UNIVERSITY OF HOUSTON
ORAL HISTORY OF HOUSTON PROJECT

Interview with: Dr. Kevin E. Kendall
Interviewed by: Ramona Hopkins and Dr. Kathleen Brosnan
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RH: Well, today's date is September 15, 2007, and we are here talking to Dr. Kevin E. Kendall for the African American physicians project. Included in the interview we have Ramona Hopkins as well as Dr. Kathleen Brosnan. Thank you for joining us today, Dr. Kendall. We are at the University of Houston. Well, I would like to start a little bit with your background, where you were born and your family.

KEK: I was born in LaGrange, Texas in October, 1965. I grew up actually here in Houston and I lived in Houston since I was 3 years old. I went to the High School for Health Professions and after that, I went to Baylor University and I graduated in 1986. I received a degree in biology with a bachelor of science. I went to medical school at the University of Texas Medical School in San Antonio and graduated there in 1994. I also completed a residency in internal medicine in 1997, also at the University of Texas at San Antonio.

RH: Now, the High School for the Health Professions, where is that?

KEK: That is here in Houston. It is in the Medical Center. It is on Shenandoah Road which is next to 288. It is near Hermann Park.

RH: All right. And just a little bit more about that high school. If you wanted to get in there, what sort of things would you . . .

KEK: When I was in junior high, I found out about it. At that time, Houston ISD had Magnet schools and they still do today where students who want to go into a particular field can go to a particular school and learn more about that field. And basically what they want to know is your interest and good attendance. As long as you have a C average and above, you can get into the High School of Health Professions because the students who go to that school, some of them want to be nurses, physical therapists, doctors, laboratory technicians. There is a whole wide range of health professions they expose us to.

KB: When did you decide that you wanted to pursue a career in health care?

KEK: In health care . . . when I used to go to my pediatrician when I was a very little boy, I enjoyed seeing the different instruments in his office and I always had that in the back of my mind. And when I was in junior high, my science teachers were very good and they really motivated me. I decided to either become a doctor or become an optometrist. And then, when I went to the High School for Health Professions, I made the decision I wanted to be a physician.

KB: Who was your pediatrician?

KEK: His name was Dr. Caruso.

KB: And was that here in Houston?

KEK: Right here in Houston. He used to work for MacGregor Clinic when they were open.

KB: Was there anyone else who inspired you in your idea of becoming a doctor at some point? You mentioned your teachers and Dr. Caruso.

KEK: Both my parents were in the education field. My mom was a teacher. My dad was a professor at Prairie View A&M University. So, they all had educational backgrounds and that inspired me to pursue an education.

KB: What type of professor was your dad?

KEK: He was a special education professor.

KB: Was education always emphasized in your home?

KEK: Yes, it was always emphasized but I enjoyed reading and studying whenever I could, so it was easily accessible.

KB: I was just going to ask you doctor, what year did you move to Houston?

KEK: My family moved to Houston in 1968. Before we moved to Houston, my family lived in Corpus Christi for about one year, and Victoria for one year also.

KB: What part of Houston did you live in?

KEK: I grew up on the northwest side of Houston, out there by Northwest Mall.

KB: O.K., and was it an integrated community when you moved in?

KEK: The community I grew up in from age 4th grade and up, yes, it was. It was about half white and half black.

KB: So, that would have been in the 1970s then?

KEK: Yes.

KB: Was there much racial tension at that point or did the integration work well?

KEK: The integration . . . at that time, the community we moved into used to be mostly white and then at that time, more black families started moving in and there were more white families who started moving out also at that time.

KB: Was there tension about that movement of people or did most folks seem to get along pretty well?

KEK: All the families in my neighborhood got along really well, however, by the time I was in junior high which was in the late 1970s, about 1977 to 1980, there were still some fights that went on in my junior high between the whites and Hispanics versus the blacks. And also at the time, they had to have a jukebox committee because most of the white students wanted to listen to certain albums and most of the black students wanted to listen to other albums so what they did is they had a jukebox committee and they would play one black album, then one white album, back and forth - that sort of thing.

KB: Oh the art of compromise . . . And what about the High School for Health Professions? Was that an integrated school when you attended?

KEK: Yes, it was integrated and it was actually about 50% black, and about two-thirds female. We had only one young man for every two ladies that was there.

KB: Those were good odds!

KEK: Those were good odds.

KB: Well, did you see any of that type of racial tension at the high school?

KEK: Not much. The students in my high school, they just wanted to learn and they were interested in all different types of the health careers. We were a pretty cohesive group.

KB: So, was the High School for Health Professions, a place where it was O.K. to be a science geek?

KEK: It was O.K. They would not be as popular with the mainstream but it was O.K. though. You know, there were some students who were into listening to music and fashion. We had a lot of them. And there were some that were more to themselves with the science. There were different groups there.

KB: Do you have any idea what percentage, even if it is just an estimate - what percentage of graduates from that high school choose careers as physicians?

