Anniversaries are appropriate occasions for both celebration and self-appraisal. This academic year, 2008-2009, our School of Medicine marks the 40th anniversary of its founding. Certainly, the occasion is a time to celebrate and to thank our many partners and friends for their abiding support and guidance. In its brief history, the School of Medicine has earned a lofty place in American medical education. As the founding institution of our thriving Health Science Center, the School now boasts over 5,500 alumni, annually educates 900 students, trains 800 residents and fellows in virtually all subspecialties, employs over 850 faculty and 1,810 staff and now sustains an annual budget of $313 million. More meaningful than these statistics is the fact that the faculty and staff provide expert clinical care for more than 25,000 inpatient admissions and more than 725,000 outpatient visits in the course of graduating 220 new physicians each year.

As impressive as these statistics are and as prodigious as the growth of our School has been, for our forward momentum to continue, our focus must remain on quality and on excellence. In proposing this, I note that being 40 years old denotes an expectation of maturity, a chance to glance back to gain perspective as we plan for the productive years ahead. There is no question that our School, by virtue of faculty achievement, has reached many milestones of excellence associated with maturity in all academic health centers. The Clinical Translational Science Award, (from the NIH), the National Children's Study, Project Strong Star (a joint project of the Department of Defense to study post-traumatic stress disorder), the National Cancer Institute designation (with more phase 1 trials than any other cancer center), and the many individual accolades for our faculty provide ample evidence that this is true.

Exciting plans for needed facilities will add almost 900,000 sq.ft. of new clinical, educational and research space in the Health Science Center over the next few years. Our new clinical home, the Medical Arts and Research Center is only months away from providing state-of-the-art, multidisciplinary care. Our clinical partners are all expanding their horizons: as an example of this, the University Health System has begun an ambitious $900 million project to build a new hospital and renovate ambulatory clinics while Christus Santa Rosa will soon open a new facility in Westover Hills. As we celebrate our School's 40th anniversary, I also want to express my appreciation for the dedication to excellence of our faculty, staff and students, my appreciation for the support from our Health Science Center administration led so ably by Dr. Francisco Cigarroa, our gratitude to our hospital partners for their support and to our colleagues in the Health Science Center: the School of Nursing, Dental School, School of Health Professions and the Graduate School of Biomedical Sciences. Reaching "maturity" at 40 with so many positive developments now ongoing, I think it appropriate we collectively face our future with optimism and anticipation.

I am confident that when the history of our institution is written, this time, with all of its opportunities and challenges, it will be noted for its exemplary achievement and progress.

William L. Henrich, M.D., M.A.C.P.
Dean, School of Medicine
Vice President of Medical Affairs
Professor of Medicine
John P. Howe III, M.D. Distinguished Chair in Health Policy
The University of Texas Health Science Center at San Antonio
Features

School of Medicine turns 40
Focused on the Future

Clinical Excellence Starts With The First Touch
Bridging the Gap Between the Classroom & the Real World

The Evolving Art of Teaching Medicine
Technology Takes A Backseat to Quality Focused Innovations

CM Leukemia 40 Years Later
The Development of a Targeted Anticancer Missile

The Sand of Iwo Jima
2 Men, 1 Island, 64 Years

Highlights

Podcasting Lectures
Music Technology Goes to Med School

Busting Silos and Improving Human Health
Institute for Integration of Medicine and Science to Implement $28M CTSA Award

Ashes Ceremony
Honoring the Ultimate Gift

Departments

Alumni Profile
Dr. Marco Lopez, Jr. Ob/Gyn

Research Notes

Highlights & Achievements

Philanthropy Notes

Alumni Updates

Alumni: Class notes

Match Day Results
Medical School and Bexar County Teaching Hospital (now University Hospital) are dedicated.

Medical School opens its doors to first class of 33 students September 3rd.
Focused on the future....

“Here’s to the past 40 years and the history we have made. And here’s to the future, and the history of medicine that we continue to make every single day.”

- William L. Henrich, M.D., M.A.C.P.
Dean, School of Medicine
“Share information. Be sure to avoid jargon. Remember, leave the room as though you are the one in charge. They need to know you are going to take care of the problem.”

Diane Ferguson, Director of the Clinical Skills Center, coaches a group of white-coated, stethoscope-wearing young men and women before they meet with patients. They listen intently.

As Ferguson preps the group, patients wait in nearby exam rooms, wearing standard-issue hospital gowns. Each is there with a different malady and medical history, as dictated in the notes Ferguson provides – and they worked hard to memorize. They are actually standardized patients, lay people trained to portray a specific medical condition to give physicians in-training a realistic patient experience. In a few moments, they will be examined by fourth-year medical students at the UT Health Science Center’s H-E-B Clinical Skills Center.

Each year, nearly 900 medical students from all four years come through the 13,500-square-foot center, the largest of its kind in Texas.

This is where first-year medical students begin their transformation into polished physicians. Foundations laid here help students bridge the gap between their textbooks and the real world of caring for people.

Beginning in their first year of medical school, students practice simulated patient encounters at the Center, learning how to take medical histories and do hands-on physical exams on real people. Students learn not only where the stethoscope actually goes, but how to put patients at ease and project an aura of professionalism. The Center allows students to start interacting with patients the same week they are opening their first medical textbooks.

By the time students begin to work with actual patients in their third year, they have experienced up to 20 exams, and just as importantly, know how to communicate and interact with patients.

It all starts in the 20 exam rooms at the Clinical Skills Center. The rooms are outfitted with the equipment found in any doctor’s office, but also with one-way mirrors, video cameras and microphones that allow School of Medicine faculty and staff to monitor patient encounters.

“Though the patient exams are simulated, the benefits are substantial,” says Ferguson. “The main thing is that they are interacting with real people. People like to say it’s not real, but it is. It is as real as you and I are talking here,” she says.

First Year Patient Encounters

At first, Christian Corbitt did not see the point of standardized patient exams. After all, the person in the exam room was not really a patient, and as a first-year medical student, he had no idea what he was talking about.

Now, as a fourth-year student, he gets it.
“That is the beauty of medical school. Looking back on it, with lots of stuff you think, ‘why are we doing this? I could be doing other things that are more productive,’” he says. “Then you realize that just having exposure with patients and being able to make mistakes, but not really have any kind of consequence, is a good thing.”

First-year students learn how to conduct a head-to-toe physical exam. Instead of just reading about placing a stethoscope on the second intercostal space next to the sternum, they locate the spot on a human body.

The encounters with standardized patients also teach students the basics of patient interactions, from knocking before entering the exam room to introducing themselves and promptly washing their hands in the room so patients are comfortable shaking their hand.

The initial experience helps to comfortably break barriers, from touching strangers to asking them personal questions about their health and lifestyle.

“It is hard to start touching people. That is what they got us comfortable with,” says Payal Patel, a third-year student now in rotation. “It helped with getting over the initial awkwardness of putting your hands on someone, even if it was just ears, nose and throat at first.”

The practice also helps students get used to pulling information out of patients, however sensitive.

“You have to ask people about sex and habits that they do not always want to tell you about. You have to get over your barriers in order to do that,” Ferguson says.

In addition to providing a safe environment for practicing patient encounters, the Clinical Skills Center also helps students – most of whom are in their early 20s – understand what patients will expect of them as doctors, from effective communication to appropriate dress.

**Standardized Patients (SPs)**

“Anna Rodriguez” is a 60-year-old woman who learned that she had high blood pressure recently when she tried to donate at her church blood drive. She also has high cholesterol, does not exercise, eats whatever she wants and smokes, but the students who examine her have to ask the right questions to obtain those details.

The fictitious Rodriguez is the latest case for Margaret Solis, a standardized patient who has worked with the School of Medicine for 13 years. For four weeks, Solis will portray the character as she helps prep fourth-year students for an upcoming licensing exam. She is one of three dozen standardized patients, ranging in age from 18 to 70-plus, who work part-time at the Center.

The main job requirement for SPs is not an acting pedigree but the ability to memorize a scenario and stick with it consistently throughout every patient visit.

“If they are supposed to be depressed, they need to be able to act depressed and need to keep it up for 15 minutes for every single student,” Ferguson says.

Many experienced standardized patients provide pointers to the students during practice sessions, from how to gently palpate a patient’s liver to the finer points of conducting invasive gynecological or rectal exams.

“I felt like during practice sessions I learned as much from the standardized patients as from the attending physicians,” says fourth-year student Brent Lacey.

To make sure students encounter all types of personalities and situations that they might find in the real world, standardized patients are sometimes coached to be defensive, ornery or tight-lipped.

Lacey recalls one situation where he was instructed to go in and deliver test results to a patient. He walked in, introduced himself and shared good news to a fidgeting man with downcast eyes who seemed anxious. Despite the report of normal test results, the patient remained nervous.

Delivering the good news took less than one minute of the scheduled 15 minute exam period.

“I’m thinking, there’s no way that this is everything I’m supposed to do,” Lacey says. “So, I start racking my brain. The patient is 26 years old. Why is he getting an echocardiogram and an EKG in the first place?”

Lacey probed the patient further, asking him specific questions until finally, with a minute to spare, he elicited a crucial piece of the patient’s family history: the patient’s father had died of a heart attack two weeks earlier.

“After we finished the exam, I was kind of annoyed, thinking, man, they made it so painful to get the information,” Lacey says. “And it dawns on me that if the patient isn’t telling me the information I need, that is my fault. It is entirely likely that I could have a patient like this someday. That was probably the most painful exam I had with a standardized patient, and it may have been the most valuable.”

The patient encounters offer other benefits to students as well. For Patel, the simulated exams provided feedback that test scores could not.

“It’s really encouraging to have someone say ‘I think you are going to be a good doctor, I like the way you smile and talk,’” she said. She was also able to ask questions of the patient about his medical history.

“Anna Rodriguez” is a 60-year-old woman who learned that she had high blood pressure recently when she tried to donate at her church blood drive. She also has high cholesterol, does not exercise, eats whatever she wants and smokes, but the students who examine her have to ask the right questions to obtain those details.

The fictitious Rodriguez is the latest case for Margaret Solis, a standardized patient who has worked with the School of Medicine for 13 years. For four weeks, Solis will portray the character as she helps prep fourth-year students for an upcoming licensing exam. She is one of three dozen standardized patients, ranging in age from 18 to 70-plus, who work part-time at the Center.

The main job requirement for SPs is not an acting pedigree but the ability to memorize a scenario and stick with it consistently throughout every patient visit.

“If they are supposed to be depressed, they need to be able to act depressed and need to keep it up for 15 minutes for every single student,” Ferguson says.

Many experienced standardized patients provide pointers to the students during practice sessions, from how to gently palpate a patient’s liver to the finer points of conducting invasive gynecological or rectal exams.

“I felt like during practice sessions I learned as much from the standardized patients as from the attending physicians,” says fourth-year student Brent Lacey.

To make sure students encounter all types of personalities and situations that they might find in the real world, standardized patients are sometimes coached to be defensive, ornery or tight-lipped.

Lacey recalls one situation where he was instructed to go in and deliver test results to a patient. He walked in, introduced himself and shared good news to a fidgeting man with downcast eyes who seemed anxious. Despite the report of normal test results, the patient remained nervous.

Delivering the good news took less than one minute of the scheduled 15 minute exam period.

“I’m thinking, there’s no way that this is everything I’m supposed to do,” Lacey says. “So, I start racking my brain. The patient is 26 years old. Why is he getting an echocardiogram and an EKG in the first place?”

Lacey probed the patient further, asking him specific questions until finally, with a minute to spare, he elicited a crucial piece of the patient’s family history: the patient’s father had died of a heart attack two weeks earlier.

“After we finished the exam, I was kind of annoyed, thinking, man, they made it so painful to get the information,” Lacey says. “And it dawns on me that if the patient isn’t telling me the information I need, that is my fault. It is entirely likely that I could have a patient like this someday. That was probably the most painful exam I had with a standardized patient, and it may have been the most valuable.”

The patient encounters offer other benefits to students as well. For Patel, the simulated exams provided feedback that test scores could not.

“It’s really encouraging to have someone say ‘I think you are going to be a good doctor, I like the way you smile and talk,’” she said. She was also able to ask questions of the patient about his medical history.

