UNIVERSITY OF HOUSTON ORAL HISTORY OF HOUSTON PROJECT
AND
THE AFRICAN AMERICAN PHYSICIANS OF THE 20TH CENTURY HOUSTON PROJECT

Interview with: Dr. S. Weaver
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TO: Ok today is December 1, 2006 and we in Dr. Weaver's office on Bellaire Blvd. in Houston, Texas. Can you discuss your educational background, plus where you are from and then go into your educational background? Yeah I think that if you look at me it is more natural.

SW: I was born in Houston, Texas. I am a native Houstonian. I grew up mostly in Third Ward. I attended Yates High School and went to college in Upstate New York at Rensselaer PolyTechnic Institute. I graduated from there and came back to Houston and went to medical school at Baylor College of Medicine.

TO: Can you speak a little bit louder?

SW: O.K., I'll try. Following graduation at Baylor, I went to Los Angeles, did an internship there in internal medicine for one year and subsequently specialized in dermatology. And so, I was out there for another 3 years. Then, moved back to Houston in 1982 and started in private practice in dermatology and have been here pretty much ever since.

TO: O.K., so what year was it when you graduated from Rensselaer?

SW: 1974.

TO: 1974. O.K., so the application process to medical school - did you apply to several or were you just interested in the Medical Center?

SW: Well, I applied to probably 8 or 10 different medical schools. I was accepted to 3 medical schools but then, between like December or January of my senior year in college. And I participated in the summer program at Baylor for college students and they actually had a summer medicine, not a summer, a winter break job working with one of the Bio-Chemistry professors at Baylor in his lab and when it came time to decide where I was going to medical school, the tuition costs at the Texas Medical School at that time for a state resident were like $100 per quarter. So, my whole medical school tuition was about $1,200. So, I came back home and went to Baylor.

TO: So, it was totally financially driven or this professor, what was his name?

SW: It wasn't totally financially driven. It was also driven by the fact that I had a personal friend that were attending Baylor. And so, one of my high school classmates who was 1 year ahead of me recruited me pretty strongly and actually at the time I was at

Baylor in medical school, there were probably at least 5 Yates graduates there, throughout the different classes.

TO: And the other schools you applied to, where did they fit as far as ranking goes because I know Baylor has a great reputation, I do not know back then?

SW: Well, I was accepted at Howard University in Washington, D.C. I was accepted at Meharry, I applied to some California medical schools but it just kind of came down to the fact that it was convenient to come back to Houston and go to school here.

TO: Now, your classmates from Yates, the one classmate that was already in Baylor, did he relate his experience that he was having a good experience at medical school here at Baylor?

SW: Medical school was tough. It was not easy and there were a lot of barriers to overcome at that time. The approach that we took to, getting, overcoming the obstacles at that time was really to work together and study together. So, we formed study groups and exchanged class notes and things like that. And all the individuals who worked together and studied together succeeded and graduated. And there were some people who chose not to participate in the study groups. They didn't stay there for 1 or 2 years, they kind of flunked out.

TO: So, these barriers were classroom-based driven barriers or just . . . barriers?

SW: I would say multi-factorial. I started Baylor in 1974. Baylor had their first African-American black medical student in 1969. So, there was probably one in that class. In 1970, there were 3 black medical students. In 1972, there might have been 6. In 1973, there were 11. In my class, there were 13 black medical students. So, there were some professors that had been there for 20, 25 years that weren't used too many black students in their classes, so it was something different. At one point, the medical school didn't have very many females in the class. They were pretty much all male and all whites. So, it was a transition. So they had ladies and then people of color. So, it was a transition period in time. Then, there were some other factors like probably 20%, 25% of our class were Rice graduates and those individuals who had gone to college at Rice had the opportunity to sit in on medical school classes as seniors in college. So, when they got there, some of the classes were review work. There were certain classes where, you would walk in to the anatomy class and the anatomy professor knows the student's first name on the first day of class and you'd say 'how did they know that student?' well they had been coming for a year while in college. So it was things like that, too, were just, say, technical advantages that certain individuals had.

