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

Interview with: Dr. Oliver C. Hunter, Jr.
Interviewed by: Vicki Myers
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Transcribed by: Suzanne Mascola

OCH: I am Oliver C. Hunter, Jr. M.D. The date is April 19, 2007.

VM: I am Vicki Meyers from the Center for Public History. I will be conducting Dr. Hunter's interview today. Thank you for coming out to campus to visit with us. I assume, like your son, that you know about the project and some of the purposes that . . .

OCH: Yes, I have been informed.

VM: O.K., good. Where did you grow up?

OCH: I am a native of deep rural East Texas. Gregg County, Texas. I was born in Kilgore, Texas, on February 20, 1935, and I grew up in Longview, Texas, 9 miles north of Longview on my grandfather's farm.

VM: On your grandfather's farm. So, being born in 1935, that is middle-ish of the Depression.

OCH: That was the middle of the Great Depression.

VM: Being rural, were there a lot of the effects of the Great Depression on your family's farm . . .?

OCH: My grandfather was lucky. He owned 200 acres of land and they had plenty to eat. You could eat what you killed or you grew. So, there was no shortage of food, clothing, or shelter, but just money.

VM: And in the community that you grew up in, a rural farm community, did World War II become a huge impact on anybody in the community, as far as a world event that would have affected . . .

OCH: Yes, it was a great impact on my family. Some of them went to California. There was a great migration west and north – Detroit or the Bay area was where most of the people went. But my father, he was a school teacher, so he stayed in Gregg County. So, we did not move.

VM: Now, your father, being a teacher, I assume that you ended up going to, at least primary and high school, going to the same school . . .

OCH: Yes, wherever he worked. Wherever he was employed is where I went to school.

VM: And the era that you grew up in, I am also assuming being deep East Texas and knowing the history, that there were segregated schools?

OCH: Well, my father educated me when I was very young. He told me that East Texas belonged to God and the white man, and he did not know which order that was, and if I was going to survive, I would have to understand that. And that was an attitude that I took.

VM: So, do you think that your father being a schoolteacher . . . I know your son talked a little bit about the study habits. Do you think that the study habits that you needed to go to medical school and be a doctor were instilled by your father?

OEC: Well, I'll put it like this: at 10 o'clock, he cut the lights out. Whatever you had to do, you had to do it before 10. And I had a job in high school as one of the janitors at the high school. I worked at the high school and I made $40 a month and he took half of it and that was it.

VM: So, it sounds like with the cutting off of the lights, the discipline.

OCH: Yes, that was the way it was.

VM: Do you remember at what point you thought you might want to study medicine and become a doctor as your career?

OCH: Well, at first, I wanted to become a chemist. So, I had a high school teacher named Mr. Scott who was a brilliant man, and he was also a disciplinarian. And you learned at your own pace. If you had a person who could learn, he would take time out to teach the person who could learn. So, therefore, if you had a dumb person in a class, he would teach him also. But the person who had the ability to be accelerated, he would single that person out also. So, you were rewarded for your efforts from the teacher.

VM: So, do you remember what made you want to shift from just being a chemist to actually studying medicine? Was there any kind of big event or did it just . . .

OCH: Well, when I went into the Army in 1957, I was assigned to the medical corps and I worked in a laboratory which was as a medical technician, and the first job I had was drawing blood. I had to draw that in the morning in the Army before I went to work in the lab. You had two tasks. You did not collect every day, you rotated a collection schedule among the corps men, but then you had your assignments in the laboratory. Then, I developed an interest and took comparative anatomy at that point.

VM: So, were you in the Army and going to school at the same time?

OCH: No, I was in the Army first.

VM: And then went to school?

OCH: I had finished college when I went to the Army.

VM: Which medical school did you end up going to once you decided to pursue medicine?

OCH: The University of Texas at Galveston.

VM: Which is now UTMB?

