LGBTQ Oral History Project

Detroit, MI

Dr. Stephen Miller

Interviewed by

Natalie Piernak

12/02/2017

Beverly Hills, Michigan

As part of the Oral History Class in the School of Library and Information Science

Kim Schroeder, Instructor

Fall 2017

Brief Biography

Dr. Stephen Miller grew up in Lancaster, Ohio. He attended Ohio University and Chicago College of Osteopathic Medicine. He has been working in Detroit since his residency at the Detroit Osteopathic Hospital in 1974. Throughout his career he has treated several cases of HIV and AIDS in his private practice and at the Henry Ford Hospital.

Interviewer

Natalie Piernak is a MLIS student at Wayne State University also pursuing the archival certificate.

Abstract

The interview focuses on Dr. Stephen Miller's experiences treating HIV patients in the Detroit area in the 1980s and 1990s. Topics include stigma surrounding treatment and care, initial confusion about how to treat the disease, and patient experiences.

Restrictions

None

Original Format

Wav

Transcription

Available

Bibliography and Footnote Citation Forms

None

Life Histories Oral History Project

Walter P. Reuther Library

Wayne State University

Detroit, MI

Transcript of interview conducted December 2, 2017 with:

Dr. Stephen Miller

Beverly Hills, Michigan

By: Natalie Piernak

PIERNAK: Ok, so this is Natalie Piernak interviewing Dr. Steve Miller on December 2, 2017 at his home for the Ruther Archive's LGBTQ Oral History Project. Thank you, Dr. Miller, for being with us today.

MILLER: My pleasure.

PIERNAK: So, could you tell me a little bit about your background.

MILLER: Um–So, medically speaking so went undergraduate school at Ohio University and then to the Chicago College of osteopathic medicine and graduated from there in 19—uh let's see in 1974 and then came to Detroit to do my internship and residency at the Detroit Osteopathic and by county hospital and that was a year of internship and then three years of internal medicine and then in 1978 I went into practice with two other internists. I'm a general internist um and—(dog barking) So, let's see—so 1978 went into practice. My office was on Woodward just north of um Seven Mile—(dog barking) and—(dog barking) and did um I did office practice as well as hospital practice. (dog barking) So, probably about fifty percent of my time was in the hospital which was Detroit Osteopathic Hospital, now closed. And um that was in Highland Park and it was a very um up to date hospital for its time. The hospital did open heart surgeries and we had a full spectrum of specialists and did that—(dog barking)—until the hospital closed. And my practice was bought by Detroit Riverview Hospital which became then part of the same system that I worked for, the St. John's system um for about eight years. And they went back into a private practice and then um actually did home health care with visiting physicians for about six years. And then I worked for Henry Ford Hospital for approximately eight years and then I retired in January of 19— er—retired in 2014. Or retired in 2014 So, that's a quick background of—the things that I should have covered, but didn't get that you want to hear about in terms of just you know

have covered, but didn't yet that you want to hear about in terms of just you know that aspect—

PIERNAK: Yeah, no. (dog barking) Just trying to set up a background before we got into some of the other questions.

MILLER: Very good.

PIERNAK: So, what attracted you to medicine? (dog barking)

MILLER: Well, I—in grade school and high school I always loved science and I came from a small town (dog barking) Lancaster, Ohio which is outside of Columbus. At the time it was about a town of maybe 20,000. And my interest had always been biologic. And when I was in college and just seeing that premed would be the best thing for me to go into. In a small town if you're into biologic science then— you know you either going to veterinary medicine or you go into medicine. And I went that route. And you know thought it was really wonderful. I love to—I loved science. I loved to educate myself, and who doesn't want to know more about their body. And—and when I was in med school I always considered maybe going into pathology, because that seemed at the time to be the most scientific area of medicine. But then when I realized—patient contact and when—the Med school that I went to had an excellent outpatient clinic and the students took care of many—patients from the South Side of Chicago—and you know just learned to—how wonderful it was to deal with—with patients and be able to help them. At least help them that would listen to you. (laughter)

PIERNAK: Um-hm.