TO: But your Rensselaer education, that's a highly rated school.

SW: Correct.

TO: And what did you major in?

SW: I was a chemistry major there. Originally, I was interested in biomedical engineering but I decided that I liked people better then things, so I switched from the engineering, and just was in chemistry which I liked a lot, and used that to apply to medical school. So, academically, I was prepared for medical school and I did well while I was there.

TO: Right. What about the transition from Yates to Rensselaer?

SW: The transition from Yates to Rensselaer was pretty much culture shock on several different realms. I went from a school that was staffed by faculties that were supportive of students, always encouraging and pretty much wanted to help you succeed. At Rensselaer, it was in upstate New York and it was an engineering school so some of the faculty were not the easiest to relate to. That is just the way they were. The culture in New York is not as personable as growing up in Houston. People were not always concerned about you and not always as friendly. So, besides the fact that I went to Rensselaer on a campus of about 4,500 students, there were like 48 black students, it was less than 1% of the student population. I think it was 45 students out of 4,800. So, it was a culture shock for that reason, from going to the south to the north, going from the predominantly an all black public school education of Houston to something totally different. So, it required multiple adjustments.

TO: My wife is from Korea and when we moved back to Houston she moved to American for the first time and she went to grad. school at U of H. They, Koreans are very cliquish, and all the people who were her friends were Korean. So, at Rensselaer, was it similar? Was it all black students together?

SW: There was an organizations of black students called Black Students Alliance that I belonged to and pretty much most of the black Americans belonged to. There were individuals who were from, say, different parts of Africa, they weren't from this country they did not belong to that organization because they really did not consider themselves as black American so there were cultural differences between individuals from other countries. But the individuals who came from New York City were a combination of, you had black Cubans, you had black Puerto Ricans, you had blacks from Jamaica - all over the place. So, it was kind of multi-cultural from that perspective.

TO: So, if a student is listening to you discuss this experience, what was it that you think that . . . some of the key factors that got you to succeed because you went to Rensselaer and then to Baylor and obviously you are now a successful practicing physician?

SW: Well, several things happened when I was at Rensselaer. You said what are some of the factors that helped me succeed, well number one was that I wanted to succeed. So I went to class. I tried to do my work. If I didn't know how to do it, I would go see a tutor and get professors to help, go to study groups and things like that. One of the professors at our school developed a community service project while we were there

which involved going out and doing sickle cell screening testing in the community in Troy, New York were Rensselaer is located. And it had been determined that there was a greater than higher incidence of sickle cell disease in that community and a lot of the people that lived there migrated from South Carolina and historically, some of the slave ships or whatever, that came to this particular community, had a higher cluster of individuals with sickle cell disease. So, the students on our college campus, the black students, actually we put together a project that we screened, set up screenings authorized by the New York State Health Department, to do some screening for sickle cell disease for the community, to help identify carriers and things like that. So, there was a fund raising event put together. There was a screening session set up at different sites. I think at that time, there was a movie put out that involved Bill Cosby and was about sickle cell disease and things like that and they showed this movie, the night before our first screening event, there was a snow storm and we still had like over 350 some people show up on a Saturday come in to get tested. It ran for about 4 to 6 weeks. So, that event was initiated by one of the, this probably was the only black professor on our campus and his name was Paul Zuber. He had actually been a, formally he was a practicing attorney and somehow or other he got transitioned from being an attorney to teaching environmental studies at Rensselaer and mostly to graduate students, but he worked with the black students to set up this project. And so I probably learned something about leadership from him and doing things there that I might not have had that opportunity at other colleges. But it was just kind of being involved and, do what you think it takes to succeed.

TO: One of the high school science teachers that in doing his lesson plans has some questions about sickle cell and he wanted a description of the patient, the symptoms, and how you diagnosed the disease. It sounded as if it was just like a cattle call of anyone that might be in that danger area to some and get a test from what you described.