KEK: That is an interesting point. It is still a small number because I know maybe 3 to 4 students that I know in each class did go to medical school but it is . . . most of them end up going into different nursing programs and lab technicians. And some of them decide to go into fields other than health. They decided at that point, I want to go into

business or law without wasting time in college taking science classes that they do not need.

KB: And how big was your class at that high school?

KEK: 209.

KB: So, a very small number.

KEK: Yes. Each of the classes were small.

RH: Well, I wanted to talk a little bit about your residency. My understanding is that there is kind of a special process to apply for and get a residency, so I kind of wanted to talk a little bit about that. I have heard it talked about, like the match day and things like that. Could you talk a little bit about that?

KEK: Yes. In order to apply for a residency, students, by the time they are in third year of medical school are going through their different rotations: OB/GYN, pediatrics, family practice, internal medicine, surgery, psychiatry, and most of them will make a decision which residency they want to do by the end of their third year. If there are a few who still have not made their decision into the beginning of the fourth year, there is still time for some electives and things like radiology and other fields. In order to apply for a residency, most of the programs start taking applications some time between September and December of the year prior to the year we start residency. There is a

match program for most of the specialties. Internal medicine which is a specialty I am in is considered not a competitive specialty which means if you want the position, there are widely available spaces across the nation - it is just a matter of getting into the specific place you want to go to. For internal medicine which is a 3 year program, the best way to get accepted to the particular program that you want to go to would be to take a fourth year of rotation there. So, let's say if you wanted to go to Emory in Atlanta for residency, it is best to go do a fourth year rotation and spend one month in a particular field and get to know some of the faculty and the doctors there. And then, there is a chance that you are more highly to get into that residency.

The other residency . . . there are many residencies that are 5 years like surgery . . . psychiatry is 4 years. . . and some of those specialties like general surgery or neurosurgery are more competitive, so they are really looking for the top of each class.

KB: And they are more competitive because there are fewer spots?

KEK: Because there are fewer spots. And so, what they will do is they will take the students at the higher rank in medical school for those positions so there are fewer spots across the nation. So, in terms of applying for the match, we fill out an application for the match and on match day which is about March 15 every year, that is when we find out where we are going to be matched to.

KB: Why did you choose internal medicine?

KEK: I chose internal medicine - one thing is because I like thinking with my mind and making decisions about a patient's care. And I did not want to do any surgery. That is the first . . . I tell any student in medical school, the first decision you have to make is do you want to do something that is surgical or not. And then, once you decide you are not going to do something surgical, you cut out half of the residencies and you can focus on the nonsurgical specialties.

KB: And why did you choose University of Texas at San Antonio for medical school.

KEK: For medical school? They also have a match for medical school. All the University of Texas schools also have a match and so, I applied to all the programs in Texas and then I interviewed at most of the medical schools in Texas and then I ranked them. And then, I received my notification of which one picked me depending on my highest rank of them.

KB: And what year did you start medical school?

KEK: I started medical school in 1989.

KB: How many African American students . . . again, just an estimate . . . how many African American students were in your class at UTSA?

KEK: Six.

KB: And how big was the class?

KEK: 205.

KB: Did you feel any concerns that there would be racial issues when you were working in medical school or did you feel you were going to be accepted on your merits?

KEK: Oh, I felt that I would be accepted on my merits because they accepted me on my merits to get in the program.

RH: O.K., well, the next question I have is about your specialty. Because we are doing this for our website and we are trying to explain the practice of medicine, what does internal medicine mean? What does that mean?

KEK: Internal medicine means taking care of adults with non-surgical treatment. Today, we see a combination of all kinds of fields, and I treat things like sinus infections, bronchitis, asthma, diabetes, thyroid disease, different types of cancers. We are often the first doctor that patients see because I have a general clinic where patients will come in, present with the first ailments and we do diagnostic testing which means looking at basic labs, EKGs, ordering chest x-rays, CTs, MRIs. I take care of patients in the hospital. Internal medicine physicians are very well hospital trained in residency. In fact, our training out of the three years in residency is about 80% based in the hospital and only about 20% in the clinic. And because we get a lot of intensive training in residency in the

hospital, we do a lot of medical subspecialties in residency, we get a lot of training. So, we have the option of pursuing subspecialties like cardiology and gastroenterology, but about half of the doctors in internal medicine or maybe two-thirds, decide to stay in general medicine.

RH: O.K., well, I also wanted to talk to you about the Houston Medical Forum. You are a member of the Houston Medical Forum?

KEK: Yes.

RH: When did you join that?

KEK: I joined that when I first moved back to Houston in 1998 after I finished my residency in San Antonio, and I enjoyed being a member because I am exposed to different physicians in the Houston area that are African American, that I would not have met otherwise. My practice is located in Katy and there are only a handful of black physicians in Katy. But also, in the Houston Medical Forum, we are able to have banquets and do fund raisers to give scholarships to black medical students here. We give scholarships to the students of the UT Houston, UT Galveston, and also Baylor College of Medicine. And I am fortunate to do this because I received scholarships from my medical school in San Antonio when I was there also. I mean, it is very well appreciated.