---

**CONTINUED ON PAGE 26**
The world has changed during the last 40 years. People, for the most part, have not. Forty years is an evolutionary nanosecond relative to the development of mammalian physiology. Dealing with that physiology has changed enormously. New technologies, the digital age, and the computerization of everything we do from typing this article, to continuous glucose monitors, 3-D ultrasounds, and emailing MRIs, means we are able to capture and relay data more efficiently than ever before - by an enormous factor. Discoveries in medicine have come at a wonderfully-increasing velocity. Many things that were fatal and/or debilitating just 40 years ago are now controllable, if not curable, today.

Teaching people how to deal with all of our physiological shortcomings is a complicated series of sciences, application and training. For the 40th Anniversary of this School, we asked a few senior faculty members to take a look back, and to give us their perspective on the evolution of educating physicians.

Carlos Pestana, M.D., Ph.D., was one of the first faculty members here at the SOM – arriving a year before the School opened. It was an exciting time in his career – having just come off a five-year surgery program at the Mayo Clinic in Minnesota where he also received a Ph.D. in surgery.

Pestana starts the discussion on the technology point – and that it has not changed what we teach much at all. Technological advances are important, but they are only a fraction of the equation. Pestana notes that medicine is not taught like law or engineering; the majority of the learning does not take place in a classroom. He explains it takes 7 to 11 years to produce a practicing physician; only the first two years are strictly in the classroom. The remaining years also involve an apprenticeship – one-on-one learning. You start as a member of a team where you are basically a “gopher”, and as time goes on, you become more and more important to the team. Eventually, you are running the team.

“That is not a lecture you can capture on an iPod,” Pestana says matter-of-factly.
Audie L. Murphy VA Hospital is built and is staffed by faculty physicians.

This sentiment was reiterated in a slightly different form by everyone with whom we spoke. Technology makes a lot of things easier – especially diagnostics and research – but it is not a significant factor in teaching the practice of medicine. It still comes down to learning the art and science of medicine through apprenticeship. "It is all about the teacher and the student at the patient's bedside," said Robert Huff, M.D., Professor and Deputy Chair of OB/GYN, who has also been here since the School opened.

Huff even gives a lecture on "things we do not worry about anymore" like breech births and deformities. They still happen, but ultrasound and genetic testing give practitioners plenty of time to deal with them – long before babies are born. "Things we used to spend months and months worrying about, we just don't. If we are concerned, we can go take a look and get an answer in a matter of minutes."

Another theme mentioned by Huff and the others was class size. The first decade (1970s), the School had a maximum of 150 students per class. It has increased approximately 15% per decade and now stands at 220. This means the student-to-teacher ratio is less than optimal according to these senior faculty.

"You used to know every student," Huff says, "And every faculty member."

Pestana was optimistic about growth. He says the evolution and growth of the Health Science Center has been a great benefit to the School of Medicine. "The trainees – whether students or residents – now work in a much more sophisticated medical center," he says. The Health Science Center has not only become large and established but has technologies and resources that were not really dreamed of only 20 years ago, much less 40. And, Pestana says, the School is now the hub of research that is leading the study and practice of medicine in many different categories. Pestana speaks like a proud father on watching his kids grow up and prosper in ways he never imagined, but always hoped for.

Everyone maintained that the quality of the education was the criteria by which all actions, measures, policies and other decisions should be made. Most everyone spoke about how this had changed simply due to the diversification and growth of the University. The University's other missions of clinical care and research take the faculty's time – and that is time that could be spent with students. Pestana was emphatic at this point as well. He admits education is his focus and passion, and it skews his perspective – "but it is a valid point, nonetheless," he says.

One of Pestana's biggest concerns is money. He points out that 80 to 90% of the School budget use to come from the state. The rest came from practicing medicine and research grants. "Now barely 13% comes from the state, and the rest we depend on our faculty to earn practicing, or, to get from grants. This means many good things, but it does dilute our time – we are not free to spend as much time with students as we like."

"Of course, this is my perspective because I prefer to spend a lot of time teaching – other faculty members like to do research, some like to practice medicine more... but there is more pressure now to practice."

"...as time goes on you become more and more important to the team. Eventually, you are running the team. That is not a lecture you can capture on an iPod."
The Development of a Targeted Anticancer Missile

Major philosophical transition in drug development began more than 40 years ago.

By Jill Byrd

This illustration shows chromosomes during cell division when DNA is transferred to the incorrect chromosome, resulting in the genetic mutation which leads to CM Leukemia.

The Cancer Therapy & Research Center (CTRC), under its new name, opens the 16,000-square-foot Urschel Pavilion occupying two acres at 4450 Medical Center Drive.
Forty years ago the five-year survival rate for Chronic Myelogenous Leukemia was almost zero. Today, it is over 95%.

Throughout the 40-50 year history of identifying and understanding chronic myelogenous leukemia, more commonly known as CML, the prognosis and treatment of this disease has not only changed significantly but has influenced a major shift in the entire anticancer drug development philosophy. Forty years in medicine is a very short period of time, and the fast-track developments of targeted therapies being developed at the Cancer Therapy & Research Center (CTRC) at the University of Texas Health Science Center at San Antonio are enabling more people with CML and other cancers to live longer, more productive lives.

CML is a bone marrow stem cell disorder caused by rapid growth of mature white blood cells in the cytoplasm. Until recently, the disease generally followed a three- to five-year progressive course, including a chronic phase, accelerated phase and, finally, to a blast crisis, the terminal phase of CML.

CML was the first malignancy to be linked to a clear genetic abnormality. The Philadelphia chromosome was first described in 1959 by Peter Nowell of the University of Pennsylvania and David Hungerford of the Fox Chase Cancer Center and was named after the city in which both facilities are located.

“This discovery changed the treatment of cancer forever,” said Francis Giles, M.D., Deputy Director of the CTRC and Director of the CTRC Institute for Drug Development. “When a target is identifiable, a drug can be developed.”

But in 1960, genes and targets could not be identified with the necessary accuracy. It would be another 24 years before the actual genes in the Philadelphia chromosome were defined.

Between the 1960s and 1980, hydroxyurea, or Hydrea, became the standard anti-CML therapy as it was less toxic to healthy stem cells than busulfan. It was also considered less toxic to patients and prolonged median survival to approximately four years. In 1968, the same year the School of Medicine was founded, 15 percent of patients had passed away after one year of treatment for chronic phase CML, and the remainder died at a rate of 25 percent per year. Very few were still alive five years from diagnosis. The year 1980 brought the introduction of interferon, a natural substance that helps regulate immunity in the cells, and while it prolonged life by an additional two years to a median survival of nearly seven-and-a-half years, it was associated with serious toxicities, both acute and chronic. However, interferon slowed the development of CML.

Discoveries leading to FDA approval of STI571/Gleevec for treatment of chronic myelogenous leukemia

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>Abnormal chromosome 22 (Philadelphia Chromosome) observed in CML patients.</td>
</tr>
<tr>
<td>1970</td>
<td>Chromosome 22 and 9 translocation observed by new staining techniques</td>
</tr>
<tr>
<td>1980</td>
<td>1982 - abl Proto-oncogene identified in chromosome 22 translocation</td>
</tr>
<tr>
<td></td>
<td>1984 - 1987 - BCR - ABL protein identified as possible cause of CML</td>
</tr>
<tr>
<td>1990</td>
<td>1990 - bcr-abl Gene Identified as cause of leukemia in mice</td>
</tr>
<tr>
<td></td>
<td>1993 - First STI571/Gleevec Laboratory studies begin</td>
</tr>
<tr>
<td></td>
<td>1998 - First human test begin</td>
</tr>
<tr>
<td></td>
<td>1999 - First human results reported</td>
</tr>
<tr>
<td>2000</td>
<td>2001 - April: Larger study confirms earlier findings</td>
</tr>
<tr>
<td></td>
<td>2001 - May: FDA approves STI571/Gleevec for treatment of CML</td>
</tr>
</tbody>
</table>

Alpha Omega Alpha (AOA) Medical Honor Society is installed.
The Sand of Iwo Jima

2 men walk the same historic beach 64 years apart, and become friends.

By Ray Hoese

The sand on the island is large, black, volcanic gravel. At the surf’s edge you can sink to your ankles with each step. Like the famous battle the Marines fought there, every step is a struggle, every step is a victory. Even though Dr. David Jimenez was never in the military, he is now considered a brother by many Marines, young and old – because he walked in that sand and shares a little of it with every Marine he meets. It is sand from that famous island, where that infamous battle took place off the coast of Japan 64 years ago. It is the sand of Iwo Jima.

Besides chairing the Department of Neurosurgery, Jimenez has a busy practice schedule at several hospitals (which includes the Audie L. Murphy Veterans Hospital), and he is active in local and national medical communities. But he didn’t really know much about the military until the Department of Defense sent him an invitation. They set up a tour for community leaders that had no experience with the military.

There were 38 civilians on the trip. Besides Jimenez, there was a CEO from Los Angeles, a public school superintendent from Oklahoma, a bank chairman from Atlanta, a college president from Milwaukee, a judge from California, a venture capitalist, and other corporate executives and elected officials who did not have a history with the military. When they received the invitation, they had no idea where they were going after meeting in Hawaii. It was kept secret for security reasons.

It was a jam-packed week-long itinerary, with 4 am wakeup calls, long days spent working with the troops, and thousands of miles of flying on C17 military transport planes – just like the troops do. Not exactly first class on a 747.

They went to Pearl Harbor, then crossed the Pacific over to Guam, the Philippines, and Okinawa. Besides meeting soldiers and commanders, tour members received daily briefings on the role of various units and commands. The whole tour is hands-on, with tour members participating in evacuation exercises, firing machine guns – they even did a 60-foot rappel from a tower that simulated dropping from a hovering helicopter. They also saw PAC 3 Patriot anti-missile missiles, and learned first hand how 500-lb bombs are attached to the undercarriage of the F-15 Eagle fighter jet. They met the crew of a B-1 Stealth Bomber. They toured a U.S. Navy destroyer and a nuclear submarine.

They met members of every branch of the armed services – Army, Navy, Marines, Air Force, and Coast Guard. Most impressive, Jimenez says, were the people they met – the men and women of the U.S. military. “They were all so young – most of them in the late teens and early 20s. And they were so mature, and hardworking. And so committed.”

The trip finished back in Hawaii on November 11 with a Veterans Day ceremony at the historic National Memorial Cemetery of the Pacific, also known as the Punchbowl.

It was an unplanned detour – a last-minute addition to the itinerary – that left the biggest impression on Jimenez and the other...
members of the tour. They were in Okinawa and were taking a quick break at Kadena Air Base, when they were told their C-17 would be leaving soon on a special stop they had arranged. They were going to Iwo Jima.

Jimenez admits he knew nothing more than the basic facts about the little island and the historic battle fought there. It was the site of that famous flag-raising picture in World War II and he had seen one or two of the movies made about it. He knew a lot of people died there.

“As we were flying in, I thought it would be like Pearl Harbor; you know, lots of tourists, memorials, a gift shop… but it was nothing like that. It was almost deserted. It is a highly-restricted area tightly controlled by the Japanese government. It is sacred ground. There is a small contingent from the Japanese Army. It is hard even for family members of the Japanese soldiers who died to visit. The Department of Defense got special permission for us to go.”

It was a two-hour flight from Okinawa. They landed on the island and were taken by bus from the small airstrip and given a tour by the Japanese Navy. The island is a five by two-mile tip of rock sticking out of the Pacific Ocean. 5,200 acres. Not much considering nearly 100,000 U.S. and Japanese soldiers fought over it in one intense, six-week battle.

First stop was the top of Mount Surabachi – sight of the famous flag-raising photograph. Most people don’t realize it’s a volcanic cone. You can’t tell from the pictures, but the flag was raised on the edge of the crater. They looked down at the beaches where all those Marines landed. They could see how they were sitting ducks for the heavily-armed, heavily-fortified Japanese troops.

There is a U.S. Marine Corps memorial on the top of Surabachi. The Japanese government has been very accommodating in honoring the dead from both sides of the conflict. The government considers the entire island a cemetery – approximately 18,000 Japanese soldiers remain buried there, most in unmarked graves. This is part of the reason the island is still very restricted.

Their bus took them on a slow driving tour of the island. They were allowed to walk around some areas. Very little on the island has changed. They saw rusted out U.S. jeeps, and Japanese machine guns – frozen in time with corrosion untouched since they were last fired 64 years ago. And they smelled the sulfur. There is still a good bit of volcanic activity. The name Iwo Jima means “Sulfur Island” in Japanese.

“It was eerie,” Jimenez says. “It was quiet. No one talked much. It’s like you could feel the souls of all those soldiers who died.”