SW: Well, the incidence of this disease that is more common in African-Americans so that was kind of the reason for folks on the black community at that time. In terms of what the symptoms of the disease can be, it really depends on, I guess, how well preventive measures are taken and at this point in time, I know there are different things that can do to try to help prevent crises but individuals that go into crises who have sickle cell disease, the oxygen, transport capabilities of the blood cells is diminished because the shape and the structure gets altered and blood flow is impaired. So, it can cause severe pain. As far as dermatology is concerned, it sometimes causes ulcerations and breakdown of the skin which is why sometimes dermatologists end up treating patients with sickle cell disease, but some of the original crises develop for individuals who have the trait and not the disease that they are in high altitude environments or low oxygen environments that can precipitate a crisis in people who are carriers of the disease but don't actually have it. I think that was one of the circumstances that led to some conclusions in the military at one point, was that blacks weren't qualified to be pilots because they couldn't handle the altitude. So, some of the guys that were getting altitude problems were actually having sickle cell crises triggered by the low oxygen content as opposed to some physical racial impairment. But I think genetic counseling and testing

and managing things related to the disease right now, they are lot better there are a lot better options on the table.

TO: I think that he was looking for the historical perspective. So you said as your specialty sometimes sees it first back then?

SW: No, I would not say first but one of the complications of the disease is ulcers and breakdown of skin, especially around the ankles and things like that just because of the impaired blood flow and circulation.

TO: So what's usually, back then, when you were doing this project, what is the first point of diagnosis?

SW: Well, back then, a lot of people . . . there was one point that I guess that sickle cell disease was actually discovered and it was publicized that it was, to the community, that it existed. And so, if the person would get tested they would find out whether they were a carrier of the trait or not and they would know if they married someone with the trait that there is a certain percentage of offspring that could be affected. Sometimes people would have sick kids and nobody would know what was wrong with the kid. This was a way of identifying the disease process. So, this was in the early 70s. So, the early 70s was still a time when there was a lot of political events were taking place related to race relations. There were race riots going on in different areas. There were assassinations. There was the Vietnam War. So, there was just a whole lot of social things happening.

TO: But in the context then . . . I study a more recent period in African-American history and I haven't gotten that deep into that period. Would you say that then, the treatment of a disease at the time, that they just know, a higher incidence in African-Americans is going to be fairly low on the overall priority list with everything else is going on?

SW: Well, one of the complaints that was issued when we started this project as college students going out testing people, was that we were practicing medicine without a license. So, we were doing something that nobody else was interested in doing, but, so we weren't practicing medicine we were testing individuals to identify a trait towards a disease, so there were still some complaints that it was improper, but the people who complained that it was improper weren't doing anything to help the situation. So, there were some lessons in that too.

TO: Then, at Baylor, how far along in medical school when you start identifying your specialty and what were the things that helped you identify what your specialty would be while you were in school?

SW: Well, when you went to Baylor, you had a choice in participating in a three year program to graduate or a four year program to graduate. Those were kind of the options. Most of the students I think participated in the three year program - you did one year of basic sciences and then you did two years of clinical work. And somewhere during the first part of the second rotation, my clinical rotation, I think I was on obstetrics and

gynecology and all the Baylor students did obstetrics at what use to be Jefferson Davis Hospital, and you know you delivered babies and things like this. So, I had a stack of applications for internship that sat on my desk for one month because I never had time to work on them. So, it is the kind of situation where, in medical school, the decision . . . whatever you are doing today is based on some decision that you made two years previously. So, I really didn't have time to work on applications. So, I decided to take an extra six months of school which I devoted to electives and not graduate in three years because I just did not have time to work on those applications. So, as a consequence of that, I took extra electives and that was when I first got exposed to dermatology. So, my choice for what I was going into to do was made in my third year actually but it was only because I had done extra time and had the advantage of seeing those areas. But some people come there, you know, from their first year in medical school, they want to be a pediatrician or an obstetrician or an internal medicine position and then other times, you get there and see how it feels in different things. I didn't know what a dermatologist was probably until I got to medical school but when I left that was what I liked the most.