MILLER: And then when I came to Detroit, I knew that I would go into internal medicine—just in terms of patient contact and really helping people at a very basic level of health care. And again, we're talking you know 1974 to 1978 in terms of clinical years. And you know medicine has advanced so much since that time. But you know it was very, very rewarding and certainly saw the need for internists in the—general internists in the greater Detroit area. So, that's why I went into practice, because I was able to stay at the hospital where I did my education and knew how that system worked.

pause in recording

PIERNAK: Um-hm, okay. And how did you end up starting your own practice? Where was that?

MILLER: Um the—again, the practice was an internal medicine clinic that was on Woodward north of Seven Mile. The founding doctor of that clinic practiced out of of Detroit Osteopathic Hospital. So, when I finished my residency he asked if I wanted to join his group. Uh, his group was all of two doctors. So, I was the third doctor. And um— so, that's—that's how I um—you know that was the first practice that I went into and was within that practice for maybe—six or seven years. Um—and then I went out with one other doctor and stayed in Highland Park which is where the hospital was. So, that's you know how I started. And you know—as I'm sure you're aware the Woodward, Six Mile—expanding up to Seven Mile—I mean

um—in you know 1974 time that was certainly a very gay area. So, I started to see a fair number of gay patients at that time. Certainly, AIDS was unknown at that time. But um—you know lots of sexually transmitted disease and other factors. Um—so—you know that's how I ended up in that original practice.

PIERNK: Ok—And when do you remember HIV showing up in cases in Detroit?

MILLER: Yeah that—that would have been—let's say I finish residency and '78 went into practice and probably saw um—I think AIDS was first recognised about 1983. So, it was right around 1983 that I saw my first case of pneumonias. Certainly, AIDS was not known as AIDS at that time. It was all—of the information that the doctors got was pretty much through the CDC [Center for Disease Control and Prevention] and the MMWR [Morbidity and Mortality Weekly Report] reports from San Francisco and New York City about these weird cases of gay men coming down with strange pneumonias and skin cancer like Kaposi sarcoma and collecting data. Um and that's how this was associated with death—sometimes you know within a year of diagnosis. And ultimately, you know it was GRID—Gay Related Immune Deficiency. Since most of the cases were of men who have sex with men—and—you know it was probably for a year that HIV was referred to as GRID. I remember before—um, even GRID, I saw one or two gay patients in the office. They had a myriad of infectious diseases mostly sexually transmitted weird skin rashes and had no idea of what this—what I was seeing, because nobody knew what they were seeing at that time. And this was before even the collected data. And I'm sure most physicians who saw a fair amount of sexually transmitted diseases you know probably would have similar stories. And those people you know I just treated the diseases that I could diagnose.

PIERNAK: Right.

MILLER: —realizing that something much worse was going on. And then eventually when by the time that there was a name for this virus or that it was even found out that in fact it was a virus that—um—You know there was quite a few people that I would see that would meet the criteria to be called AIDS. Once we could diagnose T cells and later on viral loads of—of HIV and could classify the patients. And then we went years without any treatment for you know the virus, because the first drug AZT—It wasn't till like oh—1987 before we had even a drug. And certainly, now I mean—AZT was—you know we were thrilled that we had a drug to treat. But then you know retrospectively, I mean AZT was a—not really a very good drug um—given all of the side effects. And again, we were doing monotherapy at that time with AZT. We were thrilled to have a drug that we could treat, but then we saw that it maybe just slowed down the course of the disease for a very short period of time and then people progressed and went on to die. You know initially when I was treating HIV patients you know—I could get the patients through bouts of an infectious disease problem that they may have such as a Pneumocystis pneumonia um—and certainly Candida of the mouth [unintelligible] could treat those things. But really, we weren't treating the underlying disease, because there was really no drugs to treat. So, then you realized—I realized that really what I had was a hospice practice at least in terms of the HIV patients that I was seeing at that time.

PIERNAK: Um-hm.

MILLER: So, that—you know took lots of compassion and emotion. Some HIV patients were just so angry that you know it was them that had this disease. Um—but the vast majority of patients that I would see were um very, very um—thankful for whatever treatment I could give them. But there were a few patients that just couldn't get past their anger. And you know went on to die usually pretty ugly deaths just—just because they couldn't accept. And maybe because they had no one around them that could accept that you know—the fact that they were dying of AIDS and a gay related problem. Um—I started seeing females who were having HIV. And again, those were usually women that had the disease through IVDU—intravenous drug use.