They stopped at one of the beaches and got out. At the time, it was just one of the beaches. On the landing zone maps from the invasion, it is the third section of beach, designated Red Beach 2.

They went down to the water, walked in the sand and saw it was nothing like sand back home in Texas. It didn’t even look like sand. It didn’t act like sand. The beach slopes steeply to the water, making getting on and off the island difficult in the most peaceful of circumstances.

It was there on the beach, as they talked about the difficulty the Marines faced that it happened: a small act that would change Jimenez’s life. “They handed us zip-lock bags and told us we could take some sand home. It was strange, they were so restrictive about where we went and what we did, yet here they were letting us take sand. And they were pretty big bags (about a half gallon) and everyone was just putting a couple of handfuls in theirs.”

Jimenez immediately thought of all the Marines he had met and treated as patients back home in San Antonio. “I completely filled my bag. I knew it would mean a lot to the Marines I met if I could give them a little.”

And that’s just what he did.

It was a few months later, back in San Antonio when Jimenez met his new friend, and newfound hero. Jimenez was on his way to give a vial of Iwo Jima sand to another patient (a Marine) when he stopped in to check on Mike Leal – one of his back-surgery patients. Leal, who at 81 is in great shape, was doing well and the exam was brief. Jimenez asked Leal what branch of the service he had been in. When Jimenez heard it was the Marines, he asked where he had served.


CONTINUED ON PAGE 28
Podcasting Lectures
Music Technology Goes to Med School
By Tim Presley

In 1965, Bill Lear (of Learjet fame) changed the way we listen to music by designing a stereo eight-track cartridge that actually worked. Until that point, we were mostly locked in to what was broadcast over the radio. Listening to what we wanted, when we wanted had become possible. How we listen has changed a great deal in the past 40 years.

Big, clunky eight-track tapes were not very portable. Cassette tapes fixed that, and in 1979, Sony released their first small cassette player called the Walkman. Compact discs were introduced in the early 1980s, and quality took a huge leap as we moved into the digital age of music. CD players grew smaller and more portable, but they were limited in capacity. In 2000, Tony Fadell presented a simple idea to Apple Computer: create a portable hard drive player that would hold hundreds of songs. Interestingly, the 4-gigabyte iPod Nano from Apple now sells for about the same as a Sony Walkman did in 1979: $150.

Today, we can turn on the radio and pick from hundreds of different stations with high-definition satellite receivers. At the touch of a button we can tell our radio to mark the current song. By the time we get home we can download it (or the whole album) to a media player the size of a sugar cube.

The iPod has given birth to “podcasting”, which now encompasses more than just music. Things like our favorite television shows, financial reports, world news and political commentary are now at our fingertips (and ears), often at little to no cost. And it is not just the iPod – any number of devices from video games to phones can play a podcast file (mp3 format). Some mp3 players cost as little as $20.

In July 2007, the School of Medicine decided to conduct a pilot program for podcasting lectures. Pathology lectures were digitally recorded over a three-month period. It was led by Nan Clare, M.D., Senior Associate Dean and Associate Dean for Academic Affairs, David Henzi, Ed.D., Director of Academic Enhancement and Web Manager, Tim Presley. The lectures were compressed and posted for downloading. Medical students accessed the lectures through “Blackboard”, an online student portal. From there, students could choose to subscribe to the podcast or listen to the lecture at their computer.

The results were overwhelmingly positive with 84% of students stating they used the podcast at least once during the study. Even students who did not use the podcast during the pilot said they would like to have the option of using it for courses other than pathology. At the completion of the pilot program, Dr. Clare made the decision to podcast the majority of first and second year

The entering class increases to 200.

1978 14 FUTURE

Dr. Charles Coltman and Dr. William L. McGuire start the first annual San Antonio Breast Cancer Symposium.
lectures in the School of Medicine. The podcasts are now hugely successful.

Currently, daily lectures from ten courses in the first and second years are made available as podcasts. It is a fairly simple production process. A handful of first and second year volunteers use a digital recorder to capture each lecture. After the lecture, the students turn in the SD Card, and receive a blank card for the next day’s lectures.

Linda Burrow in Academic Affairs compresses the audio files, optimizing them for size and quality. Each course is set up as an individual blog, by lecture title and date. Students can then listen or download to an mp3 player. They can also subscribe to the “blog” so they are notified when new lectures are ready.

Students overwhelmingly agreed that the podcasts are an invaluable study tool. They listen to the lectures everywhere; in the library, while running, or on the drive home for the weekend. They even have the ability to listen at two to three times the normal speed, making it easy to quickly review.

“The podcast extends my professor’s ability to teach”, says Amit Desai, a third-year medical student. “It helps focus you on the class”.

Many of the students take their notes, the PowerPoint slides of the lecture, and their podcast, and will review the week’s worth of lectures on the weekend. iPods and other mp3 players can be seen clipped to the pockets of students all over campus. It is typical at lunch time to see students sitting in the shade of a tree with their notes and textbook, earbuds plugged in, focused on the lecture. Cramming for an exam often means listening to a lecture at double-speed on the way to a test.

“A professor will finish a section in class and then say ‘that’s important, be sure you know it’ - and then you panic, not clear on which part he meant. Now I just put a mark in my notes to review the podcast,” says Jason Petrasic, a first year medical student. He often switches between both – music and lectures while studying.

One grateful student put it very clearly in the post-pilot survey: “I firmly believe that, because of using the podcast, I am able to grasp the materials as well as I do. I think that it would serve a great disadvantage to remove this technology.”
Busting Silos and Improving Human Health
Institute for Integration of Medicine and Science to Implement $26M CTSA

The Heath Science Center received an important award from the National Institute of Health (NIH)/National Center for Research Resources (NCRR) in May 2008 to support the Institute for Integration of Medicine and Science (IIMS). This Clinical and Translational Science Award (CTSA) provides over $28 million over a 5-year period to enhance research education, training and the infrastructure needed to perform outstanding biomedical research. The IIMS also receives substantial operational support from UTHSCSA and partnering organizations.

IIMS Partners
1. UT Health Science Center at San Antonio (Lead Organization)
2. CHRISTUS Santa Rosa Children’s Hospital
3. San Antonio Metropolitan Health District
4. San Antonio Military Medical Center
5. South Texas Veterans Health Care System
6. Southwest Foundation for Biomedical Research
7. University Health System
8. Other UT System Components

“This award is a crucial one for our Institution. We are now one of only 38 other institutions in the United States to have successfully competed for a CTSA. That places us in an elite group, poised to do ground-breaking research that directly impacts on improved health outcomes,” William Henrich, M.D., M.A.C.P., Dean, UTHSCSA School of Medicine.

IIMS Mission
The mission of the IIMS is to integrate clinical and translational research, education, training, and career development across all schools and programs at the UT Health Science Center, among our diverse public and private partner organizations in the South Texas region and with the community. Clinical research involves studies that are done with the participation and collaboration of human volunteers. Translational research involves studies to move discoveries from the basic science research laboratory to the clinical research realm and studies to move clinical research findings out into clinical practice to improve human health. The hope is that the IIMS will impact human health by reducing barriers to research and by stimulating the transformation of knowledge into improved health care.

IIMS Organization and Leadership
The effort to obtain this award was aptly led by the four-member leadership team, all Co-Principal Investigators on the CTSA grant, Dr. Robert Clark, Assistant Vice President for Clinical Research, Dr. Robin Brey, Associate Dean for Research, School of Medicine, Dr. Ken Hargreaves, Chair of the Department of Endodontics in the Dental School, and Dr. Michael Lichtenstein, Division Chief of Geriatrics, Department of Internal Medicine in the School of Medicine. Clark also serves as the overall Director of the IIMS, and Brey serves as Deputy Director. The leadership team works together to oversee all of the programs and services made possible by the CTSA grant.

“I could not be more proud of the outstanding effort put forth by the dedicated group who made this award possible. Over 150 individuals from all five UT Health Science Center San Antonio Schools and from our partnering organizations worked on the CTSA application,” Brian Herman, Ph.D., Vice President for Research.

Clinical and translational research and research education and training are supported in many different ways by ten different key function groups within the IIMS:

1. Pilot and Collaborative Studies provides pilot grant funding aimed at increasing institutional and community-based trans-disciplinary research.
2. Research Ethics helps create and maintain an institutional
culture supportive of the highest ethical standards.

3. Biomedical Informatics provides access to: expand bioinformatics capacity for technologies that generate high-dimensional data and develop analytic linkages with repositories of clinical and public health data; create an enterprise data warehouse that crosses the three main domains of clinical research, clinical medicine and population health; and broaden database support service.

4. Biostatistics provides access to state-of-the art collaborative biostatistics and study design support.

5. Regulatory Knowledge and Support provides the research community with regulatory support for navigation through all of the approval processes for conducting clinical and translational support.

6. Clinical and Translational Methodologies Development has resources to help reduce barriers to the development of innovative research methods by building and facilitating the interaction among multi-disciplinary research teams, financial support for novel method development and support for commercial translation of technology.

7. Translational Technology Resources has established a consortium of shared resources from each partnering organization and makes them accessible to IIMS researchers by providing funds to help offset the cost of using these resources.

8. Clinical Research Resources provides clinical research support mechanisms at every stage in adult and pediatric populations from multiple clinical and community partners.

9. Community Engagement and Research has developed resources to create a strong community-academic partnership infrastructure to aid with subject recruitment into clinical and translational studies.

10. Research Education and Career Development supports the development of junior researchers through a K-12 program, a Master’s Degree Program in Clinical Research, and a planned new PhD program in Clinical and Translational Science. IIMS programs and services can be accessed using the Single Point of Contact (SPOC) either electronically using the IIMS website (http://iims.uthscsa.edu) or by phone (210-562-IIMS [4467]). The website is under construction but is expected to be fully operational in approximately 6 months. For the time being, people are encouraged to call with questions that cannot be answered by the information currently on the website.

What Makes the IIMS Unique

There are strong, stable and highly effective partnerships including a wide range of organizations, such as higher education institutions, public and private hospital systems, military health care and research facilities, private research foundations, and public health departments who have come together to form the IIMS. The organization is well-poised to have a positive impact on human health, in large part because of some factors that are unique to San Antonio and South Texas:

- San Antonio is home to the largest military health care and biomedical research operations in the United States providing unique collaborative opportunities not available elsewhere.
- San Antonio is the home to one of the world’s largest primate research colonies, the Southwest National Primate Research Center housed at the Southwest Foundation for Biomedical Research.
- The IIMS serves a 46,000 square mile area including the Lower Rio Grande Valley populated by predominantly Hispanic residents, comprised of some of the poorest people plagued by the highest rate of health disparities in the U.S., which provides an opportunity, challenge and obligation to make a significant impact on human health.
- UT Health Science Center is the only research-intensive health science center in this region that has already made significant investments in research infrastructure at the San Antonio and at the Regional Academic Health Center (Harlingen and Edinburg) campuses.

What the CTSA Grant Award Means to San Antonio and South Texas

The CTSA program is an enormous opportunity for the UT Health Science Center and its partners, with near-perfect timing. The creation of the IIMS flows logically from ongoing strategies, developed and implemented over the last 7 years to create multi-disciplinary research and research education and training teams, expand critical infrastructure for clinical and translational research and forge partnerships between research and community organizations in San Antonio and across South Texas. A key priority is to address pressing health needs and disparities for the people of South Texas and engage community groups and leaders to determine how to best address those needs.

The IIMS philosophy encourages researchers, students and trainees to practice science as a “team sport” with mutual
“It was my first year of medical school and some complete stranger had given me a gift. I have to admit, I was confused and bit reluctant at first, unsure of how I'd repay him for his generosity. As the day went on, some of my classmates and I looked at this gift and I started to wonder things about the man who had given it. Was he a doctor? A teacher? Was he always this giving? Do I know anyone that knows him? As the semester went on, I had another encounter with the same man. He had a tattoo on the back of his left calf and a scar on his abdomen. Later, I saw that he had a herniorrhaphy, and soon, I found out the cause of his death. I would never know this person the way his friends and loved ones knew him but would learn from him the way no one else would.”

This is the experience of many first year UT Health Science Center students enrolled in the Gross Anatomy Course. Despite the mix of emotions felt by the various students from all the schools, the course is an opportunity to learn the human body in a way that no textbook or computer technology could ever simulate.