TO: So, then late 1977 or 1978 when you finished and your applying for your internships can you walk us through the process, what factors, how did that work?

SW: The way that process works is whatever field you are interested in, there are programs around the country that are available to you to apply. There is what are called matching programs. So, you apply to programs, you rank them, and then I guess its a Wednesday in March, second or third week of March every year, all the medical students

find out where they match, match day. So, your choice was from 1 through 10 and every program ranks the students that they want to accept. So that's when you will find out where you will be for the next one to three or four years is on match day.

TO: So, I guess, the question that I am getting at is, this Bakke supreme court decision, are you familiar with it?

SW: Yes. It happened right when I was in medical school I think, right about the same time.

TO: So, what is your opinion on it?

SW: Well, I am going to give you this, there is a question that is asked: What do you call a person that graduates last in medical school?

TO: Um, I can see some, bad negative thing.

SW: No, you call them doctor. You call a person who graduates first in a medical school class, doctor. The person who graduates last, you call him doctor. So, the person who finished last in our medical school class was not African-American, but he is still a doctor. He was not Hispanic, but he is still a doctor. So, I think that the decision about who gets accepted into medical school, based on test scores, based on GPAs and things like that, at that point in time, it wasn't as cut and dry. It is like, now, to get in certain

colleges in Texas, you have to be in the top 10 percent of your high school class. Well, there may be some people who may be who are in the 20 percent percentile who still do well in college at that school but they don't even have an opportunity now. So, things have become polarized with numbers, whether it is the top 10 percent to get into this school or the percentage of students in middle school or high school that gets this test grade. So, the testing is one way to try to handle too many people applying for positions but in terms of the fact that some got accepted into medical school that had a lower GPA based on color or test scores, that has always happened in another way where there were certain people whose families had enough money to donate to schools and they got accepted to schools and it wasn't brought out that they didn't have the same test scores. I think it was probably not totally complete to use that as the only example of someone who gets special consideration to get accepted into schools. It happens for a lot of other reasons.

TO: Sure, and there is a lot of subtle ways that even with laws preventing discrimination that they can do it. And that was why I was thinking about the internship, I am not as familiar with that process. I know my experience of going to Korea, and they were hiring English teachers they do not have laws about age and it is all about the superficial, and we need this kind of actor to attract money, so our English schools are extremely competitive. So they want a certain thing, and they can just discriminate on looks because they have pictures of everyone and we want the prettiest women and the most handsome men to attract business. When you were applying to these internships, that pool you put your highest ones and they pick their best candidates were you running into

any kind of discrimination that, although on its face everything was legitimate the way they operate the system, did you feel any or see anything that seemed . . .?

SW: I didn't personally experience any discrimination related to that. I ended up doing my internship at LA County Hospital which is in East Los Angeles. So it was a pretty big program and was an acceptable choice to me. I did tell people when I was interviewing for my internship that I was interested in dermatology so that was sometimes a hindrance because most places wanted you to be there for three or four years. So, I had to be there for one year and then I was going to be leaving to go to some other program. So, that kind of closed a few doors that probably would have been opened if they thought that I would have been there full time.

TO: Then, after you did three more years at a different program, you said after that, that was where?

SW: I did my derm training at Martin Luther King Hospital in Los Angeles.

TO: And then you returned to Houston to go into practice?

SW: Yes.

TO: So, did you join someone's practice?

SW: I started a solo practice and worked basically for myself for 22 years.

TO: Then, there is the advent of managed care we want to try to address. How did that affect your solo practice?