PIERNAK: Um-hm, okay.

MILLER: And um—there was a physician at Harper—a female physician at Harper who um—and she was infectious disease and she—was my referral base for females that I saw who were diagnosed with HIV. And I tried to get them to her. Um—but you know the whole thing developed over the course of you know of years once it was known what the—what this disease was really due to— then —I'm trying to think of when the first—There was a—It was in Washington D.C. at the NIH [National Institute of Health] and it was like the first AIDS um—congress and I went to that. And it was—That was the first time I realized that um—that this virus was being understood. They had a better genome type and the genes that would produce X number of um—proteins and then all of a sudden you could see that there were markers that could—could be targets to treat and then drugs would develop. But that was probably oh—eight or ten years after um—AIDS, you know had a name. Um, and I can't remember. There were several Detroit area physicians that were very um—instrumental in HIV treatment. One in particular at Henry Ford Hospital which was Evelyn Fisher. I don’t know if that name rings any bell with you. And off the record I'll talk to you about her. But she—she was just absolutely fantastic. The gay community was very, very supportive of her. But in the initial um—time when AIDS was just—just beginning to be understood there was lots of fear and there was lots of loathing of the patients. And fear by doctors and nurses and um—caregivers in the hospital, because people had no idea if they touched an AIDS patient if they could get the disease, because the mechanism wasn't really known. That was before—

PIERNKAK: Yeah.

MILLER: —they even knew it was a virus. So, I mean lots of fear and loathing. By the same token you had people that were very um—went out of their way to treat people that had HIV. And I think Henry Ford Hospital in particular had a ward for that. So, should probably give you a couple of names. I don't know if Markowitz—Norm Markowitz, but he was—He has been treating HIV since day one and he’s at Henry Ford and probably somebody that would have much insight with that. And then off the record of talking about Evelyn Fischer.

PIERNAK: Okay, yeah. So, you kind of started covering a lot of my questions in that last answer, but that's great! Um so—So, you talked a little bit about um—the stigma that people um were having and then also a little bit of—of how the

stigma that people um were having and then also a little bit of—of how the hospital's reaction was to them. Once they started kind of knowing what the disease was um—was there still like a specific stigma that people of the gay community were still facing from hospitals even though like they knew that like it wasn't going to transfer by touching them anymore?

MILLER: Well, again it was even though it was understood that it was sexually transmitted, or blood born in the case of IVDU, you know it took years for people to come around. And again, they have a lot of—oh, religious over—oh, religious—a lot of religious aspects to this and that there were absolutely people that felt that this was just God's—way of dealing with gay people. And this is a good way to kill off gay people. And that um—especially since initially it wasn't known. And B there was no treatment and they—they were aware that people would just die. I mean you—

PIERNAK: Yeah.

MILLER: —have President Reagan who never even used you know the word AIDS until maybe the year before he was out of office. So, you had high government officials who were not giving money to HIV research at least not what should have been given until groups such as ACT UP [AIDS Coalition to Unleash Power] were around that were in your face with politicians and doctors at the NIH who really were very caring and wanted at most to do all that they could do. But if it wouldn't been for organizations such as ACT UP then I'm sure it would have been—the treatment would have been delayed. But again, it was sort of accepted behavior that these are just gay people were getting none—and let's don't worry or IVDU people who maybe didn't deserve to be treated.
(dog barking) at least that's how I—(dog barking)—perceive it. (dog barking)

pause in recording

PIERNAK: Ok. So, what were some of your patient's experiences with hospitals at that time?