The cadavers are the students' first real patient. Dissection not only allows them to explore the organs of the body, but also affords the student an opportunity “to confront disease, dying, death, and bereavement early in the medical training enabling them to be more compassionate and humble,” according to Noelle Granger, a University of North Carolina anatomy professor who has written extensively on the subject.

The UT Health Science Center Willed Body Program was established through the Department of Anatomy in 1966, and to date, has had 8,290 participants. For the last 12 years, the program has held an interment ceremony, honoring body donors and their families for their lasting contribution to the medical sciences. The remains are cremated, and the ashes are placed into a drum for burial at the ceremony. Flowers and a headstone mark each year’s interment cites.

“The most memorable moment of the Medical Gross Anatomy course was the day we were introduced to these people. The feeling overwhelmed me as I realized that a person who walked down the street and drove their car, just as I do every day, lay there before me. I felt my senses sharpen and was overcome by an almost indescribable mix of emotions....,” said a first year medical student, speaking at a past ceremony.

Near the close of the spring semester, a procession of students — medical, dental and health professionals — along with faculty, staff and loved ones, are led by the wailing of bagpipes to Memorial Park, located on the University's Greehey Academic and Research Campus. It serves as a memorial, honoring the donors, and stands as a symbol of gratitude and respect by students, past and present, for the role the donors have played in their health education.

More than just medical knowledge is gained from this donation. “I’ve seen pictures of the brain since I was young, but opening the skull to expose the brain was almost spiritual. It was a strange connection to a life of the past, of a woman I never met.”
The Dept. of Orthopedics is established.

As I held it, I realized the brain represented her actions, her pains, and her dreams,” said Rachel Giese – now a fourth year medical student.

“The amount of student participation we have here is more than I’ve experienced at previous universities I’ve been a part of,” said Ron Philo, Ph.D., the director of the program and Senior Lecturer of Cellular and Structural Biology.

A centerpiece of the ceremony is a touching and insightful poem written by Amy Millikan, M.D., M.P.H. of the Walter Reed Institute of Research. Millikan’s words vividly capture the gratitude, respect, appreciation and admiration students feel for the courageous and generous person who is willing to give in such a selfless manner.

“I think it is a beautiful testament to the person who has donated his or her body,” says Dr. Linda Johnson, of the poem. Johnson is a Distinguished Teaching Professor in the Department of Cellular and Structural Biology.

A student representative of each school is asked to share his/her experience of the anatomy course and to pay final respects. At the last ceremony, Dental Student, Brian Black said “Our dental class understands the significance of this selfless act. I encourage us to mirror this willingness to serve others through the health care we provide to the community.”

Family members and students stand side-by-side during the ceremony – loved ones for the closure the memorial brings, students to reflect in quiet appreciation. At the conclusion, students are invited to drop a handful of soil into the grave while family members cast flowers.

Together they honor the donors of the ultimate gift – remembering these lives passed that will graciously benefit many more lives in the future.

---

Flowers are placed in the grave as a final tribute.

---

Anatomy Teacher

When I touched your hands,
I touched hands that had felt
the chill of 94 winters,
fingers that had stretched in the sunlight
of as many springs.

When I touched your feet,
I touched feet that had walked
the paths of nine decades,
toes curling and uncurling through
the uncertainty of five wars.

When I touched your arms,
I touched the arms that had
embraced you from and embraced the world,
a world I know only through
historians and faded photographs.

When I stared into the shell of your eyes,
I saw the screen upon which
a million irreplaceable scenes had been played,
visions of a world rapidly changing,
at once both like and unlike my own.

When I held your heart in my hands,
in a moment filled with awe and grace,
I held a heart whose mysteries I will never know,
a heart that gave me the
gift of itself.

When you invited me to know you,
in a home that
your spirit left,
to touch your body more intimately
than any lover could, you forever altered my life.

My feet, with the knowledge of yours,
will walk into the future
 carrying you with me.

My hands, as they reach out to
 comfort and heal,
will do so never forgetting the
delicacy of yours.

My eyes, as they sweep across the
 landscapes of my future,
will find in it reflections of
the world I saw as yours.

My heart, in the rhythm of its beating,
will carry with it
the stillness and wonder of your heart,
lying silent in my hands.

By Amy Millikan, M.D., M.P.H of the Walter Reed Institute of Research
Taken from The New England Journal of Medicine - April 6, 2000
Imagine having a hit song on the radio, and people lining up to see you everywhere you go. You’re getting all the publicity you could ever want and album sales are booming. Life could not be going better. Just as your rocket is about to deliver you to the stars, you open your mouth one night to sing – and nothing comes out.

That is what happened to Johnny Bush in 1972. His song “Whiskey River” was all over the radio, a national top-10. He was playing big venues now, not just honky-tonks. The club was packed, standing room only. “I went to sing and my throat just closed off.” It was really frightening... at first because speaking was fine, but singing – especially the high notes – would just choke off.” A devout Christian, he thought maybe God was punishing him for his less-than-virtuous ‘drinkin’-cheatin’-honky-tonkin’ life...” The truth was a little more down to earth.

Bush, who grew up “poor as mud” in Houston, recently returned from a tour of northern Europe (where he had no idea he had so many loyal fans) and sat down to talk about his affliction and the man he credits with saving his career -- Dr. Blake Simpson, MD, Professor in the Department of Otolaryngology-Head and Neck Surgery and Director of The University of Texas Voice Center.

“He did save my career,” Bush says of Simpson. “He gave it back to me.”

Bush was an accomplished singer – often referred to as the “Caruso of Country.” In the late 1960s and early 1970s, his vocal abilities as a tenor with a strong range, as well as the depth of his vibrato, were the talk of the music reviewers of the time.

Bush already had quite a few songs on the charts, including two top 10 hits– one being “Whiskey River (Take My Mind)” which has become world famous thanks to a recording by Bush’s life-long friend Willie Nelson. Nelson still opens every concert with it.

Bush always took good care of his voice. He was thoroughly aware of the risk of polyps and nodules that friends in the business had suffered. The year before (1971), he had just signed a record deal with RCA – the biggest record company at the time. Shortly thereafter, the “choking” symptoms appeared. He ran to his ENT, but he could not find anything obviously wrong. It soon became obvious he could not continue. He was dropped by his record label in 1974.

The search for answers became more frantic. He had to find a cure for what was strangling him.

As Simpson tells it, Bush went to a variety of doctors and got a lot of explanations that did not fit. It was the mid to late 1970s and it usually took a decade or more to diagnose this rare condition. There are a lot of things that can weaken and affect the voice, including infections, allergies, deformities, psychological conditions, and damage to the throat and vocal cords.

A string of doctors explored just about every possibility over the next 20 years. Meanwhile, Bush’s life was “completely devastated” as he puts it. “Not being able to

The Cancer Council Center (CCC), which promotes the work of the CTRC, opened for membership. More than 900 members have actively joined the fight against cancer to this day. We appreciate these amazing volunteers!
communicate is just devastating. There is no other way to say it. I couldn’t read to my grandchildren couldn’t hardly talk to them. But they didn’t think I was strange,” Bush says, crediting them for not treating him differently and for not shunning him as most other people did. “They just thought that is how I talked,” he says, smiling as he proudly points out pictures of grandchildren on his walls.

Simpson says Bush’s story is not unique. In those days little was known about SD, and a diagnosis easily took 10 years or more.

Through the 1970s to the 80s, Bush continued to lose his speaking voice, but was able to keep singing, even if just barely. His voice would give out after only a few songs. He even learned to play violin just so he could do something else on stage that did not use his voice. Playing “fiddle” gave his voice a chance to rest between songs. Things continually got worse and soon the prednisone, vaporizers and various other substances (most of them prescribed) were not helping. His speaking voice became unintelligible.

“I got stuck in an airport once. My flight was cancelled and this was before cell phones. I’m trying to call my wife collect to get a flight. I couldn’t hardly talk, and the operator just hung up on me. It affects your whole life. You can’t imagine.”

“The only thing that really kept me going was I figured if it came on suddenly, it could probably go away just as suddenly. I now know that’s not true. I’ve got it forever. But that is why I never gave up.”

A real turning point came in the late 1980s when vocal coach Gary Catona heard about Bush’s plight and contacted him. Catona, who was living in Austin at the time, asked Bush if he could talk when he yawned. “It was strange, but I told him yes, and he said, ‘I can help you.’” Because speaking was so difficult, Bush talked as little as possible. In fact, he had become a recluse. Catona told him his vocal muscles had become very weak from lack of use. Bush saw serious improvement as Catona used what he called “isokinetic exercises” to strengthen Bush’s voice.

It was around this same time that Bush tried his first Botox injection. It was at another school of medicine in the midwest. Desperate, he had the procedure as soon as he heard it might help. The technique was very experimental and they injected the “true” vocal cords. He was able to talk, albeit very quietly, but he lost the ability to control pitch. The effects lasted 90 days. This was three months of near-silence and complete unemployment for him. He swore he would never let anyone touch him with Botox again. Luckily “Whiskey River” became a national anthem in country music and Willie Nelson’s success with it meant royalties that helped Bush through the hard years. (According to Broadcast Music Inc. (BMI), “Whiskey River” has well over 1 million radio plays to its credit.)

By the mid-1990s Bush’s life had become a roller coaster of treatments, successes and failures. He continued to gain strength and control through Catona’s exercises, and though it was not the same voice before the symptoms, he was happy to be able to record and perform again. Talking was still nearly impossible, but as long as he could do a few songs before his voice gave out, he was happy to keep singing. He would go through waves of improvement and deterioration. If he had an especially good week, he would rush into the recording studio to lay tracks before it got worse. By the late 1990s, he had found a happy middle-ground as a singer who couldn’t talk. He continued working hard on his exercises and in 1998 he released his album “Talk to My Heart” to critical acclaim. “The ‘Country Caruso’ is back,” one reviewer penned.

“SD does seem to affect the speaking voice and the singing voice separately in some people,” Simpson explains, “but it is the same in some cases, and there is not enough research to pinpoint exactly what is going on.”

In 1998, Bush had a coronary bypass – and his singing voice got worse after that. No singing. No talking. “It was like I went back to zero,” Bush says, in a tone that tells you he was devastated, yet again.

Bush went to his private ENT in San Antonio, Dr. Richard Newman, who referred him to Simpson at the School of Medicine. Simpson credits Newman as a “great doctor” and a key player in Bush’s healthcare. Simpson’s first choice was the Botox treatment and of course Bush flatly refused. They discussed other therapies, but Simpson was insistent on

CONTINUED ON PAGE 37
The Dept. of Surgery begins a heart transplant program.

I, Too, Had a Dream
William H. Hadnott II, M.D., Anesthesiology
By Tracy Ross

“Growing up in Beaumont, Texas, I remember it happening in our neighborhoods - race riots. They came into our neighborhoods and burned down our houses and our churches. Racism, lynching, riots, sit-ins, freedom rides – it was all happening in the world around us. Dr. Martin Luther King Jr. propelled these events to the forefront of the world, but the world didn’t know about people like me. We were going to college and getting admitted to medical school. I wouldn’t let the color of my skin hinder me. I needed to outperform my competition, and I would not be denied. I, too, had a dream - to be the best doctor.”

“I was on my way to Wiley College in 1949 - the school of The Great Debaters,” Hadnott said with a smile, referring to the Denzel Washington movie which he feels is a great representation of the difficulties experienced by blacks growing up during that period. “It was also the same year my father had passed, leaving behind my three sisters, three brothers, and me. My mother had gone just four years before; so here we were, seven children left with no parents, no parental support, and no financial support.”

From that day in 1949, Hadnott maintained the principles his parents, both teachers, had instilled in all seven of their children: education is the best tool to overcome problems of racial hate and bias.

“You must first do what you have to do, in order to do what you want to do,” Hadnott said, reiterating a line from the movie. “To achieve and accomplish goals, you must be willing to work hard, make some sacrifices, treat others with respect and dignity, and maintain high morals and strong character. Every time you tried to do something above a certain level, somebody would push you back down.”

Months later that same year, Hadnott heard news that a man by the name of Herman Barnett had been admitted to the University of Texas Medical Branch in Galveston. Barnett would soon be known as the first African American medical student admitted to an all white, segregated institution. This was a significant event for Dr. Hadnott. It gave him hope for the right time for me. I knew that if Herman was successful, other African Americans would follow.”