SW: Well, the managed care affected the practice adversely for me because it generated a lot of administrative work that made it more difficult to just focus on taking care of patients. So, from a perspective of there were certain procedures that a person's health plan may or may not cover and the first time that I would find out about that was in my office because we would say, O.K., if you are going to get this done, your health plan won't cover it, so you are supposed to pay for it out of pocket. So people would get upset with me because I told them they had to pay for something but I didn't select their benefits and I didn't create the structure of the plan but I was the bearer of bad news. So, sometimes a mother might bring her child in with eczema or a skin rash and the first 10 minutes of the visit, we are talking about an insurance program and problems with that as opposed to what is going on with the kid's skin and how to help him get better. So, a lot of time would get diverted away from just the medical issues. So, at one point in my practice, I ended up having three full-time employees that all they did was work on processing insurance claims. So, there was one day in my office, I was walking down the hallway and one of my staff had an insurance company on hold. I heard this message that said 'verification of benefits does not guarantee payment'. I said, what did they say? This is a recorded message that said verification of benefits does not guarantee payment. So I said 'why am I paying somebody to call the company to verify benefits if they are

telling them this and they may still not pay us?' So, I made a decision to look into some other options and so actually ended up over a 2 year period transitioning out of all the health plans, because it was very costly and it wasn't fair or equitable, it wasn't really focused on trying to provide quality care. I was approached by medical directors from a couple of managed care programs and I was told that I treated too many people for hair loss. I was told I treated too many people for acne and other skin conditions. I said, "Well, I don't go looking for patients. They just show up in my office." But I was out of the standards for the usual profile for a dermatologist because I did too many treatments on certain disease conditions. Well African-American individuals who go to dermatologists go because of hair problems, they go because of skin discolorations and all these things. So, I was kind of profiled as an outlier and I was told that if a person comes in, you should tell them that after they see you for one visit, they can go back to their family doctor and they will be O.K. I didn't like being, that wasn't true, so number one so I withdrew from those programs because I didn't want to be approached like that. It wasn't even about trying to provide the best quality of care. It was just about don't treat as many people for that.

TO: So, when you say you withdrew from these programs, so now, people need to pay themselves when they come to see you?

SW: Yes. It is just purely fee for service medicine.

TO: A doctor I taught in Korea was a dermatologist and I use to teach him a couple times a week. He discussed about how the economy goes his practice went. Is that your experience too, because some of the procedures are elective?

SW: Well, that is true to a certain degree. Yes, there are two parts to that. One is the demand for dermatologists is probably pretty steady and from certain perspectives there is an under supply of physicians in dermatology right now so the demand kind of exceeds the capacity of who is able to deliver it. There is always, when you really focus on trying to do quality work and provide the best care, people will still seek you out. So, sometimes I would see patients who may have been to 3, 4, 5 other dermatologists and didn't get the results they were looking for, and on various occasions I was able to help them in spite of that. So, there was, I guess, a reputation created, that if you really wanted to get better go see Dr. Weaver.

TO: That under supply of dermatologists, is that Houston or nationally?

SW: It's nationally, it is not as critical in large cities. It is just relative to the Houston area. You get right outside of Houston in certain areas where the need is more extreme.

TO: So, you find people coming from the greater Houston area into your practice? Traveling a longer distance?

SW: Well, in my practice, we always have had clients that come from everywhere, our patients come from all over Houston, we have patients that have come from Louisiana and other neighboring states and different cities. The majority are local but you we have patients from all over kind of anywhere.

TO: So, it sounds like a lot of referrals would be from satisfied patients.

SW: Correct.

TO: So, your reputation is the key to your practices' success? What do you think in 2006 for African American doctors, not only in Houston but I am assuming you go to national conferences from time to time?

SW: I go to some. Mostly dermatology related, more than so anything else.

TO: So if you looked back to when you were just getting out of medical school and in your internship and today, can you see any vast difference in African-Americans being successful in the medical field, or vice versus in that thirty year span almost?

SW: Well, it is hard for me to really say what the, I have not really been around medical schools enough to keep track of what truly really happens in the academic environment, but I mentioned earlier that in my class year at Baylor there were 13 medical students, 13 black medical students out of 168 in the class. I think the year after

that, it was 11. I don't think there were ever 13 again in the past . . . So, that was in 1974. So, the past 32 years, they have never had 13 black medical students in a class again. There was one year when there were probably less then 9 in the whole school. That was probably like 10, 15 years later. So, I am not sure what the current enrollment is but, I guess you can think of about how much the population in Houston has increased in the past 30 years but the number of physicians being trained has not increased proportionately.

