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USF College of Public Health Oral History Project
Oral History Program
Florida Studies Center
University of South Florida, Tampa Library

Digital Object Identifier: C53-00023
Interviewee: Marianne McEuen (MM)
Interviewer: E. Charlton Prather (CP)
Interview date: February 11, 2002
Interview location: Unknown
Transcribed by: Alyssa Culp
Transcription date: February 20, 2015 to February 25, 2015
Audit Edit by: Bianca Smith
Audit Edit date: October 12, 2015 to October 13, 2015
Final Edit by: James M. Clark
Final Edit date: February 8, 2016 to February 8, 2016

E. Charlton Prather (CP): We're very pleased this afternoon to have Dr. Marianne McEuen with us. She was a longtime employee of the old State Board of Health and the Department of Health Rehabilitative Services in the area of tuberculosis control¹. She came to us as a radiologist² more years ago than she had want me to admit; and, if I have to admit when she came, I'd have to also say I was here when she came, so that would date both of us. But she preceded from an x-ray reader, an advisor on therapy for tuberculosis, to become the director of our Tuberculosis Control Program for a good while.

She is now fully retired, very involved with things, ladies and women around the Jacksonville area, and the Cedar Keys area where she's very involved with things art and artistic, I am told. Dr. McEuen, on the behalf of the University of South Florida Library and the College of Public Health at the University of South Florida, we're privileged to have you here and we say thank you very much for your willingness to come by and share with us your really exciting history in Florida public health.

Marianne McEuen (MM): Well, thank you for inviting me. I am delighted to be here.

CP: And I want you to share some of that with us. How did you get interested, what brought you to Florida tuberculosis control?

¹Tuberculosis control is a method of targeting the spread of tuberculosis with prevention and testing programs in populations of high risk.

²Radiologists are medical doctors that specialize in using x-rays and other radiation-based techniques to diagnose and treat disease and injury.

MM: Well, it was interesting because it came to me, but I didn't come to it. I was actually, had just moved to Florida, and I really didn't have too much to do. And they came and asked me if I would read the x-rays for them. And, at that time, my father-in-law was very ill, and I was basically taking care of him; so, he was a radiologist also.

So they would take little boxes of 70 millimeter x-rays to my husband's office, and he would bring them home to me. And the next day he would take back the ones I had read the day before. And I would read all the x-rays while taking care of my father-in-law, and it was nice for him because I could consult with him on things that were problems to me, and it made him feel like he was still involved with medicine too.

CP: I need to interrupt. I neglected to say that Dr. McEuen is an MD, specialized training in radiology, who married a radiologist, who is the son of a radiologist. They got radiology all through their blood. Now, I apologize for not getting that into the introduction.

MM: All right. Well, anyway, after my father-in-law died, I went into the office and began working in the office. And from then on, I just was getting more and more interested. I found it was a fascinating disease and a very interesting career.

CP: If my memory serves me correct, sometime during those early years, you continued to read x-rays and had babies all at the same time?

MM: That's true, that's true. We had to have a family.

CP: (both laugh) How did you work all that in?

MM: I had very good domestic health. If I had not had good domestic health, I couldn't have done it. I had excellent domestic health.

CP: Oh, that's good. That's good because I can witness to the fact that you obviously were a good mother since I know your kids.

MM: Well, thank you.

CP: Yeah. You managed to wiggle all this together. So you started with reading 70 millimeter. Now, what's 70 millimeters?

MM: Well, 70 millimeters were little films that actually measured 70 millimeters square. And they were chest x-rays, miniature chest x-rays, that you looked at through a magnifying glass. And they came on rolls of up to 450 films, and we literally read as many as 700 thousand of these in a year.

CP: Wow! Where did they come from?

MM: Well, they came from x-ray machines that went around the state, mobile x-ray units.

CP: Oh, really?

MM: They stayed on, six of them. They were mobile. The lung association owned a few, some of the counties owned their own, and then they were stationary x-ray units that took 70 millimeter films in a lot of the health departments. And they all sent them all into the State Board of Health where we developed them in our dark room, and they all passed through my eyes. I had looked at more x-rays probably than anybody else in the world.