MILLER: Yeah, there—many of the patients that went into the hospital did well and we learned how to use certain drugs such as steroids treatment of Pneumocystis Carinii pneumonia which initially was poo pooed, because you had someone that was severely immunosuppressed and then you're going to give them a drug that theoretically is going to make them more immunosuppressed. But um you know we found that steroid treatment would help people get off of ventilators who had Pneumocystis Carinii pneumonia. So, there was definitely some positive things, but there were some very negative things. We'll just call the first patient Tom—and Tom was an architect. And um I saw him over the course of about a year or a year and a half go from a—you know bright, interactive person to someone who had AIDS wasting. And the story is, is that I put him in the hospital because of his waisting problem. He had probably lost thirty-five or forty percent of his body weight. So, is pretty much skin and bones and I figured when I hospitalized him that he would most likely die on that hospitalization. So, I saw him and came back the next day. You know he was weak. He didn't have a lot of you know energy. He was dying. And when I came back the next day he was very, very angry. And I found out that—In the hospital systems, I will call them rent-a-

very angry. And I found out that—In the hospital systems, I will call them rent a nurses, because it wouldn't have been enough of the normal hospital staff. So, they would bring in—

PIERNAK: Um-hm.

MILLER: —nurses from agencies. And this one nurse was a—had a thing against AIDS patients. And she was dealing with him and um you know just told him that you know against God's will and good thing that your dying. You know again—

PIERNAK: Yeah.

MILLER: —this was like at midnight or one in the morning when he asked for something and you know he has IVs going. And he then—when I came in in the morning he actually got up out of bed and had this energy that I hadn't seen him since—for a long time, meaning months. And his anger ended up being a very positive emotion. I usually don't think of anger as being a positive emotion, but it got him probably two or three months of life, because of how he was so mistreated.

PIERNAK: Yeah.

MILLER: And had to deal with this person put him down, because of you know this disease and no one should have to go through that. But again, and he died ultimately at home surrounded by his family. There was a—a person whose name was Bob. And he—he didn't want anybody to know that he had AIDS. So, his only family was a sister. So, um—I didn't have a lot of interaction with her. I would see her when I would tend to Bob in the hospital. But everyone knew that it was not to be discussed that he had AIDS. and that he was dying. And he came into the hospital ninety-nine percent knowing that he would probably die. So, the staff were all very cognizant when she would ask questions they would just say, "Well please, you're going to have to talk to the doctor" or whatever. But again, there were all these you know infectious disease signs up on the door. He was a gay man and I don't think ever have that discussion with his sister as such. But um you know you would think that people would put two and two together. But at the time there was a lot of denial. So, as things got closer to death I ask him if he would like to see a gay minister who was tending to people with AIDS. And he said, "Absolutely, please". So, I brought the minister in. And he saw Bob a couple of times. And then one day he was there when his sister came in. So, the minister told the sister that you know that he—you know he was dying of AIDS. This was like a major shock to the sister. And again, you had all of this emotion that went along with the disease at the time. And so, you had a dying man now having to deal with the aspect of his sister finding out why he was really dying—

PIERNAK: Yeah.

MILLER: —And you know she was she was accepting, but he was very unhappy that um—by the hospitalization she found out. Along. There was a story that I just won't forget. There was a Hispanic man who was married and—obviously very bisexual. And he you know he looked like he was very well, but in fact he had multiple disease states going on with different viruses and fungus infections. And he had developed a couple purple spots, so he had Kaposi's. But you know when he

had clothes on you know you would think he was just an average healthy guy. So, the story is that he was in the hospital and he started to get sicker. And his wife was there. And his wife knew. They had children. His wife knew that he you know had AIDS. And you know she wanted to know when he would get out of the hospital. I said I'm sure by the end of the week he would be out. And she said, "Well, good because you know we've got to get home. I want to make sure that we continue with our sexual activity." And you know I said, "Well fine, but just make sure that you know condoms are used." And she was like aghast. She said, "Oh, I would never have sex with him using a condom." And I said, you're going to you know get AIDS." But I had no idea how many times they've been sexually active. But you know I was just—found it an unbelievable state that someone that was seeing their spouse dying of AIDS—

PIERNAK: Um-hm.

MILLER: —you know would risk that sexual behavior. I could not understand that. He eventually did go home and then died probably two or three months later again, of all of these underlying diseases. And again, that was at the time when all we had was AZT may be a drug called DDI which was the second drug. But nothing—I mean it was nothing compared to what we have today. So, I mean there's just you know tons of different hospital stories at that time.

PIERNAK: Yeah.

MILLER: So that's a few that I just wanted to talk about.

PIERNAK: Okay, and um—so, you mentioned that it kind of became a hospice service basically for you?