Hadnott’s opportunity came in 1953 when he was admitted to the UT Medical Branch at Galveston as the 8th African American to be accepted into the School. Hadnott recalls this as the happiest moment of his life, but there were still many hurdles that lay ahead. The civil rights movement was right around the corner.

Hadnott recalls being separated from his white colleagues as a result of the Jim Crow Law which mandated segregation in all public facilities, with a “separate but unequal” status for blacks and other non-white groups. This led to treatment and accommodations that were usually inferior to those provided for whites. Poorly equipped schools crippled many blacks from keeping high grade point averages and test scores. It created (and maintained) the economic, educational and social disadvantages of the time.

Hadnott was not allowed to live on campus at first. Classes were a 30-block walk from his rooming house. Five years before the 1954 Supreme Court decision Brown vs. Board of Education, UTMB started integrating. “The campus built six new dorms on campus, and I received housing assignments in 1956. There were very few black students. I spent most of the year alone in a dorm that housed about 50 students. Me, all by myself. I loved it!” He smiled and continued, “I was isolated, but I had the peace and quiet - perfect for studying.”

He graduated in 1957, at the beginning of the civil rights movements. It was not a straight path to continuing training for African Americans. There were only two places in Texas where an African American could get an internship. One option was John Sealy Hospital in Galveston, and the other was the Robert B. Green County Hospital in San Antonio. The university systems were ahead of society, but the hospitals in Texas were still highly segregated and discriminated against blacks, delaying them from further training. Black doctors in San Antonio had no privileges to practice at major hospitals nor could they put their patients there.
“We had to leave the state in order to complete our education and not always because we wanted to - that was just the environment in which we lived," Hadnott explained. California was less segregated at the time, so he chose to complete his internship at Sacramento County Hospital (now the University of California at Davis). He returned to Texas in 1958.

Hadrnott’s older sister told him they needed a black doctor in her town of Bay City, just south of Houston. It was not easy for blacks in the community to go to the white doctor with segregated waiting rooms and long waits to be seen only after all the white patients had been seen first.

“I did not have any money to open my practice,” Hadnott recalled. The bank did not want to lend him the money and the only way he could borrow it was by getting multiple people to co-sign the loan. “I had to get just about everybody in Bay City to sign a note for me to get less than $4,000 to start my practice. They were glad to have me, so it was not a problem. It was just more of a hassle.”

“In 1958, all you had to do was hang a sign, William H. Hadnott M.D., and people came. An office visit was $3, and a house call was $5,” Hadnott said with laughter. "A dollar was worth a lot more in those days. It went a lot further.”

He saw 35 to 40 people a day, six days a week. Just three years after opening the doors of his first practice, he paid back the bank, along with all of his debts from medical school. Blessed with success, he was able to help put two of his younger brothers through medical school. Hadnott said proudly.

After nine years of operating a successful family practice in Bay City, Hadnott was accepted to the anesthesiology program at the Brady Green Hospital in San Antonio. The first classes were over at Trinity, they had not built the School yet. He was one of only two students enrolled. “The other guy quit after about two months so that left me alone - the only anesthesiology resident. I worked hard and had to work more hours. When they told you that you had to work, you worked,” he said.

“I loved the study of anesthetics. It was like I was almost perfect for it.” Any extra time he had was spent studying. He was dedicated and determined to do it. Years later, in 1969, he was the first and only resident to proudly graduate from that initial class. Hadnott was the first African American anesthesiologist practicing in San Antonio.

“I don’t think that I was turned down too much because of the color of my skin - because I had built a reputation. I didn’t shy away from opportunities, obligations, call schedules, getting up at night, getting up early in the morning, or doing emergencies on weekends. I didn’t shy away from anything.”

Hadrnott was as busy as any doctor in town performing about four major cases a day, five days a week. The color of his skin did not seem to matter. He anesthetized some of the wealthiest people in town, as well as some of the poorest.

“My chief, Dr. Zauder, wanted me to be a teacher, so he arranged for me to teach at the medical school one day every week.” Each week, Hadnott spent five days in practice and one day teaching.

Hadrnott was promoted to Clinical Professor in 1981. For the next twenty years, he helped train each residency class. He focused on modeling professionalism, compassion, and steadiness in all operating room procedures. He maintained a thriving anesthesiology practice while teaching. Hadnott served as the Chairman of the Department of Anesthesiology in the Baptist Healthcare System, and Chief of Anesthesiology and Chief of Staff at the Nix Hospital, both in San Antonio.

In 2007, he formally retired from the Health Science Center.

In June, 2008, he was honored at a dinner celebrating 40 years of outstanding service as a faculty member of the School of Medicine. An Endowed Chair was established in his name. All endowments will support future faculty members who represent qualities found within Dr. Hadnott. (For more information, visit http://anesthesia.uthscsa.edu)

Hadrnott was honored for his contributions to the medical profession by the 75th Texas Legislature (House Resolution 417 – “…exemplary service to his fellow Texans”). The U.T. Medical Branch Alumni Association honored him with the Ashbel Smith Distinguished Alumnus Award as well as two scholarships established in his honor and the Texas Society of Anesthesiologists gave him the Distinguished Service Award.

“His expertise and contribution to anesthesiology and his dedication to resident education are just a few of the legacies that he leaves the field of anesthesiology,” said Francisco G. Cigarroa, M.D., President of the UT Health Science Center.

“His contributions are compelling because he has educated generations of anesthesiologists, attracted many distinguished faculty to Texas and mentored many more. He truly is a pioneer in the field of anesthesiology.”

William Hadnott, II, “…had a dream, too,” as he says. One that has proudly come true.
Breathing Easier
The Transplant Center Celebrates 300th Lung
By Tim Presley

Inhale. Exhale. Most of us take it for granted. Kevin King and Kenny Deison do not. They used to struggle for each breath, but now, they breathe much easier thanks to The University Transplant Center – a partnership between University Hospital and the School of Medicine – which celebrated their 300th lung transplant recently with recipients King and Deison.

King, a real estate specialist at Valero, suffered from interstitial pulmonary fibrosis (IPF) and needed a new left lung. IPF is a scarring in the lungs, causing them to thicken. This greatly reduced the amount of air King could take in a breath. Over time, the simplest task left King light headed. “I asked my wife to buy me an electric tooth brush because just brushing my teeth left me winded,” King says.

In 2005, Deison had portions of both lungs removed due to emphysema and chronic obstructive pulmonary disease (COPD). The small air sacs in Deison’s lungs would enlarge, hyper-inflating. This made it extremely difficult to exhale. He spent most days at his ranch near Bastrop. Instead of caring for the land, his daughter was caring for him as he waited for a right lung to become available.

At approximately 44 days for a lung, the University Transplant Center boasts one of the shortest wait periods in the nation. The Center also has some of the longest surviving lung transplant patients. Another plus for King was the Center’s expertise with IPF – which makes up over half their lung patients.

On March 20th, 2008, Deison and King received their lungs. In an uncommon occurrence, both men received a single lung from the same donor. They were operated on simultaneously at University Hospital.

“The stars and the moon have to align to do that,” according to surgeon Dr. Scott Johnson.

It was possible because King and Deison required separate sides of the lung. In Kings’ case, the surgeons transplanted the left lung, and in Deison, they transplanted the right lung. At the end of the day, both men were on their way to recovery, and the transplant teams celebrated two successful transplants.

King was the first recipient, making him the 300th and Deison the 301st, but the two men asked that they share in the honor. Barely more than a month after the operations, on June 17th, Deison and King celebrated with the men that allowed them to breathe easy once again, Drs. Johnson and Luis Angel. Also in attendance were friends, family, hospital staff and School faculty. It was a joyous day.

The Center had more to celebrate. This milestone marks it as one of the largest lung transplant centers in the nation. Their success is due in part to the continued research the Center does. Historically, only 11% of all donors are able to donate their lungs, making it one of the more difficult procedures. The Center has developed a protocol that has increased the percentage of potential successful donors to 25%. This is part of why the Center has one of the shortest wait periods for lung transplants. In 2007, the Center transplanted 25 lung patients — well above the national average.

Drs. Luis Angel, Deborah Levine, Stephanie Levine, Scott Johnson and John Calhoon developed the protocol, called the San Antonio Lung Transplant protocol (SALT). It includes a list of procedures and guidelines to follow when preparing the transplant donor. It is just another aspect of the expertise that makes the Center, and its patients, so successful.
The Cancer Therapy & Research Center, one of the nation’s premier cancer centers, first opened its doors in 1974 as a non-profit corporation dedicated to providing the community with radiation therapy. More than three decades later, CTRC has vastly expanded capacity as it continues to serve residents of San Antonio and South Texas, as well as patients from across the U.S., Mexico and other countries around the globe.

The organization got its start in 1972 as the Radiation Therapy & Research Foundation of South Texas. Two years later, it opened its doors as the Cancer Therapy & Research Center on a two-acre tract adjacent to Methodist Hospital. Adding medical oncology (chemotherapy) to the treatment offerings, the facility soon needed room to expand and obtained rights from the San Antonio Medical Foundation to 14 acres at the corner of Wurzbach and Floyd Curl drives.

The new campus opened in 1995 and grew to include the interconnected Burton and Miriam Grossman Building, the Roger and Cherry Zeller Building, and the Urschel Tower, plus a 550-car parking garage. As the square footage grew, so did the services offered, the expertise of the staff, and the affiliations that further broadened CTRC’s scope.

In 1991, CTRC launched its Institute for Drug Development. By 1992, the IDD made its home in the Alice P. McDermott Building in the Texas Research Park located off of Potranco Road on San Antonio’s West Side. The IDD’s mission is to develop new treatments for patients with cancer through integration of research programs of excellence in the translational and clinical sciences. The IDD is now a world leader in phase 1 cancer studies and is currently conducting more than 100 clinical studies.

Since its inception, CTRC had collaborated in cancer treatment and prevention research with the University of Texas Health Science Center at San Antonio. In 1993, the National Cancer Institute (a part of the National Institutes of Health) began funding the two institutions (known at that time as the San Antonio Cancer Institute or “SACI”) as a Designated Cancer Center. The institute today maintains the prestigious designation as an NCI Cancer Center.

On December 17, 2007, the CTRC became a Center of the UT Health Science Center through authorization of The University of Texas System Board of Regents. The San Antonio Cancer Institute name was discontinued, and Tyler Curiel, M.D., was made Executive Director. Francis J. Giles, M.D., was named Deputy Director of CTRC and is also the Director of the IDD.

What Is the National Cancer Institute?

The National Cancer Institute, part of the National Institutes of Health in Bethesda, Maryland, coordinates the nation’s research program on cancer prevention, detection, diagnosis, treatment, rehabilitation, and control. NCI was established by Congress in 1937, and its programs were intensified in 1971 after passage of the National Cancer Act. As a result of the 1971 legislation, the NCI has built a network that includes regional and community cancer centers, oncologists, cooperative groups of clinical researchers, and volunteer and community outreach groups. NCI also has initiated cancer control programs to hasten the application of knowledge gained through cancer research. -- National Cancer Institute

Dept. of Otolaryngology is established.

Dr. James J. Young is appointed Dean.
Second Year Skills

For students in their second year, the Clinical Skills Center offers a different experience: instead of focusing on simulated patient encounters, students meet with actual patients with real medical conditions, taking histories and conducting physical exams under the supervision of faculty.

This stage adjusts for the limitations of standardized patients by giving students a look at real-life ailments. For example, when students are learning about the respiratory system, they might get to examine a patient with emphysema or a lung transplant. Students get the opportunity to hear abnormal sounds or feel abnormal organs and talk to the patients about their conditions.

These experiences helped bring classroom teachings to life for Corbitt. “In the first two years of medical school, people are throwing out terms like murmurs and crackles. You can memorize that, but if you’ve never heard a systolic murmur, how are you going to make that discovery on a patient?” he says.

Students also practice emergent or traumatic procedures at the Clinical Skills Center in three simulation rooms stocked with full-body mannequins. The “computers in human form,” as Ferguson describes them, give students valuable practice with procedures both common and rare, from dealing with a stopped heart to inserting a tube down a patient’s throat.

Today’s clinical skills training is a vast improvement over the old school method of learning on the job. Ferguson recalls her own experience, where as a terrified nursing student she learned how to thread a pacemaker through a catheter into a patient’s heart when a doctor asked her to help him.

While many medical schools offer clinical skills training, Ferguson estimates that the School of Medicine is in the top quarter of the nation’s medical schools in terms of the breadth and extent of the clinical skills experience that students receive throughout each year and how often they are assessed on their progress.