At that point, it was our goal to try to x-ray everybody over the age of 18 that wasn't pregnant, every year. And we figured that if we did that we'd be able to find all the cases of tuberculosis in Florida, and we'd be able to treat them. That was before it became practical to screen people with the tuberculin skin test³ because, at that time, almost every adult was tuberculin positive because tuberculosis was so prevalent. Almost everybody, at least 40 percent of people, were positive. It wasn't practical to screen them with skin testing.

CP: Those are good points. I don't mean to be, whatever the word is, to ask you about the 70 millimeter surveys, but I think it's important for the historic tape for you to speak to that which is the reason I asked you because there's a lot of folks that will be watching this and—

MM: Wouldn't have any idea.

³Tuberculin skin tests are done by exposing the subject to a small amount of TB protein under the skin of the forearm. If a reaction is observed, further treatment and/or testing can occur.

CP: —wouldn't have the slightest idea. You don't know about the surveys that you all did in the early days.

MM: Well, you could take the x-rays to where the people were. In other words, some people couldn't get to doctor's office, particularly, the migrant agricultural workers, the people who were more likely to have tuberculosis than other people, just didn't have access to medical care. So we could take the x-ray units to them and continued to do that for many, many years in a limited fashion, for instance, to investigate contacts of known cases and things of that sort.

CP: Yes, you used the 70 millimeters. Are they still being used anywhere?

MM: No, not to my knowledge.

CP: Oh, they finally served their purpose.

MM: I shouldn't say no for sure, but I don't think so.

CP: I know that the units are not on the street anymore. You never see an x-ray unit running around on the street.

MM: No, you don't.

CP: Like when I was younger than I am now, there was one in my little community about three times a year, and the tuberculosis society and the county health department would come out and shake the bushes for everyone to come get their x-rays.

MM: That's right. And we wanted everybody then; we were very unselective. You just want anybody that was old enough and wasn't pregnant. You didn't want to x-ray pregnant ladies⁴.

CP: Yes, I think we all know why, and thank you for that. How long had they been doing that around here before you came? Do you know when we started it?

⁴X-rays are commonly seen as dangerous to pregnant women because of the radiation and the potential adverse side effects it can have upon a developing embryo or fetus.

MM: I should know that, but I really don't. I started in 1959 and that was probably the heyday of it. We probably started in the 19—

CP: After the Second World War.

MM: Yeah, probably the early '50s.

CP: Just a piece of history: I know the 70 millimeters were the common screening thing for the inductees of the Second World War⁵.

MM: Yes, that's right.

CP: The 70 millimeters was kind of developed for that and public health people took it over after⁶.

MM: And the first units we had were furnished by the federal government, probably left over from the armed forces.

CP: I'll bet they were, but they served very well and gave out a lot of radiation as I remember.

MM: Not as much as people thought they did, but later they gave out much less than the original ones.

CP: Was that ever a concern to you all? I think tuberculosis was much more worrisome than a little bit of extra radiation, personally.

MM: Well, frankly, it is. It is much more fatal too. Untreated tuberculosis is a very fatal disease⁷.

⁵During the Second World War, tuberculosis infections put a strain on military hospitals. In 1940, tuberculosis screenings were made mandatory for all inductees as a way to combat the spread of the disease in the armed forces.

⁶As a result of the wartime policy on tuberculosis, a public health campaign for tuberculosis screening was instituted for the general public given their importance to the wartime effort.

⁷Active tuberculosis has a death rate of over 50 percent if left untreated.

CP: And were there tuberculosis sanitary [sanitariums]⁸? Did you have hospitals?

MM: We did. We had, at the heyday, the state operated four hospitals⁹ simultaneously: one in Tallahassee, one in Orlando, one in Tampa, and one in Lantana.

CP: How many beds? Do you remember off hand?

MM: There were 2,000 beds at one time.

CP: Wow.

MM: And we had a waiting list. The beds were all full, and we had a waiting list.

CP: This was a very good time.

MM: Well, they closed the Orlando sanatorium just shortly before I was employed in 1959. And then they closed the Tallahassee one about five years later. And the Tampa one, they closed, I am not exactly—I can't remember exactly when they closed it¹⁰. And the Lantana hospital still exists
—¹¹

CP: Even today.