TO: What would you attribute that to, your best guess?

SW: I think life is more competitive now, the world is more competitive. It is harder to get into college. Everyone in the world wants to go to schools in this country. The standards that are perceived to get into professional schools are stricter probably and when I say that, I mean just like you have to be in the top 10 percent of your class to get into certain colleges and then to get into medical schools, you have to have a certain grade point average and this and that and if you don't . . . when we were at Baylor, you might have 200 applicants that all have 4.0 from college and they all have good MCAT scores and this and that. So, the admission committee's job was, how can we differentiate these people or find a reason to not accept them. Because everybody was so, there was too many people to accept, so you had to start trying find why not to accept people instead of finding reasons to accept them. So, it is more competitive and I think that as the economy usually gets worse you have more people applying to medical school, when the stock market goes down and the banking industry goes down you have more people

looking for medicine as a career. When the internet boom was happening 10 years ago, economic cycles can impact who applies to the schools.

TO: Well, I guess the one factor that always strikes me is the amount of African-Americans in the criminal justice system in America and how out of proportion that is with the population. I do not know how you can relate that, we do not know if African-Americans are under represented in the medical field, but do you think that that factor is out there? I mean, that has to have some larger effect, even if there is plenty of qualified African-Americans and just super competitive, and that their percentage in the medical field isn't rising with the population, we see the other end of the spectrum that it's way off the charts of how many are in the criminal justice system. So, do you think that there is any, if an African-American has the financial resources and the abilities, is there going to be any kind of barrier when we see how they are obviously not being treated equally in the criminal justice system?

SW: Well, the first barrier has to just be that it is something that a person wants to do, to finish a medical career and specialize requires 12 years after high school. So, most people are starting their careers in their late 20s or early 30s. So, that can be a barrier to some. It is just that it is a long process in terms of time. So, you just kind of have to be willing to make sacrifices, and that's an individual choice. The problems that are present within the criminal justice system, you know why there is a disproportionate number of African-Americans in the prison, I mean there are a lot of sociologists that are far better equipped than me to try and answer those questions but we do know that there is a high

incidence of black fathers not being in house holds. Who people have as their role models makes a big difference. I had an uncle who was a physician, a sister that was a registered nurse growing up and so they kind of impacted my career choices. I have two cousins that are physicians that live out in California, so like I said one of my high school classmates was a year ahead of me and was in medical school and every time I see him on vacation, he was telling me you need to go and do this and that so that was just kind of the environment that I was in.

TO: So you had good reinforcement, good reinforcement from family members. The rapper Chuck D came and spoke last spring on my campus, and he had a really powerful message, which I was discussing with Dr. Harris because he has this foundation where he is trying to kids interested in medical fields, and he was saying here is an African-American rapper who has made a lot of money, and that this is a false hope, this is a false dream. Being an athlete, a professional athlete or a professional entertainer that's African-American, that is a false dream that they are selling you, you need to stay here in school, this is what you have to do to succeed. So, do you see that people like this, that there is enough African-American role models saying this kind of thing, that the young kid living in my neighborhood, Freedman's Town, living in the projects, can get that from the mass media to even if they are next door. My next door neighbor is an African-American women, single parent, and she has a college degree, and she works hard but she can not afford to keep her kids in her house they have to stay somewhere else. Do you think that there is a way that kids even if they do not have the bootstraps to pull

themselves up for can get the message from the mainstream media? I don't hear that message that Chuck D is giving very often.

SW: I am not sure that they can get that message daily, on a consistent basis, that's consistent or predictable. Maybe episodically. I am not sure. That is a little tough for me to answer.

TO: It is a really tough question. I guess the question I am getting at is who is a mainstream African-American person, who, like when Martin Luther King was around it was easy to see. It seems more difficult than it is.