OCH: UTMB. Class of 1963. And my undergraduate school was Texas Southern.

VM: Right here in Houston.

OCH: The class of 1956.

VM: Yes, they are our neighbors over there.

OCH: Well, we only had Quanset House when I was over there, one building, and a bunch of displaced Army units. That is basically what we had.

VM: Your experience at UTMB graduating in the 1960s, that seems to be right around the time . . . I know that was the school that Dr. Herman Barnett had gone . . . did you go to school with Dr. Barnett?

OCH: Dr. Barnett was before me. He was 10 years . . . he finished in 1953 and I finished in 1963.

VM: O.K., I had the date wrong in my head but I did want to ask that question. But when you were there, was there still talk about him having been the first African American who graduated from UT?

OCH: Everyone there knew that Barnett had finished the school first so you did not have any excuse not to graduate, because someone else had finished already.

VM: Now, 10 years after Dr. Barnett had gone into an integrated, desegregated UTMB and it still being in the south, did you ever feel any still residual ___________?

OCH: Well, I understood the philosophy of the people in charge so there was no problem. There was a dog on the campus, he had mange. He was a scrougy dog and he had a collar which said "Colored Male," so there was no doubt about how some of the people felt. If you are going to get upset about something like that, you are never going to finish. You cannot finish from the school with a thin skin. You just have to go ahead and do your work and get out, because you will have the same problem the day that you

start until the day that you finish. You will have the same problem. Because you will have some underachievers that will want to take it out on you. And I don't control anything. It was a privilege for me to go to the school. That is the best way I look at it.

VM: When you graduated from UTMB, where did you then do your internships and fellowships?

OCH: At Los Angeles County General Hospital.

VM: You went all the way out to LA?

OCH: Well, I had to go where someone would take me. It was that simple.

VM: So, even as you were graduating, there was still . . .

OCH: Even in 1963, the only place I could get an internship was Galveston, and I was ready to move on.

VM: Now, are you still a practicing physician?

OCH: No, I retired in 1982.

VM: O.K., and when you were in practice, you were a cardiologist?

OCH: Yes, internist/cardiologist.

VM: O.K. I think most of our students know what a cardiologist is – I hope they do. It is a definitely a profession we know in the city. What is the internist part?

OCH: Well, an internist is basically a doctor who understands how to define diseases and he understands the definition of them, the natural history of them, the prognosis, and the treatment and the management of diseases, and also how to detect them cost efficiently. In other words, suppose he could make a diagnosis that is cost effective. As an internist can make a diagnosis which is cost effective. Any physician can make a diagnosis but he might order a lot of unnecessary tests. But it does not mean that every internist is great a diagnostician. Some of them are not cost effective either. A cardiologist is just an internist who has been trained to do specific procedures in the diagnosis and detection of diseases that affect the circulatory system. That is what a cardiologist is.

VM: It would be good for our students defining that as well. Once you finally finished internships and fellowships, did you immediately set up in Houston or did you try to set up practices . . .

OCH: No, I started practice here in Houston as a solo practitioner.

VM: What made you choose Houston to pursue . . .

OCH: Well, it was very simple. I had done my residency here and to go to work, I closed down the residency Friday and opened up the practice Monday. I ended the residency Friday and Monday, I went to work by myself - part-time for Baylor and for myself. So, I went to work in the morning at 50% time for Baylor College of Medicine in one of the clinics. So, I went from a full-time employee to a half-time employee.

VM: Now, at one point when you were either residency or when you set up the practice, did you join the Houston Medical Forum?

OCH: I joined the first month I was here. It had two purposes to serve: one was a social outlet and two, it gave you an opportunity to fellowship and intermingle with the doctors that were already in practice, that had similar problems that you had.

VM: When you first started out, what kind of problems would the members of the Forum have?