MM: Even today because we had multiple drug-resistant cases of tuberculosis of people that cannot be made noncontagious and there really is no place to put them.

⁸Tuberculosis sanitariums grew to popularity in the United States during the early twentieth century as a way to combat the disease. Sanitariums advocated a treatment plan of good food, fresh air, and inactivity.

⁹Named collectively, the W.T. Edwards Tuberculosis Hospitals were constructed by the Florida State Tuberculosis Board in 1952 as state-of-the-art facilities to combat tuberculosis. After antibiotic treatment began to prove itself effective against TB, the hospitals were closed for a brief time before reopening as the Sunland Mental Hospitals to treat children with mental illnesses.

¹⁰Tampa, Florida's W.T. Edwards Tuberculosis Hospital closed in 1974.

¹¹Lantana, Florida's TB hospital, named A.G. Holley State Hospital, was the last state-operated TB hospitals dedicated to treating TB patients and the last original American sanatorium dedicated to TB. Unlike the other TB hospitals created in the '50s, A.G. Holley State Hospital stayed open until 2012 when the legislature removed the hospital from the Department of Health's authority and shut the facility down.

CP: Oh, so Lantana's kind of focused on this group?

MM: And I really don't know, I am retired, you should know, and I haven't kept up with it. So they have very few beds.

CP: You retired from state government. You're not retired from life, though?

MM: No, no, no, by no means. I'm probably busier now than I ever was in my whole life.

CP: Well, how much tuberculosis did you find? What did you do with it? Did you have drugs to treat them?

MM: Yes, we did. We had drugs, of course. The drugs originally were not as good of drugs, isoniazid, para-aminosalicylic acid, and streptomycin,¹² when it first started, was just about all we had. And it took 18 months to 2 years to treat patients and, at that point, we were trying to admit patients to the hospital and keep them there for that entire period of time, which was devastating to their life—

CP: But why were you doing that?

MM: Because that was the way we thought we had to treat them. We just didn't think we could trust people to take their medicine at home, and we didn't have the personnel to follow them up. Prior to that, we had isolation cottages we'd people in, before my time. Called Burr cottages¹³, which they would put in the backyard and the individual patient would stay there because we didn't really have any good medicine for them.

But I want to read you a letter from a patient, give you some idea, because these people would be put in the hospital and they'd stay there for two years or so. So by the time they got home, they'd be totally disrupted from their families, from their employment, from their life. It was just

¹²Isoniazid, para-aminosalicylic acid, and streptomycin are all various types of medications created to treat against *tubercle bacilli* (TB).

¹³Named after Miss Burr, nurse in charge of the Twin Hills Camp of the Indiana Society for the Study and Prevention of Tuberculosis, Burr cottages were little houses made for tuberculosis patients in their back yard. Typically, the cottage contained the patient's bed, one chair, and a small stand for articles needed by the patient. The cottage was designed to assure proper ventilation, sunshine, and fresh air.

devastating to them financially as well as everything else. But this is a letter which I brought with me from the files from 1969.

CP: We sure would like to hear that.

MM: And it's written by a lady who's not had much schooling, it begins (reading): "Listen, this letter from Ms. Thelma Cray and I want to find out something. Can I be sent from here to my own county? Listen, Leesburg is not my home, but it's where I took sick there and was brought into this clinic by Dr. Tomlinson, Leesburg, Florida. I has two children. I'll leave them behind me with strange people. No help but the help from them. My people are at my home. I wonder if it could be that I would be sent near my county so I can have someone care for the children. I'm fine here, but my church people and my family are all behind. I have already heard from my county and waiting on an answer. Where I is, I am fine. Could I find out, could it be done? My doctor here is a lady named Dr. Wilson, and she is very good. I want to know how long I have to stay here. But the first week in next month, I will be here two months and haven't been on the ground."—She's been in bed all that time— "Would you let me know? Ms. Thelma Cray, Bay Boulevard, Tampa, Florida, room 364." Isn't that pitiful?

CP: Yes, it is pitiful.

MM: Pitiful. But this is what we did to people until we started treating them at home.

CP: That's just '64; that's not that long ago.

MM: Sixty-nine, 1969.

CP: Oh, '69. Now, that's sad. I don't remember hearing. Why didn't they have more social services? Why didn't they have more dialogue with the patients?