The School of Medicine has run a standardized patient program since 1995, but before the Clinical Skills Center opened in

University Hospital – 40 Years of Partnership

The partnership between the School of Medicine and University Hospital dates back to the earliest planning stages in the late 1950s. Bexar County and City of San Antonio officials, as well as civic and business leaders, worked with the State Legislature to bring the two institutions to life as a powerful asset to the community’s healthcare. The educational, research and community-service missions of both the School and the Hospital have been intimately linked ever since. Thousands of Texas physicians have been trained at the hospital, and millions of Texas residents have been served there as well.

The future of University Hospital is depicted in the rendering of its planned expansion due to be completed in three phases and opened in April 2012. The new Trauma Tower at University Hospital will include an expanded Emergency Center and operating rooms, as well as 488 new beds. The project is part of a $900 million Master Facility Plan for the medical center location, as well as University Health Center - Downtown (home to the historic Robert B. Green Memorial Hospital).
2005, there were no dedicated, specially-equipped facilities for such training.

“The addition of the Clinical Skills Center was a tremendous milestone in the School of Medicine’s 40 year history,” says Dr. Nan Clare, Senior Associate Dean and Associate Dean for Academic Affairs.” Providing a high-quality setting has translated into a better experience for students,” she says.

“It is hard for the standardized patients to play their part when they are in a lab room,” Clare says. “Having the Center has helped the standardized patients to be better. It has helped the students in that they feel they are in a real medical environment, and it allows us to directly assess the students. It has been a huge boost to the educational program.”

When the School’s graduates enter residency programs, Clare says, they consistently receive high rankings for communication skills, professionalism and ethical behavior, all qualities linked to the School’s clinical skills training.

“I got to third year and was doing exams on real patients for the first time… and I realized just how well I’d been prepared,” Lacey says.

While the demands of rotations are rigorous, the diversity of experience is invaluable — and uncommon. Many medical schools have access to a university hospital and a veterans’ hospital, Jones says. However, in San Antonio, students can also experience a county hospital, private hospital, military hospitals, and hospitals and clinics in smaller communities such as Harlingen, Brownsville, McAllen and Corpus Christi.

As he progresses through fourth year, Lacey feels “light years” ahead of where he was a year ago. During fourth year, students continue through four-week rotations of their own choosing that zero in on their professional interests.

Lacey quotes a line from the movie Jerry Maguire to describe his medical school experience so far: “It’s an up-at-dawn, pride-swallowing siege.”

“It is an absolute assault on your ego,” he says. “That being said, I think it’s totally worth it. I absolutely love what I do. It’s the kind of thing that you can look back on and say ‘I worked really, really hard for that.”

Corbitt agrees with that assessment.

Rotations: “Into the Fire”

While the Clinical Skills Center builds a foundation in the first two years, the third year is when it is put to the test.

That is when students take rotations, hands-on, six-week clerkships in pediatrics, psychiatry, family and community medicine, and obstetrics/gynecology, along with 12 weeks each of surgery and internal medicine. It is their first time caring for real patients in a fast-paced, real-world setting.

“The growth curve both professionally and personally is pretty tremendous,” says Lee Jones, Associate Dean for Student Affairs. “They see people that they never would have seen before. They take care of happy situations with newborn babies, very sad situations of someone with a terminal illness or someone with a heart attack who is dying.”

Students work on teams consisting of two or three third- and fourth-year medical students, two or three interns in their first year out of medical school, a senior resident, maybe a fellow and an attending physician.

While students work under the guidance of a physician, they do take on a heavy load of responsibility for patient care. During his first week or so on rotations in the emergency room of a local hospital, Lacey helped car accident survivors, gunshot victims – even a man who had been attacked by a tiger at the zoo. Third year rotations, he says, is being “thrown into the fire.”

Corbitt agrees with that assessment.

John Calhoon, M.D. transplants heart into a 17-day-old infant in the youngest transplant patient ever.

CTRC launches the Institute for Drug Development (IDD).
“I was just visiting there,” Jimenez told him, “with a tour group.”

“I was there under different circumstances…” Leal recounted. He did not elaborate. It was not something he talked about.

Jimenez pulled out the vial of sand, and said, “I have something for you.”

He presented Leal with the small glass bottle. Jimenez told him he had been on Red Beach 2. This was the same beach Leal landed on so many years before. Jimenez remembers Leal was a bit stunned. They both were.

Leal held the bottle to the light. The large granules of black rock were unmistakably the unconsolidated stuff that made the invasion more difficult for Leal and the 4,000 other Marines that landed on that beach with him.

Not many people survived the battle, and very few of those survivors are still alive today. “It didn’t feel like a coincidence,” Leal said later of this meeting. “It felt like it was meant to be.”

Leal began to tell his story to Jimenez. It is a story he had never shared with anyone before not to his wife of 50 years, who is now deceased; not his grown son, a teacher here in San Antonio; not even to close friends. He had only discussed it in general terms with a few fellow Marines who were also survivors of the battle.

“I don’t like to remember things that hurt. I like to think about the beautiful things in life,” Leal says.

5th Marine Division, 27th Marine Regiment, 2nd Battalion, 3rd Platoon. Or was it 2nd? It’s been 64 years. Some details aren’t as clear as others. After weeks of waiting, Leal says they were called to a briefing. Their Colonel told the platoon this would be a “relatively short operation.” Leal says he remembers the colonel’s words like they were yesterday… “Those of us that are left should be back on board in about 72 hours.”

Iwo Jima was considered strategically important to both sides. Besides being Japanese territory — and the “doorway to the mainland” — Iwo Jima was to be a vital location for refueling U.S. long range bombers heading for Japan. Meanwhile, Japan had fighters based there, which they were using to intercept bombers.

“We had no idea what we were getting into,” Leal says casually. His words delivered simply, honestly — the understatement not intentional. Historians, filmmakers and authors of all sorts have spent the last 60 years explaining just how seriously we did not know what we were getting into at Iwo Jima. Some accounts say battle planners underestimated the Japanese presence on the island by 80 percent. This was the threshold to Japan and there was no cost too great to the Japanese government. They were prepared to defend it at a huge cost a cost that was known only to them. They underestimated our invading force. There were an estimated 110,000 troops amassed among the invading fleet. Some 70,000 U.S. servicemen would go ashore before all was said and done.

The ships arrived and commenced bombarding Iwo Jima for almost five days. The shelling would stop for a day while hundreds of Air Force bombers ran raids over the island. On the fifth day the order was given to go in. Everyone, including Leal, thought all that bombing had done most of their work for them. It was February 19, 1945.

“We went in and it was quiet. Deathly quiet. We went in at Red Beach 2. We assumed the steady bombing had cleaned it out.”

If you have seen any of the movies, or read any of the accounts, Leal’s story sounds very familiar. Just getting onto the island was a task. “It was a tough beach. Volcanic sand, steep beach, so with big waves and your 60 pound backpack, you’d just sink into the sand.” Many men had to throw off their backpacks just to keep from drowning.

“It had been about two hours — we were just starting to move inland — then all hell broke loose. A lot of guys never even made it off the landing boats after that.”

The five days of constant bombing had done virtually no damage to the fortifications on the island — or the 22,000 Japanese soldiers that lay in wait for the U.S. Marines. The Japanese strategy was very simple — wait patiently and quietly out of sight — until the beaches were full of invading troops.

The Japanese had truly embedded themselves in the island. The marines mapped more than 11 miles of tunnels in the months after the battle.

“We couldn’t even see the enemy. I don’t think I ever did see them. I saw a bicycle. An old jeep. Never saw who was shooting at me.”

More than one thousand Marines would die each week over the next six weeks. In his own words, Leal recounts the next two weeks.

The National Institutes of Health (NIH) funds work on Genome Project.

1992
There were two airstrips on the island. Our job was to take one of them. I figure that’s the most expensive piece of real estate on the planet. We lost almost 3,000 men just taking that one airstrip. A lot of people thought the flag raising was the end. Actually, it had just begun. We lost thousands of men after that point. (The flag picture was taken on day five of the battle.)

We had been there about two weeks, and then we got called back to the headquarters – which was just an outpost back on the beach – for 24 hours of R&R. We thought we’d get to sleep maybe take a shower. Nope. We were selected for a special detail. An order is an order… We had to follow along behind dump trucks – picking up the dead. It was the most horrifying experience in the world. The island was not just a volcano, but it was a sulfur mine. So it stunk of that sulfur smell all the time. Combined with the smell of the dead… it was unbearable. I’m just fortunate to be here, to be alive.

You get to a point where you don’t care what happens. I have friends who got the Medal of Honor. They did unbelievable things, but if you talk to them, they’ll tell you honestly, “I was just trying to cover my butt!” You start off scared to death – first of losing your life, then it turns to fear of losing your mind. Then fear turns to anger, and eventually, it turns to hatred. And then you don’t give a damn what happens. You get so mad, you just don’t care, but you keep on going…

In the conversation Leal had to pause many times. He’s had nightmares now that he’s started talking about it. It is not an easy thing to hear, not an easy thing to tell. The rest of his story is very simple. He watched as everyone else in his squad, and every soldier around him was killed, one-by-one. And then it was his turn.

Pretty soon I was alone. I was the only one left. I started moving back toward the beach and a mortar round landed next to me. I woke up back at the HQ on the beach. Eventually, I ended up back in San Francisco for rehab. Got a desk job. Been behind a desk ever since.

Leal is very close to his son, Michael, an only child, who brags that his father was always very supportive of everything he did. He distinctly remembers that his father was quietly proud of his military service, but never spoke of the details. “It’s a part of his life he wanted to leave behind, and you respected that. He didn’t talk about it much,” the younger Leal says.

Leal Sr. and Jimenez harbor a tremendous respect for one another, for different reasons. Leal has some other health issues being handled by other doctors, but Jimenez is staying on top of it all for Leal.

Leal maintains a deeply-seated commitment to country, saying clearly he would do it all over again if he had to. “You do what you have to do for your country,” he says.

Jimenez is left with a new level of respect for Leal and all veterans and active duty troops.

“I was always patriotic,” Jimenez notes, “but I was never in the military – and nobody in my family was in the military. After this, well… I’m just filled with such pride in my country, and these people who do this – who keep us safe and put their lives on the line every day. To meet them and see this… it just puts it all in perspective. I can not even put into words how it made me feel. It’s beyond patriotic.”

Battle of Iwo Jima

February 19 to March 26 of 1945, 6,821 US Marines Died. Of the 22,000 Japanese soldiers, 317 were taken prisoner. The remainder perished. More than a third of the approximately 72,000 Marines who landed on Iwo Jima were killed or wounded.

Twenty-seven of the 353 Congressional Medals of Honor awarded during World War II were given for heroism on Iwo Jima. Thirteen of them posthumously.

The United States returned possession of Iwo Jima to Japan in 1968 – the year the School of Medicine opened its doors.
White Coat Ceremony welcomes 1st Year Students
It’s a Family Affair

The School of Medicine welcomed our first year medical students with a white coat in a special ceremony attended by their friends and family. This year is special in many ways. Besides the 40th Anniversary, it was a family affair with many of the proud parents being faculty members and alumni. The guests of honor were three early alumni, Drs. Marco Lopez, James Rogers and Mary Arno.

Dr. Lopez is from the second graduating class. He is a diplomate of the American Board of Obstetricians and Gynecologists and has a private practice in San Antonio. He was a faculty member for five years, and a military physician before that. He placed a white coat on first-year Samuel Overley – whom Lopez delivered as an obstetrician 23 years prior.

Dr. James Rogers, class of 1973, serves as the Medical Director for the Texas Department of Family and Protective Services. Dr. Rogers, was also a faculty member for almost 30 years and was a proud father at the ceremony, placing a white coat on his daughter, Celeste.

Dr. Arno, class of 1974, is an ophthalmologist in private practice and has a daughter entering her second year at the School and another daughter who is already an alumnus.

Dr. Nicolas Walsh, Chairman of Rehabilitation Medicine, put a white coat on his daughter, Rorey.

Dr. Donald Dudley, alum class of ’84 faculty, an OB-GYN and director of The National Center of Excellence in Women’s Health, was honored to put a white coat on his son, Christopher.

The ceremony ended with the recitation of the Physicians’ Oath of Hippocrates. It was led by Claudia Miller, M.D., from the Department of Family and Community Medicine. She noted that when she graduated from our medical school in 1985, she was pregnant with her son, William, who had just received his white coat at the ceremony. A family affair indeed.
The best place to beat cancer is in your own backyard.