RH: Yes, I noticed that you were a member of the student scholarship committee.

KEK: Yes.

RH: How long have you been a member of that?

KEK: The scholarship committee?

RH: Yes.

KEK: Just this past year and I am on that committee also again this year also.

KB: Dr. Kendall, obviously the Houston Medical Association and the National Medical Association find their origins in the historical reality that African American physicians were frequently denied membership in local medical societies or even the AMA where that is often depended upon membership in a local society.

KEK: Exactly.

KB: In today's world, where African American physicians can be admitted to any society, is the Houston Medical Forum still important?

KEK: It really is important. It really is important because if you went to a meeting of the AMA, you would learn a lot of different things but they would not emphasize the history of the black physicians, they would not emphasize as much about targeting things

that we can do to young black students, high school students. The Houston Medical Forum, because it is a local branch of the National Medical Association, one of its goals is to target young students in junior high and high school and help mentor them in any field, whether it is law or medicine or any program, and I as a physician, because I was mentored when I was at that age in college, in medical school, I have students who come to my practice and I give them tips on success in college, no matter what college they want to go to and I think it is very important.

KB: And why is it important? I am assuming it is important but why is it important to improve health care in the African American community? Why is it important to have more African American doctors?

KEK: It is important because we as African American doctors are also role models for the young people and also the old. It is important because we can understand some of the ethnic barriers that are seen in the elderly black people. I have patients in my office who are in their 70s and 80s who come to me today and they do not take their blood pressure medications the day of their appointment. And I tell them, you know, "Did you take your blood pressure medicine today?" "No, Dr. Kendall, I did not take them today because I wanted you to see what my blood pressure really is." I said, "I want to see what your blood pressure is on the medicine to know if it is working or not." There are still a lot of cultural barriers that we are still working with and I am still working with today in my population and it is something that will continue.

KB: Is hypertension or high blood pressure a particularly significant problem for the African American community?

KEK: Hypertension really is a significant problem for the black American community because hypertension in itself can cause an increased risk of heart attack, strokes, all kinds of heart failure. It is associated with aneurysms and all kinds of problems like this. And it is one of those things that even though we have been knowing about it for decades and we have wonderful treatments . . . the medicines for hypertension and also for diabetes are wonderful - we have so many of them . . . most of the patients still today either . . . I would say half of them are not controlled on their medication and a lot of the patients do not realize that. And, in fact, there are a lot of doctors who do not aggressively treat the blood pressures of their patients well, and I do believe that in general, even today, African Americans who are elderly are not treated as aggressively. I have patients who come to me with blood pressures of 170/100 having been treated by other doctors and their blood pressures have not been controlled.

KB: Why do you think they are not treated as aggressively.

KEK: I still believe today, some doctors who are, whatever race, not black, in some cases, might not pay as much attention to elderly black patients.

RH: Well, you also, for special interest, it looks like you have hypertension down and cardiovascular disease. Also diabetes.

KB: What is diabetes?

KEK: Diabetes is a condition in which . . . the patient is diagnosed based on the patient's blood sugars which are elevated but it is more than that. It is a condition that affects protein, carbohydrates and fat metabolism, and increases the patient's chances of getting heart attacks and strokes. It is an organ disease that affects all different parts of the body and a lot of people do not realize that today.

RH: And so, when you are treating the diabetes, you need to kind of look at how it is going to affect the rest of the body?

KEK: Yes, exactly. What diabetes does, in type 2 diabetes which is the most common cause of diabetes, probably about 90% or more of the patients have type 2 diabetes in America and about 10% have type 1. Type 2 diabetes has two major factors: insulin resistance, which means the body is producing insulin but the cells are not able to use the insulin. And so, the body tends to make more insulin and over years, the insulin resistance will raise, the body will make more and more insulin and eventually, the pancreas will burn out and cannot produce enough. And then, there is the condition of beta cell dysfunction which means the beta cells that produce the insulin in the pancreas, after so many years of producing so much insulin get burned out. And so, you have this insulin resistance and the beta cell dysfunction and that is how you get type 2 diabetes.

KB: And how is type 2 diabetes treated?

KEK: It is treated with medications, which we have oral ones and insulin and also, we always encourage diet and exercise.

RH: Since you have been in the practice, have there been great changes in the medical field that you have been practicing in terms of the way you deal with diabetes?

KEK: Yes. When I was in residency, the basic medicines we had to treat type 2 diabetes were what we call sulfonylureas which are like glymiperide or, let's say, glycerol, glyburide, and glipizide, and then we had insulin. And as I was a medical student, metformin came out which is an oral medicine that helped the body from producing glucose. After I got out of residency, then we had medicines like Actos and Avandia which are out today that actually slow the progression of diabetes. We have other medicines that are oral and injectable now that we can use to treat the diabetes without having to place the patient on insulin. So, we have a wide armamentarium of medicines for treatment of type 2 diabetes that we did not have available.