MM: Well, it was pitiful. This was obviously a migrant agricultural worker, and they couldn't find the family, you know; they were moving around. So it's difficult. I just thought that you'd be interested in that.

CP: I am touched with that. Yes, I am. It tells us what we did. Have we changed anything?

MM: Oh yes. Now we treat everybody, almost everybody, at home. Basically, our philosophy was to treat people where they were: if they were too sick to stand up, then you treat them in bed; if they were standing up walking around, you certainly did not put them in bed because it has been long ago proven that you get better just as fast if you're treated while working, while up and about, as you're treated if you're home in bed.

CP: In contrast to these rest homes of tuberculosis in the late 1800s¹⁴. You know, where folks were sent. They went and sat and rot.

MM: Oh yes, in the sanatorium on the mountain tops. It was a lifestyle, completely a lifestyle, which I know the book *The Magic Mountain*¹⁵ by Thomas Mann, describes it just beautifully. But it is very expensive to treat people in hospitals now; I mean, you think about how much it costs to keep a person in the hospital versus treating somebody at home with pills on an outpatient basis is much, much cheaper.

CP: And much better from a human point of view, too.

MM: But at this time, it was less expensive to be in the hospital. And I want to read you one more little letter, very short. This is all I've got to read to you today. And this was dated August 1, 1966 (reading), "Effective August 1, 1966, a hospitalization charge for patients hospitalized in any of the State Tuberculosis Board Hospitals will be \$13.35 a day, and this is based upon our cost figures for the year ending June 30, 1966. The revised *per diem* rate for a full-paid patients does not affect the assessment to the counties which will remain the \$1.25 per day. Sincerely yours, Sierra Wanamaker, administrative services director of the State Tuberculosis Board." Isn't that fascinating? That's what it costs to be in the hospital. I wonder what they said to patients on that time? (both laugh)

CP: As I recall, that the food was very good because in '66 I personally was doing a lot of eating in the hospital cafeterias.

MM: I didn't mind it. I always enjoyed eating at the hospital when I went there.

¹⁴Rest homes for tuberculosis in the 1800s is another way to refer to the sanatoriums that rose to popularity in Europe. Switzerland was particularly associated with the sanatorium trend in the nineteenth century because of the belief that cold, clean air from the mountains was the best treatment for lung diseases like tuberculosis.

¹⁵Thomas Mann wrote *The Magic Mountain* in 1912 to 1924. Set in the Alps, the story revolves around several characters that are patients suffering with tuberculosis in an isolated Swiss sanatorium on a mountain.

CP: Maybe the patients got a different feel, but we the staff ate very well. Those are fascinating, the differences in the cost and a sharply different philosophy during your time both the finding of tuberculosis and the treatment of it.

MM: Right.

CP: The finding, that was a new little subject. Speaking of finding, in your day, it was the x-ray. In your day, in the early days, it was the x-ray and you mentioned it was impractical to tuberculin testing. Now what's a tuberculin test? You tell me about that.

MM: In the early days, in the '40s and '50s, so many people were tuberculin positive, if you went out and tuberculin tested everybody you would end up having to x-ray half the people you tested because half the people would have been tuberculin positive. It didn't really save you any time. And also, the other point was, you have to see people at least twice to read the skin test and get a chest x-ray. And then you have to follow them up, so if you are looking for actual disease the chest x-ray will show it.

Now, if you want to prevent the disease, which we went into in the '60s. Later, it was the prevention and the child-focused tuberculosis prevention program where we tried the tuberculin test to as many people as possible and then give them treatment to prevent the development of active tuberculosis. And that was the next focus after trying to find all the active cases. Then we decided, Well, let's prevent them, to start with, in the medicine field.

CP: How was your preventative program in finding tuberculin positive people without active disease? Was that good? Did it work good?

MM: Yes, it did. But it became impractical to mass screen after a while because as tuberculosis became less prevalent, fewer and fewer people became positive so we did selective screening. And we didn't just go out and screen everybody in the street. You went into population groups which are known to have a high rate of tuberculosis such as prison inmates, migrant agricultural workers, homeless people—that sort of person—and immigrants from foreign countries where tuberculosis is very prevalent. And, of course, anybody HIV¹⁶ positive, it was very important to tuberculin test them because tuberculosis is an opportunistic disease.