MILLER: It—it was a hospice service—

PIERNAK: Yeah.

MILLER: It was a hospice service up until the time that we started to use multiple drugs.

PIERNAK: Um-hm.

MILLER: A that we had multiple drugs to use and that they were given all at once. It wasn't like one drug at a time—

PIERNAK: Right.

MILLER: which was the case for years. You know one drug at a time and then we started to use multiple drugs. And the real change was when protease inhibitors came along and then—then you could actually see treatment when you would follow a viral load you could see it go down—

PIERNAK: Um-hm.

MILLER: —and stay down. And initially the first protease inhibitors were given multiple times a day. But um you know my because now I mean you know you can

multiple times a day. But um you know my heavens now I mean you know you can take a pill with three or four drugs in the pill and it's you know once a day—

PIERNAK: Yeah.

MILLER: —as opposed to maybe five or six drugs with all their side effects and usually GI side effects that would really affect you know people's lives. And once the protease inhibitors were coming along then you could see real effect on the—on the disease.

PIERNAK: But with um—same with hospital providers, did you see any stigma with hospice providers once people left their hospitalization or went home did they have any problems like even getting like that end of life care as well?

MILLER: Well, interestingly I was sort of the hospice provider.

PIERNAK: Yeah.

MILLER: And I mean so people that had families they would take care of the patients and I would go to the homes. But you know initially it wasn't—it wasn't like you were giving care to the patients for months and months it was usually like —

PIERNAK: Okay.

MILLER: —once they got really sick they usually died within a month or two

PIERNAK: Okay.

MILLER: —um of the hospice that I would use—actually, there was more trouble finding funeral homes that would take the AIDS patients.

PIERNAK: Okay.

MILLER: That was you know a real problem initially. I think there was only one or two funeral homes that would even show people with HIV you know during this time

PIERNAK: Right.

MILLER: where people were really, very, very much afraid. One time I had a patient to die. He very much wanted me to do an autopsy on him so that I could learn what I could learn from his death. He had something called the Cryptococcus meningitis and this was in the day before we had Diflucan. You know Diflucan is just used everywhere now. But at the time I actually had to get the drug as part of a study. This was before it was approved. And you know you had multiple Cryptococcus meningitis and Cryptococcal organisms in his brain. There's a test called an India ink stain and that was just loaded with organisms. Well, he died and the—you know I ordered an autopsy. He died in the hospital. I ordered an autopsy and um the—it was a weekend—it's always a weekend and the covering pathologist for our hospital was from a different hospital and he told me that he refused to do an autopsy. And I said, "Well you know this person wants me to learn

refused to do an autopsy. And I said, "Well you know this person wants me to learn from him. And I very much want him to have the autopsy." And the person who died was a lawyer and he—and I told the pathologist I said, "Well, you know he is a lawyer and there are legal forms here." So, the next thing I knew was that that pathologist refused to do it, but that pathologist got another pathologist to—even though he wasn't working that weekend to—

PIERNAK: Um-hm, yeah.
MILLER: —come in to do the autopsy. But and— I had physicians come up to me and say, "Well, you know Miller, why are you treating all of these HIV patients?" You know um—and again some of that would be because I would ask specialists to come in to see them and you know they really didn't want to have any part of that. You know not necessarily the pulmonologist, but I mean lots of lung complications.

PIERNAK: Yeah.

MILLER: So, you know it could have been a cardiologist or a GI doctor—lots of GI disease with HIV before there was effective treatment. So, there was—there was definitely fear and loathing. The ID doctor that was at our hospital—you know again there was not drugs to treat you know—the ID doctors really didn't come along and really get active with treatment other than Evelyn Fischer as I mentioned and Markowitz, Norm Markowitz at Henry Ford. There was nothing to treat them. So, they were you know just being primary care doctors and also doing hospice care.

PIERNAK: Um-hm.

MILLER: But once there was drugs and they could be used with efficacy then they —then the ID doctors started to man the ship to do what is right for—in the Detroit area of HIV patients.

PIERNAK: Um, so—so, also talking about a little bit before what you said that a lot of your patients had different emotional reactions to having the disease. Were there any community based counseling or support services available at that time in Detroit or—?