KB: Are there environmental factors that contribute to people developing type 2 diabetes?

KEK: Definitely. Obesity, being overweight, are major factors. Decreased activity, decreased exercise. These are the major problems that face America as a whole today. In

fact, Americans are getting heavier. The children are getting type 2 diabetes. I have been diagnosing several young patients below the age of 18 each year each year with type 2 diabetes. When I was in residency or a medical student, that was unheard of, for a patient to have type 2 diabetes as a child. I have a 14-year-old with type 2 diabetes that I diagnosed.

KB: And are there any other environmental factors? Are people who are experiencing poverty more likely to be diabetic? Does it matter where you live, exposure to toxic chemicals or anything like that?

KEK: The interesting thing about type 2 diabetes - we see it in all cultures, we see it in all backgrounds, it is present all over the world. We do see an increased risk in certain Indian groups and also Hispanics. We see a lot in Hispanics and African Americans. We do see an increased risk with it but it is not bound by any cultural or ethnic or poverty group at all.

RH: Well then, the next question that I have was just what made you decide that you wanted to come back to Houston after you got done with your residency?

KEK: The major reason I decided to come back to Houston was because my mom still lives here. My dad passed away . . . it was actually 3 days after I had my interview for medical school. He had colon cancer. I had an interview at University of Texas Medical School in Houston 2 weeks before my interview at UT at San Antonio. And when I had

the interview at UT Houston, when I came home, it did not go very well. I did not really talk to him much and he did not ask me much about it. But then, when I told him I had an interview at UT San Antonio, he was happy to hear that. I drove up there on a Friday, had my interview, came home and when I called my dad and I said, "The interview went very well," he said, "Fine." I finally got home. I spent a night with a friend of mine, and then I came home on Saturday and he was happy to see me. He passed away on that Tuesday. So, I believe that he was waiting to get to know for sure that I was going to be accepted.

KB: And is your mom still here in Houston?

KEK: Still here.

KB: And is she still living in the northwest area?

KEK: She is not living there anymore. She is in an assisted living facility today.

RH: Well then, when you decided to go out to Katy, why did you decide to go there?

KEK: At that time, MacGregor Clinic had their clinics and my first job when I came back from residency was actually at MacGregor in The Woodlands. And then, I was at another facility on loop 610. MacGregor at the time was getting ready to downsize. They actually went out of business now. So, I was looking for another job, and I knew of

another doctor who knew of a doctor in Katy who needed a doctor. And so, I interviewed and I got that position. I worked there for 3 years and I finally opened my own practice in 2002.

RH: I kind of alluded to this a little bit in terms of what has changed with the technology of diabetes in medicine. What are some other changes that you have witnessed in medicine over the years?

KEK: Over the years, just in the past 10 years since I have been out of residency, there are so many improved treatments for different types of cancers. Let's say, for example, colon cancer: patients are treated even at the worst stage with different chemotherapy and radiation treatments that would have been unheard of 10 years ago. There is so much more technology. We use PET scans now that we did not use to use much when I was in residency. There is a lot more information about more diseases. And the thing about medicine in general that I enjoy is there is going to be more technology and there are going to be more advancements to come.

RH: Could you talk a little bit about managed care and the way that that has affected medicine. When you came in, managed care was already kind of going on, it already started. Could you talk a little bit about managed care?

KEK: Managed care involves the use of different types of insurance programs and insurance plans, and different employers from different companies will negotiate

insurance plans with the different insurance companies. So, that leads . . . a lot of different patients who have that particular insurance have to see certain doctors who take that particular insurance and those particular plans. There are also medical organizations like Kelsey-Seybold that take only certain insurances and the patients can only go to certain doctors or hospitals that deal with that insurance plan. It is common. . . in many ways, there are insurance programs and HMOs that do not allow patients to see certain doctors so, in certain ways, patients may be limited, but we still see a lot of it.

KB: I wanted to go back to discussion of technology. As an internist, as a specialist in internal medicine, what type of technology are you using in your practice or, alternatively, are there certain types of technologies you send people to be used for diagnostic exams? How has technology specifically changed your practice?

KEK: We have all kinds of testing that we can do. We have CT scans, MRIs. Patients can get these done right away if they are needed. There are better types of MRIs that are available now. Patients can sit down. There are open MRIs that were not available 10 years ago. So, there are different types of testing and there are different types of machinery and equipment that are going to be in use in the future also.

KB: And MRI means?

KEK: Magnetic resonance imaging.

KB: And that essentially gives images that are almost cross-sections of the body?

KEK: Exactly. An MRI will give images that are cross-sections of the body and it gives more information than what a CT scan can tell.

KB: And the patient has to go essentially inside a big tube, right?

KEK: Yes, a big tube, and a lot of patients, when they have the MRIs in these big tubes, get very claustrophobic so, in a lot of cases, we have to give them something to sedate them a little bit or at least decrease their anxiety before they have these.