CP: Yeah, that's today even.

¹⁶HIV/AIDS is the human immunodeficiency virus that causes acquired immunodeficiency syndrome, a condition in humans in which progressive failure of the immune system allows life-threatening opportunistic infections and cancers to thrive.

MM: Right.

CP: Well, the rates during your tenure, the rates of tuberculosis in Florida and the nation got to the lowest levels ever recorded.

MM: Yes.

CP: And in the last three or four years, it is come from that rock bottom and is headed up again. I know you haven't been involved but as a person terribly interested in such subjects, speculate on that some.

MM: Well I think, probably, the reason is because of HIV positivity and anybody who is HIV positive and tuberculin positive will develop tuberculosis, if they don't die first, unless they are treated, just about, because it will come out. And then immigrants from foreign countries where tuberculosis is particularly prevalent and, of course, in the African continent now and in Southeast Asia we have a tremendous double epidemic of tuberculosis and HIV positivity, which makes it so much more common. And then we're getting drug-resistant tuberculosis which is harder and harder to treat and, therefore, becomes more likely to be spread to other people.

CP: In drug resistance, do you want to speak a little to that a bit, how come?

MM: How come?

CP: Yeah, how come we're developing strange resistance to every drug we know?

MM: Well, the main reason is because people are improperly treated to start with. And in many countries it's because they don't have access to good medical care; they do not have adequate treatment. They can't afford to pay for the drugs; they're not furnished free by the state or the country. And then, if they don't take them regularly, if they don't do—what we now do is supervise therapy where we make sure the people take their medicine and that they don't just take it home and put it in the cabinet and never look at it again, which sometimes people will do that. People do forget to take their medicine sometimes.

CP: What do you think about the cost effectiveness of this supervised taking of the medication? Is that sending a nurse or somebody—

MM: Well, it is much cheaper than putting a person in the hospital.

CP: For thirteen dollars a day?

MM: Well, it's not thirteen dollars a day anymore. (both laugh)

CP: That's right. I'm sorry. Yeah, it is secret. I can see that. That's what you do, or that's what they do today, is send the special worker to the home to watch the patient take his medicine.

MM: It has other benefits too. It gives a person a chance to observe the patient, to look for toxic reactions, to see how they're getting along otherwise, in general, to see what social problems they might have, financial problems they might have, and to encourage them and to make them feel like they are a part of the human race. You have to remember that tuberculosis has been a disease which people have been shunned, been isolated, and shunned. And people feel immediately rejected by the world when they have tuberculosis.

CP: Until they have it.

MM: And you start out with the patient, usually, who behaves almost hostile because they're very depressed because of this feeling that nobody is going to want to be near me. And then it turns around, after a while, when they know they have a good crowd(??).

CP: Even in quote, modern times, there's still a house that you mentioned. You know, a case was diagnosed; the health department would help build that house, provide the money, and isolate you.

MM: That's right. Little tiny building, it's like a dollhouse. It was about 10 feet by 10 feet. And that person would have to stay in there and the family would bring them out food but that was it. They had to stay in that little building. That must have made you kill—

CP: There was a little trapdoor to put the food in so that the screen doors were not opened. There was no interface between the patient and his family.

MM: It was terrible.

CP: Those who followed the advice of the health department, it was a bad existence. I am glad that you came along after that and helped fix that.

MM: (laughs) I remember seeing a Burr cottage. It was in Leesburg, downtown Leesburg, Florida. Somebody had converted it into a little home. (both laugh)

CP: In my hometown there were a number of them. I am very familiar with the Burr cottages. I visited with some childhood friends—

MM: I didn't grow up in Florida, so I can't remember that era.

CP: Not everybody can be so lucky.

MM: That's true, that's true.

CP: Now, if you had to put your finger on a highlight of the progress of tuberculosis control over the years, what would you do? Where would you put it?

MM: A highlight?

CP: Would you do drugs?

MM: Probably, probably the rifampin¹⁷ maybe was probably one of the best drugs to come along and really, I think, revolutionized the treatment of tuberculosis and made it so much more curable in a shorter period of time. I think that in combination with other drugs that can treat it so much shorter period of time.