MILLER: Yeah, they—they came along relatively early. Oh, well you know the only one I can think of right at the moment is CHAG [Community Health Awareness Group]. And CHAG pretty—pretty much was tended to the black community—

PIERNAK: Okay.

MILLER: —in Detroit and had an office on Jefferson. And I don't know why there was at least three or four other—two or three other agencies like AIDS—AIDS prevention. I can't think of the name of—

PIERNAK: Okay.

MILLER: —these organizations—

PIERNAK: Yeah.

MILLER: —but there were absolutely support groups.

PIERNAK: Yeah.

MILLER: Um, there was a—a social worker. Her name was Eve Mokotoff and she may still be doing things with HIV now, but I think it's more of a state level. But I mean there were—and there was support groups definitely at Henry Ford and my patients absolutely would go to these support groups. One of my patients who's a long-term survivor and I took care of him up until the time that I retired in January 2014. And you know I was talking to him one day and I said, "Well, are you still going to you know the AIDS support group?" And he said, "Well no." And I said —I said his name. And I said, "Well why—why aren't you going?" And he said, "Well, because you go, and you see these people. And then you go and they're no longer there because they've died." And so, a lot of the patients just saw the handwriting on the wall and couldn't deal with the fact that you know they were —Everyone is doing all that they could—

PIERNAK: Um-hm.

MILLER: —but there were fellow AIDS people—fellow people you know were dying and the handwriting was on the wall. So, they were there for a while and then quickly stopped going because they couldn't deal with the inevitable loss was going to be for their life. So that was—I'm sorry I can't think of the name of the different organizations but—

PIERNAK: Yeah, no that's fine.

MILLER: there were—there were several. There were several.

PIERNAK: So, there was a presence.

MILLER: Absolutely—

PIERNAK: Yeah, yeah.

MILLER: Absolutely.

PIERNAK: And how do you feel the stigmatization affected patients in the 80s compared to now? Do you think there's less of a stigma for anyone with AIDS or —?

MILLER: Oh I—you know I do. I think that its—I think some of it is age related.

PIERNAK: Um-hm.

MILLER: If someone is really, young and they know now that all they have to do is to take PrEP they're left –they're less—they may be less likely to have condomless sex which is really you know you know bad but—So, I think there's less stigma. I mean you know we certainly have gay marriage now and you know a

lot more you know acceptance of gays. But I think as far as AIDS are concerned —AIDS is concerned it's really just you know there's still some stigma. I think that people can certainly live their life now and get to be you know old whatever that means.

PIERNKAK: Yeah.

MILLER: But they—I think still a lot of risky behaviors. Plus, now I mean you know with—well, there's treatment now. But in the past, I mean like even for hepatitis B there wasn't good treatment—

PIERNAK: Yeah.

MILLER: —and people would die of that—hepatitis C. So, people with HIV could have both A—excuse me could have both B and C hepatitis which would advance their demise. You know syphilis—and several patients who are HIV positive who had syphilis that were treated multiple times for it and both because some of it was a failure of treatment.

PIERNAK: Um-hm.

MILLER: Or number two they would get reinfected. (dog barking) There was one HIV patient that I had who had pretty severe HIV disease. I'm sure he was in—well for sure he was in his last year of life. He kept coming back with gonorrhea that he would get from his partner. So, I couldn't (dog barking) understand that a whole lot either.

PIERNAK: Um-hm.

MILLER: Again, obviously no condoms being used. But again, people have there you know life. It's just that they could have had a longer life had they done things —that would have protected them more.

PIERNAK: Yeah.

MILLER: So—(dog barking)

PIERNAK: That kind of goes into—to my other question is like—Do you feel that people are being more—using more protection now or are they starting to use less again because they think that they're—it's not that big of a deal to have AIDS since there's more treatment?

MILLER: I think you know—I think with the PrEP people use people may not be as—may not be as vigilant (dog barking) in using condoms now because—because of that. But again, it's so individual.

PIERNKAK: Yeah.

MILLER: I mean you know it's so—can't really make blanket statements. At least there is some protection as long as someone has insurance that will pay for it.