KB: And what is it about the imaging? It is almost more of a 3D image than, say, an x-ray, for example? Why does that help you make diagnoses?

KEK: In terms of the images, they are so precise and they can give so much information to the radiologist or the orthopedic doctor or the neurosurgeon who is looking at, let's say, an MRI of the brain or of the neck or of the back. They are able to make decisions on whether ligaments are injured or cartilage that is injured that would not show up on an x-ray, and they can make decisions better about whether the patient will need surgery or what type of surgery ahead of time, and it is going to be good for the patient and the physician.

KB: So, MRIs are particularly better, for example, looking at soft tissue injuries, whereas, an x-ray would show you a broken bone?

KEK: Exactly. X-rays are good for bones and MRIs are very good for soft tissues. And CTs also are going to be good for soft tissues but not as specific as an MRI in terms of the head or the neck.

RH: We are kind of wanting to talk about specifically sickle cell anemia. That is one thing that we have been actually looking into, trying to develop into our narrative. Do you have experience with sickle cell anemia, working with that?

KEK: Yes. Sickle cell anemia or sickle cell disease is a condition that patients get two recessive genes for that trait and when they get those, they will have the disease. Patients with sickle cell disease usually will have an anemia and her hematocrit will be maybe 25% or even lower. There is breakdown of the red cells. They can go through what we call crises in which they are sickling . . . the red cells will turn into a shape somewhat of a sickle and they go through veins that have very little oxygen content and then they can cause a lot of pain trying to make their way through capillaries. So, patients will have episodes of pain in their joints, in their abdomen, and I have approximately 2 or 3 patients in my practice with that disease.

RH: Now, when you say anemia, can you explain what that means?

KEK: Anemia is a condition that refers to a decreased percentage of red cells in the total blood and anemia in itself could be due to many different types of anemia. What we do is we can look at the blood count, look at the size of the cells as reported on the blood count and classify anemias in terms of what we call microcytic anemias where the red cells are very small or macrocytic where the red cells are very large, and we can do other testing like hemoglobin electrophoresis that can tell exactly what types of hemoglobins are more present in the body and we can make the diagnosis of sickle cell disease versus other diseases that way.

KB: Is sickle cell disease more prevalent in the African American community?

KEK: Yes, it is. It is more prevalent in African Americans and also in some African Americans in Africa.

KB: And why is that?

KEK: It is more present in African Americans because they are carrying the traits for the gene and a lot of African Americans, when they do not get tested for it, end up marrying someone and having children who have both traits and then end up getting the disease. And so, it is in a higher percentage because of that.

KB: O.K., but there is a test that people could take?

KEK: Yes.

KB: Approximately what percentage of the population has sickle cell?

KEK: Maybe 25%.

KB: So, it is a relatively small group?

KEK: It is a relatively small group.

RH: Well, just to clarify, when you say that it is a hereditary disease, it is recessive, it is on the genes, just to explain, what does that mean by the recessive genes? What has to happen?

KEK: There are different genes that a patient gets. When the two cells come together, when the egg and the sperm come together, before a baby is born, they transmit . . . there are different genes to that baby as it is an embryo and it is growing. And the two recessive - those are genes that are not commonly transferred, but when you have one from the mother and one from the father, they can get together and cause a change in amino acids that are on the red blood cell hemoglobin. And therefore, you can get the disease - sickle cell disease.

KB: If an adult has a recessive sickle cell gene, does that necessarily mean that that adult has sickle cell disease?

KEK: No, if you had just one recessive gene, you would have the trait. You would have to have one gene from the mother and one from the father. Therefore, if patients would get tested, they would know before they get married that they would have that chance of getting a child with sickle cell disease or not. So, it is good to get tested. It is very important.

KB: And if both the mother and the father have the recessive gene, so they have the sickle cell trait but not sickle cell disease, is it a 50% chance their kids could have sickle cell disease or a 25% chance?

KEK: It is a 25% chance but that is looking at a large population. When you are looking at a mother and a father, that 25% chance each time could end up with every child having it.

KB: You could have 4 children and just 1 would have it and you could have 4 children and none would have it?

KEK: Right. Exactly.

RH: What are some of the other diseases that affect the African American population in a greater proportion? Are there any others?

KEK: Most of the major diseases like heart attacks and strokes affect African Americans in great proportion than whites. Type 2 diabetes also. Those are the main large ones. And then, there are other very rare diseases. Sickle cell disease is one of the most common rare diseases that does do that.

KB: Doctor, one of the things we have been talking to all the physicians about is how things have changed in Houston over time, and I am just curious what you have noticed as big changes in Houston since your family moved here in 1968?

KEK: Just in terms of changes in the city itself?

KB: Changes in the city, changes in the way people relate to each other, whatever comes to your mind.

KEK: I think Houstonians in general get along better today than they did 20, 30 years ago, in terms of TV shows, sports shows. I think that the different ethnic groups are better well represented on TV shows in Houston and also, they have better jobs now than they did 20 years ago. There is still going to be a gap but I think things are better.