CP: In terms of diagnostic modalities¹⁸ that we have gone through over the years, that we wanted to get into treatment—

¹⁷Rifampin is an antibiotic used to prevent and treat tuberculosis.

¹⁸Diagnostic modalities are tools and techniques used to enhance or confirm a diagnosis made by a clinician, such as radiography.

MM: Well, the gen probe, the genetic probe¹⁹. No question. The gen probe for diagnosing tuberculosis is a much more rapid because it grows so slowly on a culture.

CP: Yeah, that was a problem in the early years.

MM: It would take so long to know whether you have tuberculosis because there are other organisms which microscopically look exactly like tuberculosis, but they're not contagious. And some people were isolated for months, literally, before they realized they weren't contagious because they couldn't tell for sure that they weren't.

CP: So what's this probe thing you're talking about?

MM: Now, that's a laboratory test, it's a genetic probe to identify, which can be accomplished in a very short period of time, a matter of hours rather than weeks.

CP: Yeah, I'm constrained to remark you haven't walked through the laboratory here. Today's laboratory, it doesn't even look like a laboratory. It looks like a computer workshop.

MM: Yes, which it really is, I gather.

CP: Yeah, the incubators and the other stuff that you would have associated with, in fact, all the laboratory, none of those trappings are apparent.

MM: No, they're isolated—

CP: They use them little probes.

MM: That's right. And that certainly revolutionized the diagnosis and, I think, for rifampin, revolutionized the treatment.

CP: Yes, okay. Did you have a feeling on immunizing with tuberculin? And I understand that certain parts of the world still practice that fervently, using tuberculin.

¹⁹A genetic probe is a form of testing that identifies a region of genetic material unique to the bacteria that causes tuberculosis and amplifies this area using DNA replication. This method is relatively quick, thus reducing the mortality rate of the disease.

MM: Using the thing about BCG²⁰?

CP: Yes.

MM: BCG vaccination, which is derived from the bovine *tubercle bacillus* and it's better than nothing. If you have absolutely nothing, it is better than nothing. It's a one shot deal; you give it to a person once and you don't have to follow them up or do anything more. But it doesn't prevent much tuberculosis, but it's probably better than nothing. It has very little adverse reactions, almost none, and it's pretty innocuous.

CP: Does it confuse your tuberculin testing?

MM: Not terribly, usually reactions to the BCG are smaller. But it can. The problem is, you can't really be sure when a person is tuberculin positive and they have a history of BCG. And so there is some confusion but generally, the larger the reaction, the more likely it is to be due to tuberculosis.

CP: Do you have BCG as a—

MM: I had BCG, yes. And I've been tuberculin negative for many, many years. Despite my career. (both laugh)

CP: Yes, around tuberculosis. You moved from a, quote, position from reading x-rays, playing like a radiologist, never seeing patients, only seeing pictures of patients. And then, at a certain stage in your career, you got very involved with patients by telephone, commonly, but you did a lot of patient care.

MM: I did a lot of travel.

CP: And you also did TB clinics—

²⁰Bacillus Calmette–Guérin or BCG is a vaccine against tuberculosis that is prepared from a strain of the live bovine *tuberculosis bacillus*. The main use of BCG is for vaccination against tuberculosis. The BCG vaccine can be anywhere from zero percent to 80 percent effective in preventing tuberculosis for a duration of 15 years according to the FDA.

MM: All over the state, including Key West. (both laugh)

CP: Talk about that some, in terms of your feelings. But I want to finish my side quote, you move from that to pure administration where you sat in an office and seemed to—

MM: No, never totally, I always had patient contact. Always. I feel like it's always important to keep some patient contact.

CP: So do I. Okay, that's good.

MM: I also was a consultant with the prison system for a number of years.

CP: That's right you were.

MM: I took care of the tuberculosis patients.

CP: But that was patient contact, patient care. Yeah, you traveled on to clinics and to prisons.

MM: I did.

CP: Yeah, as I remember. That's right.

MM: And at Duval County, I used to go to the clinic in Duval County about once a week and other—

CP: And see patients.

MM: Yes. And even after I retired, as a volunteer, I did some clinic work.

CP: Good, where?