PIERNAK: Right

PIERNAK: Right.
MILLER: It's quite expensive if they don't have insurance that will pay for it. And certainly, I think just you know general knowledge people you know know about it more. (dog barking) I think—I think teenagers are less likely to have a true understanding of–of what really it's all about. I am aware of you know people coming out of high school and you know having HIV you know that they—that it happened in high school that–and yet and I'm talking of recent date—

PIERNAK: Yeah.

MILLER: And I would expect those kids to be relatively well-informed, but you know being informed and acting out sexually are really two different things.

PIERNAK: Right.

MILLER: Certainly, the information is there.

PIERNAK: Yeah.

MILLER: That's a very—very disconcerting point. You know where one young man who came out of high school, graduated relatively recently. And yet this child's grandfather or young man's grandfather has been HIV positive for years.

PIERNAK: Um-hm.

MILLER: And you know certainly this kid knows all about the stigma—the physical stigma of HIV from his grandfather. And yet you know he acted out with someone who gave him HIV. And that—

PIERNAK: Yeah.

MILLER: —that to me is so hard to understand. But again, the passion of the moment versus understanding.

PIERNAK: Right, right. And just kind of going—piggybacking on just those people having information about the disease. Do you think there's any better ways that people could've handled treatment or the education surrounding it at the time?

MILLER: And like what time are we talking about? Your talking about—

PIERNAK: Oh, when it—when it first started coming out—

MILLER: Oh, absolutely—

PIERNAK: —first started understanding it.

MILLER: Starting with the government with—with—with recognizing that this problem existed and putting the monies into try to stop it. Look at all the hullabaloo that we had with oh what's it—the disease that pregnant women were getting that was causing the agenesis of the brain recently? Oh, it's oh god—Sorry, can't think of it.

PIERNAK: Yeah, no that's fine.

MILLER: But it's a— it's a mosquito—carried virus that cause the brain—So, I mean there were lots of monies that you know were put forth to attack this problem.

PIERNAK: Yeah.

MILLER: This is within the last couple of years, but you know there was just so much stigma against AIDS and in particular against you know gay men that you know nobody really got (dog barking) behind that from the president at the time you know on down. So, if (dog barking) if they would have recognized that we need to do more and again that's where this ACT UP—I really think the ball turning there goes back to ACT UP and really getting (dog barking) pharmaceutical manufacturers and you know the medical system (dog barking) to really come around that I think that (dog barking) was what really turned the tide for HIV. And the myriad of physicians and researchers to develop these drugs and learn how to you know to use them and in a relatively timely fashion. Once the monies were available for—for development of the drugs.

PIERNAK: Um-hm. And do you remember any like education campaigns that were going around at that time? Or how they were treating the education surrounding it at all?
MILLER: Well, you know again in the medical journals and in you know billboards that I would see, yes. I saw very little on television as opposed to now where you know sex is talked about a bit more freely. And you know condoms and lubricants and whatever are advertised on TV. But you know I just think there was not—there was not an organized educational program other than the written word.

PIERNAK: Um-hm.

MILLER: It's certainly not though—certainly not on TV at the time everything that's coming out was always the negative aspect (dog barking) of AIDS. But yeah there could have been more. (dog barking) And again nurses and nursing educators (dog barking) but see guys would actually have to go to these meetings to hear about these things—

PIERNAK: Okay.

MILLER: —as opposed to (dog barking) you know it being more freely shared maybe on TV or whatever.

PIERNAK: Right.

MILLER: Or go to a doctor or whatever to you know to learn more. But you see now a doctor would see a patient because they're sick and HIV will be diagnosed. You wouldn't have a healthy individual come in and say, "Talk to me about HIV and what they should know."

PIERNAK: Right, yeah. (dog barking) So how did you feel about becoming a well-known HIV AIDS doctor? Was it intentional or just come kind of fell into?

MILLER: Oh, I—I think they just fell into it.

PIERNAK: Yeah.

MILLER: There were—there were um (dog barking)—first of all that—you had to be someone that wanted to treat this problem—

PIERNAK: Yeah.
MILLER: —and to treat in my case gay patients who were sick. And so, I remember I think it was at Marygrove where there was a day (dog barking) that the HIV treaters—and this was early (dog barking) in the course of HIV—you know got together and had different lectures. And there was a fair number of people that came to that, but it was one of those things that you know your friends would refer you patients—

PIERNAK: Um-hm.