There are only three NCI-designated cancer centers in Texas. The CTRC is the only cancer center in San Antonio to achieve this designation. Our patients have access to a team of world-class specialists and the most effective therapies. Let CTRC help you choose life over cancer.
rate of death, and 40 percent of patients were alive after 10 years. In 1984, 25 years after the Philadelphia chromosome was discovered, the chromosomes involved in the abnormality were identified. A year later, it was understood that the abnormality resulted from an exchange of genetic material (or translocation) between chromosomes 9 and 22. The exchange fuses together two genes – the BCR (breakpoint cluster region) gene on chromosome 22 and the ABL (Ableson leukemia virus) on chromosome 9. The fusion of the hybrid BCR-ABL protein speeds up cell division and growth, inhibits DNA repair, and is ultimately the cause of CML.

Two very important characteristics were learned as a result of the discovery of the BCR-ABL protein. Science has proven that it is easier for a drug to reach the cytoplasm than the nucleus. The BCR-ABL protein resides in the cytoplasm. In addition, the BCR-ABL protein is an enzyme, which acts as a "mini-factory" that can be shut off. Together, the advantage of the protein being an enzyme in the cytoplasm of the cell means it is open to inhibition by drugs.

The BCR-ABL protein functions by using ATP (adenosine-tri-phosphate) to energize the cell, causing it to divide rapidly in an unchecked fashion. This discovery led to the development of imatinib, or Gleevec, in the late 1990’s. Imatinib competes with ATP and displaces the energy source, causing the CML cell to die. Because healthy cells do not have this protein, they are not harmed. At last, a targeted therapy was born, and patients with CML who were treated with imatinib saw a 95 percent survival rate after five years.

“It is difficult to accurately convey the importance of Gleevec (imatinib) in cancer treatment overall,” said Dr. Giles. “Gleevec showed that if you can identify a critical kinase or enzyme or target, you can develop therapy that affects only the cancer and leaves normal cells largely alone.”

This was just the beginning of the tale of targeted therapies. Some CML patients, approximately 15 percent, become resistant to, or intolerant of, imatinib. Much of the current research being conducted at CTRC is focused on developing new agents for these patients. Giles gladly notes the subset is rare.

“Resistance to imatinib is a phase that is theoretical for the great majority of chronic phase patients, but for those rare patients who still present in the blast phase, the need to deliver better therapy is absolutely urgent,” said Dr. Giles. “CML blastic phase is a condition that we want to avoid, so we have to develop drugs today for those people who need them today and for those who may in the future.”

Dr. Giles describes two scenarios that could lead to the imatinib resistance. The first scenario concerns a patient with CML still driven by BCR-ABL. The imatinib can still “switch off” the enzyme, shutting down cancer cell growth. But if the patient cannot tolerate the drug, or does not take the proper dosage, or the leukemia cells do not retain a sufficient dose, another treatment option is necessary for survival.

The second scenario examines the idea that the disease “gets smart,” and learns to move the target or structure of the gene, prohibiting the drug from doing its job of killing the cancer.

“Gleevec was revolutionary, not because of what it achieved, but because of what it promised,” said Dr. Giles. “It was considered a wonder drug, but we wanted to see how exactly to make it better.”

Dr. Giles and his team designed a preclinical experiment using a chemical derivative of imatinib, termed drug AMN107. When the drug showed promise in the laboratory, Dr. Giles was named the principal investigator on the Phase I clinical study, a study in which patients are exposed to the drug for the first time. The first patient received treatment with this drug in May, 2004. The results of this Phase I study demonstrated that almost 90 percent of chronic-phase patients, over 60 percent of accelerated-phase patients, and over 30 percent of blastic-phase patients who had failed Gleevec, the current frontline treatment, showed hematologic response and adequate clinical control of their symptoms with this new drug.

The drug AMN107, or nilotinib, continued to show success in treating patients with CML, and progressed to Phase II and Phase III clinical studies. Nilotinib was approved by the U.S. Food and Drug Administration (FDA) on October 29, 2007. Nilotinib, marketed by Novartis under the brand name Tasigna, was synthesized a mere six years ago, which is one of the shortest times such an agent has been moved from concept to FDA accelerated approval.

Both Gleevec and Tasigna have revolutionized the treatment of CML and has also demonstrated efficacy in some Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL) patients. Nilotinib is ineffective for a specific form of imatinib resistant/intolerant CML and Ph+ ALL patients where the cells are carrying a T315I BCR-ABL mutation, which confers the highest degree of drug resistance. There is a dire need to identify and develop novel drugs for patients that do not benefit from imatinib or second line BCR-ABL inhibitors. Dr. Giles reported last year on the first clinical activity of a kinase inhibitor that has activity against T315I CML and ALL, an agent called MK-0457.

The medical community can expect more from the CTRC drug development team in the future. Because patients continue to
need effective treatment after front-line therapies fail, Dr. Giles and his team continue their development of novel targeted therapies. Aside from MK-0457, his group is focused on an agent, MLN8237, which is promising as an anti-CML and Ph+ ALL agent with activity against the T3151 mutation phenotype. With the help of a grant from Dallas-based charity, Leukemia Texas, his team will further investigate the preclinical and clinical safety and efficacy of drug MLN8237 for CML and Ph+ ALL patients.

“Modern developmental therapeutics has delivered, and I expect it to keep on doing so,” Dr. Giles said. “We are learning to develop targeted agents better and faster, and that is going to apply to traditional cancer drugs, targeted drugs, immune modulation, cancer vaccines and the use of viruses as anticancer agents.”

The CTRC stands as a leader in the development of these targeted therapies, promising new breakthroughs for patients around the world with all forms of cancer.

BUSTING SILOS AND IMPROVING HUMAN HEALTH CONTINUED FROM PAGE 17

respects among all team members. This is what it is going to take to solve the large complex health problems that face us today. The IIMS will also provide these scientific teams with resources to help them communicate with each other and work together without the boundaries and barriers that typically exist between researchers who work at different institutions, basic scientists, clinicians, researchers, and members of the community. It can only help the scientist working in the laboratory do better and more relevant work to understand how his or her results could be taken into studies with human volunteers and then into the clinics where health can be transformed.

“The process of organizing ourselves to prepare this grant application has brought about significant progress in breaking down institutional silos and getting people with different experiences and areas of expertise working together to benefit our community. Now that the grant is funded, even greater things are going to happen,” Dr. Fernando Guerra, Director, San Antonio Metropolitan Health District, IIMS Community Advisory Board Chair.

San Antonio Cancer Institute (SACI) receives comprehensive cancer center status from National Cancer Institute.

Houston Goodwin, foreground, with Drs. Swami and Giles.

Twelve years ago, Houston Goodwin was diagnosed with chronic lymphocytic leukemia (CLL). He traveled from his hometown of Granada, Mississippi to MD Anderson Cancer Center in Houston, where Dr. Francis Giles had recently accepted a new position as an associate professor and physician scientist. Mr. Goodwin quickly learned two things: he was the first patient Dr. Giles would see at his new practice at MD Anderson, and Dr. Giles was one of the world’s leading leukemia specialists and drug development experts. On that fateful day, the pair made a pact that they would never give up.

After being treated with a combination of drugs fludarabine and cytoxan, Mr. Goodwin’s cancer went into remission. When the cancer came back, Dr. Giles held true to their pact and fought the cancer again, the second time with a chemotherapy combination of alemtuzumab, rituxan, fludarabine and cytoxan. Again, treatment sent the cancer into remission.

In early 2008, Mr. Goodwin knew something had changed and he needed to see Dr. Giles again. Knowing that Dr. Giles was now leading the CTRC Institute for Drug Development, Mr. Goodwin sent his blood samples to San Antonio and was told by Dr. Giles to be at CTRC for treatment within 24 hours. The disease he had battled and beaten twice had returned, but this time something was different. In April, Dr. Giles and Dr. Swami Padmanabhan, Director of Hematological Malignancies at CTRC, diagnosed him with Philadelphia (Ph+) adult lymphoblastic leukemia (ALL).

An interesting twist emerged as Mr. Goodwin once again put his fate in the hands of Dr. Giles, along with his colleague, Dr. Swami. Mr. Goodwin learned he was the first patient that Dr. Swami diagnosed and treated since joining the medical staff at CTRC. He again learned that while he and his doctors may all be relatively new to the CTRC, he was in good hands, being seen by specialists and leading experts in his disease.

“I travel to CTRC every 21 days for treatment,” said Mr. Goodwin. “Dr. Giles and Dr. Swami are the best. I truly believe God put me in the hands of these doctors, under these unique circumstances, and at these crucial times in our lives. They are honest and lay everything out on the table. I never have any doubt about what the plan is or what they hope to achieve … a cure.”

Mr. Goodwin is being treated at CTRC with a novel combination of chemotherapy and Tasigna because of the tendency of ALL patients to have resistance to Gleevec. He is responding to treatment and immediately went into remission after the first cycle of treatment without any evidence of cancer cells in the bone marrow nor any evidence of the Philadelphia chromosome by sensitive molecular tests. This is the first time that this combination of chemo and Tasigna is being tested in Ph+ALL.

“I don’t ever think about giving up; I fight this disease,” said Mr. Goodwin. “Even at 72 years of age, that’s why I am still here. There are new drugs being developed every day, so I keep fighting and keep living. And I do that with the help of Dr. Giles and Dr. Swami.”
decades. As proof, he points to the general health of Americans. “We have never been healthier as a population or had a greater number of options available in healthcare.”

Nan Clare, MD, Associate Dean for Academic Affairs stepped into Dr. Pestana’s shoes when he retired from the Dean’s office in 1998. “Big shoes to fill,” Clare says, adding that the admiration and respect that students carry for Pestana continues well beyond the decade since he left teaching full-time.

Clare’s observations are similar to Pestana’s. “It is not a perfect system and that is why we work on constant improvement.” Clare graduated from the School in 1975, did her residency here as well, and became a junior faculty member in 1979.

The core of teaching medicine has not changed, she says. The subject matter and the basic techniques have remained very much the same and the product at the school has not changed, she says, “We produce physicians who offer excellent clinical care.”

“The periphery has changed somewhat. We now have a generation that grew up with technology and expects to see a lot of it in their classroom.” Meanwhile, she says how we teach has changed but has little to do with technology. She is talking about curriculum changes.

“We just completed a review and adjustment of our first two years. We are coming full circle really – back to an integrated curriculum,” Clare says.

When the school started – and Dr. Pestana and others put together the first curriculum – it was integrated into modules for each of the major systems. Anatomy, microbiology, and biochemistry were all taught in context of the system being studied, whether endocrine, skeletal, cardiovascular, etc. That all changed in the late 1970s, and the School went back to a more standardized approach with the basic sciences and clinical sciences taught separately. This is now returning to an integrated curriculum.

Going back to the integrated curriculum is the outcome of a thorough review (and rewriting) of the School’s goals and objectives. This exercise has also resulted in a strong movement toward a competency-based curriculum.

Clare explains the the Curriculum Committee has adopted a list of core-competencies that they believe every physician should have, such as the ability (and commitment) to improve their knowledge and skills. Nolan emphasized the same competency-focus from the graduate side, which includes teaching physicians how to navigate the complicated systems that now fund most healthcare. This will include a basic knowledge of healthcare delivery systems like HMOs, PPOs, county, state and private systems. “It is the physician who must extract resources for his patients from these complex systems,” Nolan says, “We need to send them out there knowing how these organizations work.”

“We are now reviewing our curriculum to make sure we address this long list of competencies. In most cases, we do, but we have definitely identified gaps that we will need to fill,” Clare says.

Looking back at the last 40 years of residency training, Nolan says the biggest difference he has noticed is faculty supervision. Faculty and residents are virtually side-by-side everywhere -- in the clinic, in the operating room, and on the wards. “Forty years ago, residents were in the hospitals at night, by themselves, performing relatively major procedures that we would not even consider letting them do alone now.”

Nolan and Clare both emphasized the move to focus on outcomes and competency is driving changes in curriculum. Competencies have been defined by the ACGME specifically and include: Medical Knowledge, Patient Care, Interpersonal and Communication Skills, Professionalism, Practice Based Learning and Improvement, and Systems Based Practice.

Nolan says residents are evaluated more, and on a broader range of criteria (and by more people) than ever before. This means a 360 degree type evaluation that includes faculty, other residents and staff, students, and patients. These evaluations include grading communication skills, professionalism, and ability to teach.