MM: In Putnam County and St. Johns County, primarily.

CP: Good, good you did. Did you have fun? Did they appreciate you?

MM: I did enjoy it very much.

CP: But you quit that, didn't you?

MM: I did because I felt like I was getting rusty.

CP: Oh, I understand.

MM: And I don't think people should continue practicing medicine when they're rusty.

CP: I totally concur. Now, what's the highlight of your career? We talked about the highlight of tuberculosis control.

MM: The highlight of my career? I can't really think of any one particular highlight. I think to see some people get better, to get up out of the wheelchair and start walking again too. I mean, to me that was always the most rewarding thing was to see. And that was one of the nicest things about tuberculosis. It's a disease, but if you treat them, most everybody gets better. So it's—not many diseases that everybody gets better. You get diabetes, you're still stuck with it the rest of your life. But tuberculosis, you can cure it.

CP: Yeah, and a lot of the cancers are that way too, beyond those guys that can treat cancer, you know, they must have a real strong something because their success rate and saving lives is so low. But in tuberculosis it was very high during your career.

MM: Yes, yes.

CP: And through your personal contact, you encouraged them to stay the regiment, stay the course, yeah. And most of them would personally contact (inaudible)—

MM: If they died, they usually died because they had AIDS as well or some other debilitating disease.

CP: Yes.

MM: Not just of the tuberculosis itself, very seldom.

CP: So the height of your career in tuberculosis was seeing patients cured. Seeing patients well.

MM: That's it. It was rewarding.

CP: And none other?

MM: Pardon me?

CP: No other highlights?

MM: None I'd care to mention. (both laugh)

CP: Okay, I won't push you. What have we left out of your career? What should a student 30 years from now want to know something about tuberculosis control by the official health agency—it really became a focus in the United States, which was the 1946 that the nation began to focus through health departments, on tuberculosis control, to do something about it. So if I were a student wanting to research that, what would I have wished that you would have mentioned?

MM: I'm not really sure. I think you have to remember that tuberculosis was the leading cause of death in Florida up until 1917. It was an extremely prevalent disease and throughout the history. It's only been very recently that we have—if you think about, it was the major killer in the Industrial Revolution in Europe and the death rates were like 700 or 100,000 a year in the 1700s, and up to 200,000—up 200 per 200,000 in the 1900s. So it was just amazingly prevalent disease and a very important cause of death and illness. The fact that it has been controlled, I think, as low as it has been is a major medical triumph.

CP: Yes, not to put you in the corner, but what are the current rates?

MM: Well, now, I don't know that because I am retired.

CP: I don't either, but maybe because I'm retarded, but I don't know that either. It's just for comparison and we're not doing a statistical study here, that's not where we're at.

MM: No, so I thank you.

CP: No, that's not what we are after—

MM: I appreciate that.

CP: You just peaked my curiosity, what is it now? I know it is higher now than it was in '96. In '95 was the lowest we've ever recorded in Florida and in the nation, Melbourne or wherever it was. Now, you were dominant part of all of that.

MM: Let's see, when I retired it started going up again. That's—(both laugh)

CP: But it seems like we're missing—we're leaving out something that should be said. I'm trying to think like a student. I am interested in tuberculosis, and I have the opportunity to see, and I can read a lot about you, and I can read the annual reports, I can read the reports of a lot of stuff. There is a lot of written material about tuberculosis and tuberculosis control in Florida. And if I'm a good student, I can find all of that. But to have the opportunity to interview the person who was in the middle of so much of that, what sort of question would I want to ask you? What kind of answer would I want?

MM: I don't know; you're the one that's interviewing me. I did want to say one more thing and that is there was a time when we thought we had tuberculosis completely cured, just about, and totally under control. And the Lung Association [American Lung Association] and everybody, their whole focus was close all the tuberculosis hospitals and treat everybody at home.

And I remember fighting against the Lung Association and just about everybody else to keep our one remaining tuberculosis hospital open. And a few years later, it became very clear that it was the right thing to do, because we have these few cases of tuberculosis that cannot be cared for at home because, basically, they have no home or there is no place to put them because they are too contagious to be around anybody else.

CP: Are too sick.

MM: Are too sick. And so we needed it. So I was glad that I was able to keep that hospital open.