OCH: Well, you had problems with getting financed. Just like in the early 1960s, if you had never practiced and you were in a small business, you had to first find a bank that was willing to take a chance on you. And someone in the Medical Forum could direct you to a bank and vouch for you. I had a doctor named Dr. Minor that was in the

Medical Forum, Walter Minor, who was a graduate of the University of Minnesota, class of 1931, he was directing me to the Bank of the Southwest and they financed my practice.

VM: When you set up your practice, did you think about taking up any kind of partner at the time or did you just want to set up practice yourself?

OCH: No, I just set up by myself. That was more feasible.

VM: Rather than trying to work with anybody?

OCH: Well, if you were going to fail, it is cheaper to fail by yourself than to fail in a group.

VM: Throughout your membership with the Forum, did you ever hold any offices or become any part of the board or any kind or organizational structure?

OCH: No. I was just a voting member.

VM: Just a voting member. Are you still an active member of the Houston Medical Forum?

OCH: No, I am not an active member anymore. The only thing that I am a member of is Texas Medical Association, the state board is $750 every 2 years, whether you practice or

not. So, the fee for membership and everything in the Medical Forum is $235, I think. Anything that you join, there is a fee. So, after you retire, you just let some things go.

VM: Yes, that makes sense. The Texas Medical Association, I know that right now, if I remember my notes correctly, that is one of the more . . . the Houston Medical Forum is a branch of the Texas Medical Association. Is that right?

OCH: It is separate. It has its own by-laws and codes and everything, the Medical Forum. And a mission statement, if I remember correctly.

VM: O.K. We will have to look them up for some more information about them as well. When you were practicing cardiology here in Houston, what were some of the changes in medicine, especially in cardiology, that you saw as you were practicing?

OCH: Well, the biggest change that we saw, when I first finished, say, in the early 70s . . . you did not have that many procedures that were done. If you finished cardiology and you could read an EKG, that was all that was sufficient in the first part of the 1970s. You could call yourself a cardiologist. But later, they developed . . . technology came in, as far as diagnostic procedures were concerned, you had to identify the anatomy of the coronary system, which was done by injecting dye, and this was done, and I think that is where . . . Oliver was introduced one morning with me in the cath lab . . . I injected a lady, she was 38 years old, and she went into ventricular fibrillation. And Oliver fainted because he saw her going down. We shocked her and she came back. But that was the

first time . . . I did not inject but a small amount of dye in the lady but she was a diabetic and she just fibrillated. But she was shocked, she was walking, so I never shall forget her. She came back to my office, walked in 2 months after that, after she had come back from walking herself with 2 of her grandkids so I could see them. But I did not forget her.

VM: Obviously!

OCH: I do not think Oliver forgot that, because he fainted. He said, "I don't feel good." But now, a lot of the procedures are noninvasive and the patients have less risk. In other words, it is not as dangerous going to the cardiologist now as it was, say, 20 years ago. You are safer.

VM: You said you retired in the 1980s?

OCH: No, I just retired in 2002.

VM: I am getting my dates mixed up.

OCH: Yes, I am just 72 years old.

VM: I am sorry. So, towards the more recent years when you were still in practice, managed care and HMOs really started to build up. What kind of effect did that have on your practice?

OCH: Well, what happened is I was not an advocate of managed care, so I just did less and less. They say it is just like a grape in . . . my vinyard just dried up because I did not sign off for a lot of the patients. So, I mean, now, I am just living off of my pension.

VM: What was it about managed care that made you not want to sign up for it?

OCH: Well, the biggest thing about it is you had no control but you had all the liability. In other words, if a person would not give you the approval to perform a procedure or to take care of a patient for 72 hours, then if you cut it short after you admitted the patient, had a premature discharge, the doctor was left with the liability on himself and not the insurance company. I have had patients, admit them to the hospital and then they would come by the next morning and the manager would say, “The patient had to leave.” In other words, you would have no control over it. If they would not approve them saying over for the extra 24 hours, they would have to leave if you could not justify it. So, there was something called admit to observation. It would give you a chance – 24 to 48 hours – to prove that the patient had a malady. If you could not prove it, well, then a patient had to go. Sometimes it takes a little longer to prove it. Now, I do not think it is quite as severe as it was 3 years ago.