KB: And when you opened your practice or began practicing at the MacGregor Clinic, did you have a diversified population of patients there?

KEK: When I first started working there in The Woodlands, it was predominantly white but I always had a few Hispanics and a small percentage of blacks. And then, when I went to the MacGregor on the loop, there was more percentage of blacks at that facility than I did before.

KB: Have you ever, as an African American physician, encountered any resistance from patients, black, white or Hispanic, about your treatment?

KEK: My treatment of them?

KB: Yes. In other words, have you ever encountered any patients who were hesitant to go to you because you were a black doctor?

KEK: If they went to me . . . let's say, for example, they were patients who did not realize I was black and they came to see me and they may not have wanted to go to me had they known I was black, but after I treated them, they came back.

KB: I mean, for example, Dr. Bacon told us when he first came in the 1950s as a specialist in urology, that even some members of the African American community were hesitant to go to him as a physician because they were not ready to accept that African

Americans were specialists. And so, I am just curious what kind of resistance you might have encountered, but it does not seem like it has been a big issue.

KEK: No, I mean, my patients at my office right now in Katy are predominantly white and I would say maybe about 20% of them are black, and maybe about another 20% are Hispanic. So, at this point in my practice since I have been out of residency, there has been really no resistance to me as a doctor in terms of my schedule.

RH: I would like to go back. When you went to med school at University of Texas at San Antonio, there were only the 6 African American students with you. What were some of your experiences? Did you experience any discrimination when you were going to school there? You did not have any problems?

KEK: No, I did not experience any discrimination at all in my medical school. The good thing about medical school is 200 is a small group and we are all there for a common reason - to get through medical school - and we actually worked together very well, in terms of studying together, helping each other out, giving us information about the testing programs. It worked out very well.

KB: What type of classes do you take in medical school?

KEK: The first two years of medical school are considered basic sciences in which we take anatomy, physiology, histology, biochemistry, neuroscience, microbiology, and we

are in class from about 8 to 5, Monday through Friday. We have labs on at least 4 days of the week in the first year. In fact, we had labs 5 days a week so we are studying or are in labs the whole week. By the time it is the second year, we still are in class 8 to 5 all year. We take more advanced classes including pharmacology and introduction to the different medical and surgical subspecialties. The third and fourth years are clinical years in which we do the rotations of family practice, OB/GYN, psychiatry, internal medicine, surgery, and we actually are working in the hospital or the clinic, and we are working as part of a team in the third year with residents and interns and attending doctors. And so, the first two years, we are mostly in class. The second two years, we are mostly in the clinical, hospitals mostly.

KB: What is physiology?

KEK: Physiology is the study of the disease processes of the body and that is the class which we take . . . we learn about how diseases start, the cause of the disease and how it affects the body.

KB: What is histology?

KEK: Histology is the study of the tissues, on the tissue level in terms of how cells work together and how they form organs.

KB: And anatomy? What is involved in an anatomy class?

KEK: In anatomy class, we spend time, about 2 days, 4 lectures 4 days a week learning about the different structures of the body, and then we spend 3 afternoons a week in the actual lab. We dissect a cadaver from the beginning to the end of the semester and we go through the whole semester learning all the different details of the small body parts. We have to memorize the body parts and we also have to know how they function and the relationships with other structures.

KB: What is a cadaver?

KEK: A cadaver is a dead person that has been preserved in formaldehyde or some other substance and we put them in these tanks and we keep them there. We raise them up and we dissect different parts of the body. And that is how we learn.

KB: And the bodies you have are from people who purposely donated their bodies to that goal?

KEK: Yes, the cadavers that we have in medical school are patients who have either said before they died, I am donating my body to this particular medical school or they may have told their children to do this with their body before they died.

RH: Well, one of the things that I was kind of thinking about was what sort of classes did you take when you were in high school at the High School for Health Professions? What sort of things did they offer?

KEK: We had the basic classes like English and biology, physics and chemistry. And then, in the 10th grade which was the first year that I started there, we had 2 hours of health careers in which we were taught each of the different health careers, and we had nurses come by and speak, doctors, veterinarians, microbiology technicians that came by and talked to us to learn all the different health careers. We also learned first aid - this was in the 10th grade - and different exposure to things like that. In 11th grade, we took a medical laboratory class where we actually learned how to do urinalyses and look at blood cells under the microscope - more advanced than you would get in a regular high school. We also went to spend time in the hospitals. I was a nurse's assistant when I was in high school. I was also a physical therapy assistant. So, we actually got to spend a month or two in different rotations at the VA Hospital or The Methodist Hospital.

RH: Is that something that students can do like if they are interested in possibly getting into a health career? Is that something that they can still go ahead and do?

KEK: Yes. The High School of Health Professions is still open. There is one in Houston. There is actually one in Dallas. But ours was the first one of its kind in the nation. That is what is particularly special about ours.