CP: Yeah, there was an effort during that time.

MM: There was a tremendous effort to close all hospitals, treat everybody at home, and everybody would be just happy.

CP: There's actually some money appropriated by the legislature to pay private hospitals.

MM: Yes, that's right. That's right.

CP: To set aside a bed or two, for keeping these sorts of people. Do you remember that? Talk to that just a little bit.

MM: Well, I don't remember it terribly well, but that's the truth.

CP: You're sure it didn't get off the ground a little?

MM: But the problem is that tuberculosis is so un-prevalent now that the average doctor doesn't see a case of tuberculosis. Even if they were all spread out evenly, maybe once every 15 to 20 years the doctor would see a case. So how can you get any experience treating tuberculosis if you don't see any cases?

CP: If you've never seen any cases.

MM: So that was one thing.

CP: You probably wouldn't diagnose it if you didn't think about it also, wouldn't you?

MM: Well, that's true. And that's one of the biggest problems with it; if you don't think about it, you don't make the diagnosis.

CP: Well, you've had an exciting career. You lived through the—or you participated during the period when it was—to me, it was exciting because in the early days there was a lot of money poured into it, both by the feds and the state, and it was the focus of the public health community. And the legislature listened and the general public knew what you were talking about when you said tuberculosis, which is not true today, by the way. And you were right in the middle of all of that. That could have been so much fun.

MM: It was. One of the most fun things about it was when we did all those x-rays, they were x-rayed, everybody was x-rayed with all their clothes on, and we always told everybody to take off their jewelry and take the money out of their pockets so anything metal or something might show up. Well, people would take the things out, but sometimes they didn't. And so I have a large collection of x-rays that have guns in their bras, mostly they are in their bras, because that's where ladies put things, guns, knives, scissors, icepicks, even brass knuckles. So it's a kind of an interesting collection of things.

CP: Really?

MM: Um-hm.

CP: And all this in ladies' bosoms, in ladies' bras?

MM: Yes, mostly.

CP: (laughs)

MM: So that was kind of interesting.

CP: Did you ever have to have any x-rays taken over because this metal object was covering an area of special interest?

MM: Well, usually, it would cover the heart, probably, primarily, and we never, I never did get the—number one, you didn't want people to know that you found the guns or you found the knives because that would keep them from getting x-rays. It wouldn't keep them from carrying

the guns and the knives; they just wouldn't get another x-ray. And they're the type of person that carry guns in their bras are more likely to have tuberculosis than someone who doesn't, you know, in a lot of cases because they probably come from a socioeconomic group that would be more likely to have tuberculosis. So we never made any report about it. Treating them was kind of interesting.

CP: Over their heart, I seem to recall that you found—you were the first to see a lot of cardiac, and liver, and lung disease. You reported that.

MM: I did. At one time, yeah. To see what we found besides tuberculosis, whether it was known to the patients' doctor, whether it could be treated, and whether the patient improved. Because I thought that was important, that if you found something that they couldn't do anything about or something was already known, it didn't make any difference whether you found it or not, so that was sympathy.

CP: Yeah.

MM: But we didn't have any money for research, and it was kind of tedious to do that because I had to write to all the doctors and then call them up if they hadn't responded because I wanted to get 100 percent response to find out if (unintelligible) patient—that was interesting.

CP: Okay, so that's another highlight. You have a lot of highlights. And I don't want to leave anything out.

MM: Well, I think you've covered it all, just about.

CP: You do? Okay, for our audience Dr. McEuen has left with us her CV²¹, which will be available for review, legitimate request to see the tape. So if there're no closing remark, I would tell you, for all of our viewers, on behalf of the library of University of South Florida and the College of Public Health of University of South Florida, again, we are complimented that you would take the time to come and share with us and, in their behalf, I just thank you, sincerely. And, besides that, Dr. McEuen, it's been good seeing you.

MM: Well, thank you. I appreciate very much having been invited.

²¹CV stands for Curriculum Vitae. People in academia and medicine tend to use CVs rather than resumes. CVs include information on one's academic background, including teaching experience, degrees, research, awards, publications, presentations, and other achievements.

CP: Okay, and I am Skeeter Prather.

End of Interview