VM: In your day-to-day practice as a cardiologist, I know most of the students who will be seeing the website and most people now just hear heart disease in general, would those be cases that you would see or would you see . . . what kinds of cases would you see?

OCH: Well, what you would like to do is you would like to see them in a preventative mode where you see the patient earlier and you can screen them for diseases. The key to it is to prevent the disease from progressing. If you can identify it early and then you can prevent the progression of the disease, that is better than making the diagnosis once the disease is advanced. In other words, like one of the major things is just like smoking education. Just don't smoke. That is the key to living longer. It does not require much. All it is, is just a change in lifestyle. Some changes in lifestyle are the things that . . . preventive cardiology is a major emphasis now, rather than waiting until the disease has expressed itself.

VM: Your son had mentioned that growing up, you had long hours in your practice. What was it about how your practice was set up that required the long hours?

OCH: Well, the basic thing is that you were a solo practitioner. After you saw the ambulatory patients in the office, you also had to take care of the ones that you had in the hospital. So, when you closed at 6 o'clock, you had to go to the hospital to take care of the ones that you had admitted during the day and get the others ready for discharge the next morning. It was an ongoing process.

VM: And as an individual practitioner, in your individual practice and admitting patients to the hospital, were there certain hospitals, at least early on, that you were really relying on to . . .

OCH: Yes, well, you were developing allegience to the hospitals that you used because they made it convenient for you and vice-versa. You had to get the staff privileges.

VM: Which hospitals have you been on staff?

OCH: O.K., I was on the hospital staff of Riverside Hospital, St. Joseph Hospital, Park Plaza Hospital, and Hermann Hospital.

VM: What was the first one that you were able to become a staff member of?

OCH: Riverside Hospital. That was in 1967. The first one.

VM: Did you choose Riverside or did they . . .

OCH: I sought the hospital out. I forgot to mention Ben Taub. When I finished the residency, I worked at Ben Taub every morning, Monday through Friday, from 8:30 until 11:30.

VM: When you sought out, especially early on in your practice, any of the hospitals to become a staff member of, did you know that there were these certain hospitals that would not have accepted you when you first started out because of the culture in the South?

OCH: Well, what you did is you just filled out an application and you waited for a response. That is what you did. You did not go crazy if you did not get a response. You just waited. If you received one, you were lucky and that is the way it is. It is sort of like fishing. You just put it out. Someone is going to say something at some point. Plus you can have a friend that you train with. See, the key to it was having a sponsor. So, if you could get someone to sponsor you, then that is the key to the admission.

VM: And was the Houston Medical Forum a good place to get one of the sponsors that you were talking about?

OCH: Yes, if you could. That is correct. Or if someone in the Medical Forum knew someone who was willing to sponsor you at a major hospital.

VM: Besides seeing patients as a staff member of a certain hospital and having your individual practice, were you ever on boards for any of the local hospitals or any kind of administrative duties, or did you always focus on the patients?

OCH: No, I was not on any boards. I was on the board of one hospital that failed.

VM: Which hospital was that?

OCH: It was one called Mercy Hospital and there were 5 of us that put it up. I distinctly remember it because we failed to pay the board, failed to pay the payroll taxes of the employees, and the government fined us 100% penalty on the payroll taxes. The payroll taxes were $36,000 and when the federal government settled the case, the fine was 100%, made it a total of $72,000, that 6 physicians had to pay and my share was $12,000. And I paid it off. That was the last board that I was willing to serve on.

VM: I can imagine! When was Mercy founded?

OCH: In 1972.

VM: And you were one of the founding members?

OCH: Yes.

VM: Who did you go in with to . . .