SW: That is true.

TO: Who, now with what happened in New York a few days ago. You see Al Sharpton and then what happened with the comedian on the West Coast, we see Jesse Jackson. Is there someone consistently speaking that positive message to, I mean the meeting we had last night at Allen Parkway with the mayor, and council women and Sheila Jackson Lee came, I was just reviewing the video and it is like it is the 1950s. It is like absolutely nothing has changed. So, who can someone living in the projects, in my neighborhood, who can they look up to and say, I want that and I am going to get that no matter how much . . . ?

SW: Well, you mentioned earlier that one of the pioneers, Dr. Edith Irby Jones. I mean she has been here and been through all the different arenas in medicine in Houston and then Texas. Hers' is a story that carries a lot of weight, but I do not know how kids would hear that story everyday. I just know all different things that someone like her has done. I am not sure.

TO: It is a question that I always try to get to, it is somewhat rhetorical question, you can't get that answer. But it is interesting to hear peoples' views on it I think.

SW: Yeah, one thing about being in medicine, is that it requires a commitment so the more you get into it and the more you do, it is harder to stay connected to certain other things that are going on in the world because medicine itself can be all consuming. So you always have to fight to keep that balance with your time. Especially in certain specialties, but dermatology is a little bit easier than some others.

TO: So then, I guess the message for our middle school or our high school students that you are giving is, you really have to want success?

SW: You have to want success. You have to be willing to sacrifice in exchange for the type of satisfaction that can you get from doing things in this career that you don't get from some other choices. But it has to be something a person likes and would want to do. You have to like people. It requires a commitment and there are benefits.

TO: So, the satisfaction you are deriving sounds like from practicing medicine is that you get a lot of personal enjoyment out of helping people.

SW: Out of helping people and I get to express myself in a way that . . . as a dermatologist, I have had the opportunity to take care of medical skin diseases, there is new technologies that have come out over the years so there is an ongoing learning, I like to learn, so there is always something new and something different that comes up in the field so it keeps me stimulated. And then I can learn something new. A lot of the treatments I do today didn't even exist when I was finishing my initial residency training in dermatology. I like adventure, I like to grow and do things that is ongoing growth that gets translated into helping people. So, I don't get bored.

TO: So, being on the cutting edge of medicine, it really stimulates.

SW: Correct.

TO: I think the one thing on the HMO that you touched on, that's probably everything, I do not want to take any more of your time. Then your view of the managed care was a negative overall for American health care?

SW: I think it has been proven that it was negative, in that . . . here is how managed care worked, they collect premiums for the services, but then there is a barrier for the people who want services to get them, that was created by referrals and denials of

medical necessity and a whole bunch of other different things, physicians delivered the services but the physicians had to deliver the services for reduced fees and reimbursement and more administrative work and more hurdles to have to go over and once a physician delivered the service, the patient got the service but they didn't want to pay any more than they didn't had to. The primary person who had all the liability were the physicians. Sometimes you get paid, sometimes you didn't. So, if you didn't get paid, then you had to go fight the health plan to try to get reimbursed. The clients got the service and you can't get that back. So, the physicians were the ones who really had all the liability in that system.

TO: Yeah, cause you had the payroll . . .

SW: Right.

TO: All right. Anything else that you think would be useful to stimulate someone's interest in the medical field.

SW: Go spend a day or two with a doctor and see if it is something you really like. I have had students who rotated through my office from the High School for the Health Professions and there were some people who went to the High School for the Health Professions and later ended up in other fields in life. They decided that health care wasn't for them, but see what it is like by spending time with someone who is actively involved in the field.

TO: But those options are available?

SW: Oh, yeah. That can be worked out pretty easily. There are volunteer opportunities in hospitals for high school students. There are all kinds of community service projects that involve the health care field. That is real easy.

TO: So, do that as much as possible if you know that you are going to make this kind of . . .?

SW: Yes.

TO: Great. O.K. I really appreciate your time.