RH: Maybe you said it but when did that school open?

KEK: About 1973. It now has been renamed the Michael DeBakey High School for Health Professions in honor of Dr. Michael DeBakey.

RH: Well, if you are not going to a high school for health professions, what would you need to do in order to be able to . . . would you be able to go into a clinic and help out or shadow or something like that?

KEK: Oh, yes. In fact, most of the students who go to medical school did not go to a high school like that. In fact, you may find in most medical schools . . . in fact, in mine, only 1 out of the whole medical school that did that. . .almost all high schools no matter where you go are going to have Health Occupation Students of America or HOSA chapters in which you can learn to work with doctors and other health-related fields and professions and in high school, students can go and meet with their counselors and they were exposed to different types of fields just like that.

KB: I wanted to ask you a question which will help us fill in some things on the website. We were talking about residencies and you explained the match program. Very basically, what is a residency?

KEK: A residency is a training program that a medical student applies to go to, to get advanced treatment and learning in that particular area. So, what we were taught in

medical school in the basic sciences is the actual biology and chemistry of the body. And then, the second 2 years, we learned how to become a doctor, by seeing patients, by doing their histories, doing their physical exams, writing progress notes, giving updates, reviewing labs and we do that, but we have not learned the actual specialty that we are interested in. Because medicine in general is so broad, you have to pick a certain field and then specialize in that, and that is called a residency. The first year of a residency is the internship year. An internship year is the first year that you get to write prescriptions and sign M.D. behind it and nurses can take those orders without having to be co-signed with a resident or attending like we had to when we were in medical school. And most residency programs are 3 years which includes internal medicine, family practice, pediatrics, and then you have other ones that are longer than that.

RH: When you were going through the match to get your residency talking to other people, did you notice any sort of . . . were you noticing or hearing other people talking about difficulties in finding that residency or prejudices or that sort of thing that would kind of make that a problem? Hindrances?

KEK: No. There are some students who are medical students who do not get the residency of their choice but it is usually because they were not in the top of the class. There are some very competitive residencies that if you wanted, say, a residency in radiology or ophthalmology or neurosurgery or urology, those are very competitive and some students will apply and might not get accepted. But really, there is not much . . . at

least, I never noticed much prejudice in terms of race or anything like that. It is mostly just competition in terms of grade rank and things like that.

KB: Do you interview as part of the match process?

KEK: Oh, yes, we interview just like we did in medical school but it is more relaxed by that time because we are already doctors and we know we are going to get accepted somewhere. It is just a matter of where.

KB: If a youngster, say, freshman in high school approached you today and said, "I am thinking about being a doctor," what is it that you like best about being a doctor? What would you tell them?

KEK: What I would tell a student about what I like best about being a doctor is being able to make decisions on patients' treatment, take an illness and actually help either cure the patient's illness or at least help them improve with that illness. I have really enjoyed saving patients' lives. There are situations that happen . . . patients that have been seriously ill and I have been involved in saving lots of patient's lives. I look back on it and I feel a sense of inner peace with that and it is something I have enjoyed. I enjoy being around the vast technology. I enjoy being exposed to the different types of . . . the knowledge base and there is always so much knowledge in terms of going to medical programs and CME that we could get to continue, and I enjoy being in a field where you never will know everything in it because there is so much new information, so you have

to keep on learning and studying. I tell any high school student or college student when you go into medicine, you are going into a career but you are always going to have to be learning and that is a good thing because you never will feel that you know everything in your specialty.

RH: So, if you were going to give a student advice about going into the profession of medicine, what sort of advice would you give them?

KEK: If they are in high school and they are deciding that they want to be a doctor, I tell them to study as hard as you can in high school, learn as much as you can, do as well as you can on your SAT and ACT scores because when you do well, then you have a higher chance of getting scholarships and the scholarships will help you to afford college and you will be able to be in a position to pick different colleges that you want to go to. And once you get into college, you have to take your science classes. I tell the students to make sure you meet with your professors. If you do not understand something in class when you are in college, make sure you get him to clarify it or meet with him at office hours so you can do better on the tests. I tell them to meet with their advisor at least twice a semester so they can get an idea of what classes to take the next semester or what programs they should go to in the summer. I give them tips about scheduling of the classes and not to schedule too many science classes in one semester. You can take some in the summertime. That way, you can do better in all of your classes. So, I give them tips about the studying part, too.

KB: Part of what you are saying is even a student at age 14 starting high school, as long as you always do your best, you are giving yourself more options for the future?

KEK: Exactly. The better you do, it gives you more options for the future, it increases your chance of getting acceptance to different schools that you might want to, getting more scholarships. It gives you a better foundation for the classes when you take them in college and you do better.

KB: You mentioned that when you were in college, you had some physicians who acted as mentors for you. Was that here in Houston or at Baylor?