OCH: Well, it was Dr. Edith Jones, Dr. John V. Coleman, Dr. Robert Harris, and Dr. Jarvis Whitfield. And the other doctor was Gurney Pearsall. I think that is everybody.

VM: What made you decide to try to start a hospital?

OCH: Well, it was a nursing home at first and the nursing home closed and the beds . . . they were trying to keep from giving the beds back . . . in other words, there was an allocation of hospital beds one time. If you lost them, it was hard to get them back. So, we decided that we would open a hospital to just try to keep the beds. But then, Medicare has a lot of regulations, and if you followed the regulations, you would go broke every time. What I would like to say is Medicare's regulations are so severe, unless you have anonymous donors that are contributing to the hospital, it is hard to stay open. And this is something that people do no realize; that most major hospitals, say, like Methodist or Hermann, they have anonymous donors that give to the hospital to make up for the money that Medicare does not give them. It is just not part of the official budget. But it comes in.

VM: Mercy opened in what year and how long was it open?

OCH: It closed in 1974.

VM: So, only 2 years?

OCH: Two years.

VM: Two very stressful years, it sounds like.

OCH: Yes. It would have still been open if it had not been for the . . . we developed what I called a zero balance budget. That means, you do not spend any more than you take in.

VM: And one more question on Mercy: What part of town was it?

OCH: It was where Cullen and the South Loop were located.

VM: Third ward?

OCH: Do you know where the South Loop is?

VM: Yes.

OCH: Well, Cullen is the main street that goes straight through. It is right down from this university. Straight up the street.

VM: Do you know what is on that property or in that building?

OCH: What is on that property? It is a shopping center now.

VM: Really? O.K. Sometimes it is just fun to know what buildings have become once they have left.

OCH: I think the Cullen Inn is located exactly there.

VM: We will have to go by and check that out. What contributions do you think that African American doctors have made to medicine in general or medicine in the city of Houston?

OCH: In Houston?

VM: Either in general or just in the city of Houston, what are some of the biggest contributions of African Americans?

OCH: The greatest contribution is just to survive.

VM: What do you mean by survive?

OCH: Well, what I mean by that – in order to have a group of people to survive, they first have to have food, clothing and shelter. Only then can you pursue the arts and the higher achievements, is after you have the basic necessities of life. Like I like to say about my family. The good thing about my family is that we always had food, clothing and shelter. And after you have that, you can achieve anything if you have the basic

necessities. But some people forget that they expect people to achieve when they do not have the basic necessities of life. How can you be cultured when you are scrapping at the table like a wild animal? In order to have a culture, you have to have a stable environment. But when you talk about the greatest achievements for African American doctors, I think you should just talk in terms of physicians in general because you can only achieve like a community. You can only achieve through a community effort. So, if you are lucky enough to go to the institution, it is like if you go to a majority institution, you will meet some people that have access to power and money. Like in my class at the University of Texas at Galveston, the head of Blue Cross Blue Shield at the time, his son was one of my classmates and he had just finished Duke University. I never would have met him if I hadn't gone to Galveston. So, he enabled me to get a loan. When I finished medical school, he asked me what would I want? I told him, "With freedom, there comes responsibility." That is the greatest contribution of African American doctors. The income is sufficient that they will have enough money left over that they can have some freedom and responsibility. If they act responsibly to the citizens of the community, that is the greatest contribution because they usually make more than it takes for just basic essentials. In other words, they can educate their family. Like, the biggest contribution that I think I have is my family. Oliver's mother went to law school after we were married. His middle brother, 39 year old brother, is in Tokyo now with the Space Program, and his 39 year old twin sister is also with the Space Administration, and his 35 year old sister is an engineer. So, my greatest contribution is my family. And we have 6 grandchildren. And so, what we are trying to do is make sure

that the legacy continues. In other words, freedom breeds responsibility. That is your greatest contribution.

