeah.

CP: Yeah, there are those, some others who would—public health workers, who would say had it not been for the public health program, Florida would be uninhabitable.

DC: You bet. Absolutely. That's absolutely fact.

CP: I think that's worth noting, and if we neglect the matters of the public's health in the future, we may return, we may regret it. Even more than we regret now.

DC: Yep. That's very true.

CP: Well, Dr. David L. Crane, on behalf of the University of South Florida, and the School of Public Health, we're grateful for your willingness to come and share with us today.

DC: It was fun. It was fun.

CP: And it's enlightening; and I hope the future historians will get the undercurrent of a lot that you said today. And we thank you. And I'm Skeeter Prather.

DC: That was fun. I enjoyed that.

CP: Good, good.

End of Interview