KEK: When I went to Baylor University, there was actually a time that after my first 2 years, because I found college very tough . . . in my opinion, college was just as tough as medical school was but in a different way. College was tough because you are taking different classes and every semester, you are with different groups of people and you are not in the same program with everyone. Medical school is tough just because of the volume of it. It is not that the information is tougher, the information is just as tough in college but the difference about medical school is everyone is taking the same classes and you could get very good study groups that can help you through. So, in college, every semester you go to, you will be with different people, so you will have to be studying with different people. In that way, college was harder than medical school in that sense. But medical school was hard because of the volume.

KB: And you mean just simply the volume of material you have?

KEK: The volume of material. It would be equivalent to about 25 hours a semester of just pure science if you added up the hours and compared it to what you did in college.

KB: And most kids in college take 15 hours.

KEK: Exactly. Most kids in college take 15.

KB: That is 40% more.

KEK: In a shorter period of time. Exactly.

KB: Have you ever regretted your choice of becoming a physician?

KEK: No, I never have regretted it and I never will.

KB: And I do not want to necessarily force you to give us details about your family but do you have kids and would you be glad if they pursued a career in medicine?

KEK: Yes. My wife and I have a 7-month-old baby daughter. She was born in February. We love her to death. Oh yes, I would highly encourage her if that is what she wants to do. Now, if she wants to do something else, I would encourage her to do

whatever it is that she wants to do because everybody is a unique person. I think that you should do what you really want to do. If she wants to do something else, that is fine. I would give her all the encouragement.

KB: And is your wife a physician?

KEK: No, she is not but she is my office manager.

KB: She is sane! Well, I also wanted to ask you, you mentioned second year classes and one of the ones you mentioned is pharmacology. What is pharmacology?

KEK: Pharmacology is the study of drugs and drug interactions and the way drugs work in the body, and that is a very difficult class, especially . . . the first part was very difficult for me.

RH: I do not think I have any more questions. Do you have anything else that you wanted to talk about?

KB: . . . to share with the students who will see this?

KEK: If any students want to go into medical school, I highly encourage them because there are so many opportunities. There is one thing I will say about medicine: the different specialties in medicine are, let's say comparing psychiatry to general surgery or

pediatrics to radiology, or physical medicine and rehab to dermatology, they are as different as apples and oranges or night and day. I mean, some doctors work mostly with hospitals, some doctors work mostly in the offices, some doctors work with drug companies. Different doctors do speaker series. Some doctors fly across the nation and give speeches. You have the ability to become members of different medical organizations all through the nation. You get exposed to different technology. You get to travel. There are so many things I like about being a doctor. In fact, there is more that I like about it now then what I thought I would like about it when I was in high school and college.

KB: I hear from some physicians and I have to admit it is probably older physicians who practiced under different systems, that they get so frustrated with the paper work involved in managed care, that it gets in the way of being a physician. Does that bother you or ever frustrate you to the point you considered not pursuing medicine?

KEK: It is frustrating but the way I think of it is . . . I mean, I have a stack of papers on my desk about different insurance companies wanting me to change a prescription of one statin or a cholesterol lowering medicine to the next one. And every day I get faxes of, you know, will you change this medicine to the next one? This one is not on the plan. Will you give prior authorization for this particular drug because our insurance plan does not cover it? And it is frustrating but the way I handle that is just when I have time, spend a little bit of time and do that and then put it aside and take care of my patients. So, it can be but, you know, I limit that. I do not let that slow me down.

KB: You mentioned cholesterol and I do not think we have had anybody talk about that either. We always see the advertisements on television about cholesterol medicine. What is cholesterol?

KEK: Cholesterol is a type of molecule, it is a steroid in the body, and cholesterol is something that is involved in terms of plaques in people's arteries. A plaque is just a deposit of a combination of cholesterol which has fat in it and other molecules that are involved in the arteries of the body and these can develop . . . high cholesterol increases your chance of getting heart attacks and strokes, so it is something that we see and there is the . . . you have different ways of breaking it down. There is an LDL, which means low-density lipoprotein, which is a carrier of cholesterol. The cholesterol cannot go through the body except it has to be carried through the body by a lipoprotein. So, the LDLs are carriers to the arteries where it can accumulate in plaques. The HDLs are the high-density lipoproteins. These are smaller units that carry cholesterol through the body away from the arteries and carry it to the liver where it can be broken down. So, there are different type of cholesterol that cause plaques and hardening of the artery problems and strokes.

RH: What are some of the environmental factors with cholesterol in terms of high cholesterol? What are some of the environmental factors of that?

KEK: When people are overweight or have less exercise, they tend to get higher cholesterol levels. As we get older, our cholesterol levels will go up. Our body in terms of the liver will actually produce higher levels of cholesterol as we get older.

KB: And there are. . . genetic factors in cholesterol, too, right?

KEK: Yes, part of it is genetic. If you have a parent with high cholesterol levels, it increases your chance of getting it, just as if you have a parent with an increased risk of strokes or heart attacks, you have an increased risk of getting those, too.

KB: I think we are good. Thank you very much Doctor. We appreciate it.