VM: What kind of advice, possibly similar to what you may have given your son when he was pursuing medicine, what kind of advice would you give to those who ask you for advice about becoming a doctor?

OCH: Well, the advice that I would give someone who wanted to become a physician – the first thing you have to understand is this: you have to be willing to commit your time to whatever you are pursuing, because the first two years you are in medical school, you are just in isolation if you are going to survive, because when I started medical school, the first thing that the dean told us on the first day of chapel when there was an introduction, he said, "Look around you. There are 200 students." He said, "Half of you will not be in these chairs at the end of the year." So, he just told you up front that the attrition rate was 50%. So, all you had to do was look over to your left and look over to your right and figure that if you want to stay in your same seat, just claim it now. That is just how it was. And lo and behold, at the end of the year, 50% of the class had to repeat or had gone home. And we ended up with 122 of the original 200 to finish school. Of the 200 that started, 122 eventually graduated. I do not think it is that bad now because the school did not have facilities. If they did not have facilities for you, they did not pass you. So, the only advice that I can give a person is you have to be diligent. Eternal vigilance is the key to survival.

VM: Thanks to my colleague for reminding me. The time that you spent in the Army with the medical corps, I think you said it was 1967, did you serve overseas?

OCH: No, I was at Fort Sill, Oklahoma.

VM: Fort Sill, Oklahoma? So, you stayed mainly in the States?

OCH: In the States. Yes, ma'am. No, ma'am, I was not . . . no hostilities where I was.

VM: O.K., so they didn't say your corps has to go to Korea?

OCH: No.

VM: Well, and now I think Korea and the Army Corps _________.

OCH: Well, it was really a good assignment because they had civilian personnel that cooked all of our meals. By serving in the Medical Corps, it was sort of like a little elitist group, that they took care of our meals and things, and we did not have to pull any KP or anything like that, and it was so-called scientific and professional assignment.

VM: And you had mentioned drawing blood and doing lab work. What kinds of diseases or what kinds of advancements were you . . .

OCH: It was a military hospital and we were just assigned to the Medical Corps for work in the lab. It was just like it was a general hospital and we had what they called a scientific and professional assignment. And they assigned . . . like, I worked in the chemistry lab doing basic tests and all that.

VM: So, like the civilian counterpart would be if you go in to see the doctor and you would draw the blood and just test for whatever . . .

OCH: Yes, and then someone would have to run the basic tests, the screening tests.

VM: And that is what you did in your lab work?

OCH: Yes, we did the lab work.

VM: Was it working with the blood tests that really when it came to choosing your specialty, made you choose cardiology?

OCH: No, ma'am.

VM: What made you choose cardiology as your specialty then?

OCH: Well, I had already finished residency. I had done a pulmonary disease fellowship and then what I did is I was looking around for a subspecialty that I could do a

reasonable number of tests and still be in control of my practice; that I would not have to take a job working for somebody else. So, cardiology provided . . . they had enough outpatient procedures that you could do that you did not have to belong to a hospital group. See, that would be another option. A lot of the early cardiologists worked for the hospitals just like Oliver working as a radiologist because someone has to pay for doing the labs. The labs were so expensive until they had to have an institution to provide them. And then, they also controlled who could do the procedures. So, it is a matter of control. And in the beginning, the radiologists did most of the procedures that the cardiologists are doing now. They just finally decided to let us do some of them.

VM: What kind of procedures did radiologists used to do that cardiologists do?

OCH: Well, the coronary arteriograms, etc. They developed the Judkins procedures. Do you know about those?

VM: What is a Judkins procedure?

OCH: It is where you go in through the leg. You put the catheter in through the leg and siphon it around to the aortic arch, and then you just selectively inject the dye into the coronary artery.

VM: I think both you and your son have talked about dyes being used. What does injecting dyes help the cardiologists and radiologists . . .

OCH: It helps to define the anatomy.