MILLER: —initially and then all it took was just someone (dog barking) that was compassionate, and could you know handle and wanted to handle the problems. And the practice just grew exponentially. It's interesting when AZT first came out and I believe that was in 1987. And I had a detail person come in my office who worked for Glaxo Wellcome and that's who made AZT. And I don't know if you know how the pharmaceutical system works, but every physician in the United States is monitored by the pharmaceutical industry. (dog barking) So, the—when a doctor writes for a drug, in particular a brand name drug as opposed to a generic, but in the time that we're talking about there really was no generic drugs it was all brand name drugs. (dog barking) So, they would collect that data. The pharmacies would collect that data. So, when I got this detail person come in— and I don't want to say his name. He said, "Oh I see that you're prescribing AZT. So, do you have a fair number of HIV patients?" And I said, "Well yes I do." And so, (dog barking) the pharmaceutical detail people for all of these drugs were instrumental in educating HIV treaters about—you have use of the drugs, because these were you know new drugs. And so you know I found out that in the Detroit area there were really only two doctors initially writing for AZT when it first came out. Me and one other doc (doctor). So, and then—exploded once they—you know over a period of time. But initially, because we were all so much in need of you know of a drug. But the pharmaceutical industry was very good about educating us on you know the drugs. Too bad that more wasn't studied about using multiple drugs at one time as opposed to just one drug.

pause in recording

PIERNAK: So, you talked about it a little bit before that to be—doing this kind of work you had to be someone who is compassionate enough to want to deal with the situation. Could you talk a little bit about, if you want to, how it impacted you personally to be dealing with this all the time?

MILLER: Yeah, um. It definitely impacted me just because in the normal population of patients that I would deal with I mean you know it was hypertension and diabetes and you know colds and whatever um—common diseases. But

and diabetes and you know colds and whatever uh—common diseases. But initially dealing with all of these deaths—just actually showed me how important life really was. You know when I was going through residency most of the people who died were you know older people. They lived their life and you know they would die of congestive heart failure or whatever. And you felt bad, but here you had people—that were my age or younger you know dying these horrific—wasting deaths. So, I think it taught me how important life really was. And the vast—by far the vast majority of these patients you know were very appreciative of whatever I could do for them as were their families.

PIERNAK: Um-hm.

MILLER: And again, some families were very angry that you know their son–you know had died. Why couldn't we have done more? Or—when really there was little—little that we could really do. In the hospital there was one time a young man probably in his early 30s died. And again, this was before there was much there could be done, and his significant other time had the same disease that was not as—progressing as fast. But one gentleman—his first name was Andy and I had taken care of him for a while—he died in the hospital. His sister came in and was with him when he—er no, he died and then the sister came in and maybe about an hour later. And I just you know told her that I was so sorry that Andy had died. You know she says, "I don't want to hear that. You know you could have done more to have kept him alive." And you know you just have to look inward and realize that— so people were just dealing with their own anger and frustration.

PIERNAK: Yeah.

MILLER: You know why this happened, but—it really taught me to be as compassionate as I could. I always liked working on the oncology unit when I was in my residency and you know you're dealing with death and dying there.

PIERNAK: Um-hm.

MILLER: But you know usually now with at least in my case not with the younger people—

PIERNAK: Right.

MILLER: —but at that time you know middle aged and older. But you know this was—this was such a different you know disease. And here you have a virus that is causing all of this death *and* the amount of knowledge that we learned through HIV—I mean about you know viruses and how to approach the treatment in particular of retroviruses which is what HIV is. And it doesn't necessarily translate to like treating the common cold or anything—

PIERNAK: Right.

MILLER:—but it's just gave us so much insight into you know this disease. So, I was very happy to you know—to be part of that from the—from the get go. I mean that was very—it's been you know really very rewarding so—and obviously the ongoing problem.

PIERNAK: Yeah. And just—just the last question. Was there any other story that you wanted to share?

MILLER: On my cheat sheet here, I have some other stories, but—I'm afraid that I can't really—can't really go through those.

PIERNAK: Okay, yeah! No that's fine. Thank you so much for everything that you have talked to us about. I really appreciate everything that you shared!