VM: So, when you are taking the x-rays or the MRIs, kind of outlining?

OCH: Yes, that is right.

VM: It is kind of in laymen's terms.

OCH: Yes, it is contrast and so it gives you a road map of the arteries. See, as they come around and go to the back, then that gives you an idea about the arteries – the way they are supposed to look. And then you can tell grossly the amount of obstruction, if it has any obstruction.

VM: You also mentioned some of the procedures that you could do in the hospital as well as doing on an outpatient basis for cardiology.

OCH: Well, one of them, say, is like you can do an exercise stress test. Then they have a 24 hour monitor where you look at the heartbeat for 24 hours and see whether the rhythm is regular or irregular. And then, they have an echocardiogram which is the basis of seeing whether or not the person is in congestive heart failure. There are three core procedures that you can do as an outpatient.

VM: What does congestive heart failure mean and how does an EKG kind of tell you that?

OCH: Well, heart failure is a broad term but basically, it is this: It is when a person has difficulty breathing associated with increase in his level of exercise. In other words, we have to move so much oxygen in and out of the body in order to keep up. So, your heart fails when it is not able to keep up with oxygenated blood.

VM: So, the kinds of procedures that you would do on an outpatient, it would not be the bypass surgeries . . .

OCH: No, ma'am. That is institutional. I guess what we are trying to say, the highly technical things are always done in the confines of an institution where you have the protection that you need.

VM: And you yourself might refer somebody to have those kinds of procedures if you catch them in time and they are not in the ER. But you would not do them yourself?

OCH: No. You can select the level of risk that you want to take. The person who takes the risk is the one that is rewarded; say, a group of cardiologists and cardiovascular surgeons that take care of the patients at that level are the high risk takers, and they are the ones that you see on TV. The grunts, you do not see them on TV!

VM: You mentioned your other children were involved in the Space Programs. We have also talked to Dr. Bernard Harris. Have you had interaction with him or have your children had interaction?

OCH: The only interaction I had with him once was talking about some venture capital that he was _______ but other than that . . . I was not a candidate for that.

VM: Did you ever really try to encourage your 4 children to pursue medicine or did you just want them to pursue whatever made them happiest?

OCH: Steven is the one that is in the Space Program. He just did not have any interest in it. But I did try with Oliver . . . and I tried to encourage Steven but Steven just had no interest in it. I am sure he told his brother the truth.

VM: But it does sound like at least the love of science. I know engineering has a little bit of science as well and one of your children was an engineer. So, it sounds like even if they did not pursue medicine, the sciences were important to your children.

OCH: Well, my baby daughter, I always thought that she would be something, but she chose engineering. And so, we just waited on her and she finally got out. She finished at University of Houston in civil and environmental engineering.

VM: How important is it . . . for me, as a student, it is too late but how important is it for students in high school and middle school whether they are going to do medicine or go and do other things, how important do you think that the sciences are in general for general studies?

OCH: They are critical in your ability to understand things because the basic thing is you have to read with comprehension. That is the key to a good study habit, is to be able to read with comprehension. If you cannot read, then there is no way you can learn. And so, if you can work a video game and focus like that, they should be able to read. It is just a matter of what you are focused on.

VM: I think that is probably good as any advice to kind of wrap up on. I know we are a little bit over time with our room allotment here. I know your son dropped a name for us. Do you have any of your colleagues that also retired that you think might be interested in sharing their stories as well? Not to necessarily put you on the spot. If you cannot come up with anybody now, that is fine, too.

OCH: I have not thought of anyone. I came over here with him today but let's see . . . I will try to think of . . . not necessarily medicine. Does he have to be medicine?

VM: Well, we are focusing on actual doctors since that is what the Houston Medical Forum . . .

OCH: Have you interviewed anybody else in the Forum?

??: _______.

VM: Well, it could also be if you think of it later, you can always give us a call.

OCH: O.K., well, I certainly thank you.