Pestana brings up what he views as a major change over the years – seldom discuss – extreme restrictions on the use of animals. This used to be a very large part of surgery training. Thirty years ago, they would use dogs from the pound destined for euthanasia. This is now impossible due to the animal rights activists and his is true of all medical schools.

On the other side of that coin, he says the new level of sophistication with the H-E-B Clinical Skills Center, has been a boon to teaching medicine and the School as a whole. Students
get hands-on practice with real patients almost immediately into their medical school careers.

Pestana remembers back when the only time medical students could practice giving exams was on Saturday mornings when the hospital’s exam rooms were free. “When we got our first clinical skills center, it was a huge benefit to the school.”

Like Pestana, Clare says the addition of standardized patients was a major improvement. “Not many schools have invested as much in clinical skills as we have,” she says, “and it shows. By the time you are a third-year student here, you are completely qualified to do a thorough physical exam of a patient.”

Regarding the more quantifiable measures of change, demographics were brought up by most everyone. Fifty percent (some years slightly more) of the class are female. Huff says about 75 percent of Ob/Gyn residents are now female. For a long time, it was less than 10 percent. His Chairman, Dr. Robert Schenken, actively recruits women for the Ob/Gyn program, which did not happen 40 years ago.

Pestana said the City of San Antonio has been great for the School. The city’s growth and support of the School from day one – and the significance of that support – are key factors in the School’s success. He points out that San Antonio is now a large and thriving city with all of the advantages of the largest U.S. urban centers. A strong economy, commerce and access to technologies are necessary to support an institution on this level.

Pestana ended his discussion with a wonderful sentiment. He said the best thing has not changed at all -- the people.

“The people that gravitate toward medicine tend to be very bright and motivated – the cream of the crop, superb individuals. I find this as true now as it was 40 years ago. Consistently, all of these people -- the people who are drawn to medicine -- are great people. Probably the greatest pleasure in my life has come from a career surrounded by these wonderful, wonderful people.”
Lopez made the decision to attend medical school in Mexico at Universidad Autónoma De Guadalajara. After two years, he took the U.S. Medical Licensing Exam (USMLE-1) and passed. In the Fall of 1968, Lopez transferred to “that new medical school in San Antonio.” He remembers working hard, pushing himself to excel. His area of interest was Family Medicine (like his father) and Surgery. He didn’t care for OB/GYN the first time around. Laughing, Lopez recalls, “I saw my first delivery and told myself, I knew what I did not want to do.” He was soon to change his mind. “After learning more from the outstanding faculty in the department I learned OB/GYN had all the aspects of medicine I was interested in.” Lopez graduated in a class of 30, in 1971 - the second graduating class.

Spending the next few years practicing at University Hospital and the Brady-Green, Lopez completed his residency. He spent the next four years in the U.S. Army Medical Corps in Frankfurt, Germany. In 1979, after completing his service to the Army, Lopez came back to San Antonio and opened his private practice in the medical center. “Part of the reason I opened my office in the medical center area was the attachment I felt to the Medical School. I am immensely grateful to the School and the wonderful faculty,” he says.

Along with his wife of twenty-three years, Lopez remains an active member in professional groups, the community and the School of Medicine. To date, Lopez has delivered approximately 5,000 babies. On July 20th, during the White Coat ceremony at the School, he placed a white coat on one of the babies he assisted delivering, Samuel Overley, who is now a 23-year-old medical student. This ceremony was special as it was the beginning of the 40th Anniversary of the School and the start of medical school for the student. “I feel like I have come full circle now,” Lopez says. “I would like to let medical students know they live in the kindest, gentlest country in the world,” Lopez says, proudly. “There are not many countries where you can arrive with $450 and become a doctor, have two sons who are doctors, daughters who are speech pathologists and a paralegal. I look upon myself as a success, but not because of me but because of the wonderful country we live in.”
giving Botox another try. Based on some anatomical and physical studies Simpson had done, he thought injecting the false cords might provide some relief without hindering the ability to control pitch. Simpson was honest with Bush – injecting the false cords was untested.

“It took almost two years to talk him into it,” Simpson says, “And Johnny’s voice was not really getting better, so I finally got him to give it a try.”

It takes about five days to take affect – but the affect was nearly miraculous. It is Simpson’s theory that injecting the false cords allows the Botox to be diffused through the tissues so the affect is more subtle. When talking about it, Simpson is humble and very matter-of-fact. He’s just truly glad he was able to help this patient.

This is in stark contrast to Bush’s take on it – who says meeting Simpson was divine intervention. He makes a good case for it in his autobiography.

It’s been five years now. Botox has been cleared by the FDA for addressing adductor spasmodic dysphonia. Bush goes back for injections about every eight weeks. He says he likes being a baritone instead of the tenor he used to be. He lowered the keys to his songs a bit, and he’s working a lot more now that a younger crowd has discovered “real Texas country music.”

“I’d say I’m singing at 100% now. And it’s all Blake’s fault,” Bush jokes.

Listening to Bush’s latest album, you wouldn’t think there ever was a problem. He has a deep, rich tone and the crowds are coming back to hear him – and to dance to the classic Texas rhythms his band is known for. Bush released an autobiography and a new album last year. He also just finished producing an album he recorded with Willie Nelson and their other good friend, the legendary Ray Price – all fellow members of the Texas Country Music Hall of Fame. “We take country classics and do them up big band style,” Bush says. The album will be released next year.

Bush and Simpson are now a dynamic duo of vocal disorders – helping singers, trial attorneys, a prison guard, and others who depend on their voices. Bush and Simpson talk weekly and the men have become good friends. Bush recalls one of his favorite lines when he asked Simpson a question about cardiology. “Don’t ask me, I’m not a doctor,” Simpson replied.

Bush openly advertises his offer to help people with vocal disorders, and he means it when he says “Anyone. Anywhere.”

All they have to do is contact him. “I don’t send patients to Blake,” Bush says, “I drive them to him.” Simpson verifies this with a big nod of the head.

One example was about two years ago when Simpson got a call from Willie Nelson. Nelson was in Hawaii and an old friend was starting to talk like Bush in the early days of his condition. Nelson knew that “strangled” voice so well, he was certain the man had adductor spasmodic dysphonia. “And he did,” Simpson says. Nelson flew the man from Hawaii to San Antonio two days later. Simpson evaluated him, and treated him with excellent results. Simpson has been to see Bush and Nelson in concert, but it now seems they are bigger fans of “Our Hero, Dr. Blake,” as Bush refers to him.

Bush insists this article include a note to anyone interested in help with a vocal disorder. They can contact him through his website, www.johnnybush.com, where you can also find his new album Kashmere Gardens Mud which was released last year along with his autobiography, aptly named Whiskey River (Take My Mind). Bush’s autobiography is a raw, honest account of his life, and the rise, fall and rebirth of not just his career, but real Texas country music over the last 50 years. And the forward by Nelson is entertaining.

Simpson is a board-certified head and neck surgeon, with research interests in laryngotracheal stenosis and office-based treatments for laryngeal disorders, including pulsed-KTP lasers. His research has been published in numerous journals including the American Journal of Otolaryngology and Ear Nose Throat Journal. He practices in the medical center. For appointments call the ENT clinic at (210) 450-1500.

Simpson also has co-authored a book coming out this fall entitled Operative Techniques in Laryngology which he wrote with Clark A. Rosen, M.D., of the University of Pittsburgh Medical Center. Shipping is free if you pre-order it on Amazon now.

Francisco Cigarroa, M.D., appointed President, UT Health Science Center.

Steven A. Wartman M.D., Ph.D., appointed Dean.
Dr. Scott Johnson, Associate professor of Cardiothoracic Surgery, is leading a study in collaboration with a team at UT Austin to test a new aerosol therapy spray to help lung transplant patients suffering from rejection, as conventional rejection drugs can harm the kidney. The team has developed an aerosol whose particles are nanometer sized and much more likely to assist those patients who cannot use existing aerosols.

Dr. Sunil K. Ahuja, Professor of Medicine and Infectious Disease, has reported a genetic variation that may have protected people of African descent against a pandemic of malaria long ago now appears to increase their susceptibility to HIV infection. The variation, described in the journal *Cell Host & Microbe*, is one of the first genetic risk factors for HIV to be identified only in those of African descent and puts a spotlight on the differences in our genetic makeup that play a critical role in susceptibility to HIV-AIDS. The study provides strong evidence that two genes are linchpins in defining the course of immune restorative HIV-positive individuals undergoing virus-suppressing therapy and these new results suggest that the personalization of HIV treatment is.

Dr. Ahuja has also co-authored a study revealing that a protein, which is one of the major predictors of Alzheimer’s Disease, also predicts the pace at which HIV-infected persons will progress to death. The report is in the online *Proceedings of the National Academy of Sciences*. The research team studied a population of 1,300 European and African-American HIV-infected patients. The scientists compared HIV clinical outcomes of individuals who have two copies of the gene that makes the apoE4 protein with outcomes of those endowed with two copies of a gene that makes a related protein, apoE3. The latter differs from apoE4 by a single amino acid. They found the subjects with two copies of apoE4 were more likely to have a twofold faster HIV disease course, noticeably marked by progression to death, than subjects with two copies that make apoE3.

Dr. Amelie G. Ramirez, review leader, Professor of Epidemiology and Biostatistics, and Director of the Institute for Health Promotion Research, has released the *South Texas Health Status Review* which states that obesity and diabetes are the two most significant health disparities in South Texas. The review was in collaboration with the UT Health Science Center’s Regional Academic Health Center in Harlingen and Edinburg, and the Texas Department of State Health Services. The review found that South Texas residents were at a disadvantage, regarding the incidence of disease, compared to the rest of Texas for 12 of the 32 health indicators analyzed, including; diabetes; obesity; birth defects; and cervical, liver, stomach and gallbladder cancers. Also, incidence rates for many of the 32 health indicators were higher for South Texas Hispanics than non-Hispanic whites. The report urges health workers, researchers and policymakers to focus their efforts on reducing obesity because of its link to many other major health issues.

The Institute for Drug Development (IDD), a division of CTRC announced the results of a new phase I clinical study on NPI-2358, a targeted anti-cancer agent designed to rapidly disrupt blood flow to the tumor mass, causing tumor death. The novel agent destabilizes the cells in the blood vessels leading to

---

The CTRC completes construction of the Urschel Tower and the Zeller Building, which includes the H-E-B Ambulatory Surgery Center.
the tumor, resulting in a toxic effect on the cancer cells, leaving the healthy cells unharmed. The data were presented during the Annual Meeting of the American Association for Cancer Research (AACR) in San Diego, California. Results presented show the novel anti-cancer agent NPI-2358 to be well tolerated by patients with solid tumors and lymphoma. Minimal side effects included intermittent nausea, fever, tumor pain and temporary hypertension, demonstrating a successful drug effect on stabilizing the tumor growth.

The study, “Phase I Dose Escalation Trial with DCE-MRI Imaging of the Novel Vascular Disrupting Agent NPI-2358,” was authored by Dr. Monica Mita and her colleagues at the IDD, Virtual Scopics Inc., Northwestern Medical Specialties, Karmanos Cancer Institute and Nereus Pharmaceuticals.

Dr. Daniel DeArmond, Assistant Professor of Cardiothoracic Surgery at the CTRC’s Thoracic Cancer Center announced a new, less invasive option to traditional large incision procedures for patients in the early stages of lung cancer. Called VATS, for video-assisted thoracoscopic surgery, it neither fractures nor involves spreading the ribs like conventional procedures. Fewer post-operative complications are seen and recovery time is shorter.

Dr. Ande Bao, Assistant Professor of Radiology and Otolaryngology-Head and Neck Surgery, along with Dr. William T. Phillips and Dr. Beth Goins, Professors of Radiology (all from the CTRC) recently discovered a way to incorporate a radioactive isotope, 186rhenum, into nano-scale lipid spheres, which are called liposomes. The scientists demonstrated that the radioactive liposomes could kill cancer cells. The technology has been licensed to Azaya Therapeutics Inc., which will develop and commercialize the novel cancer treatment. If the first clinical application of 186rhenum liposomes in head and neck cancer patients is successful, follow-up clinical studies may target prostate, breast and brain cancers.

Cancer Therapy & Research Center (CTRC)

Dr. Ian Thompson, Director of the CTRC Genitourinary Clinic and Professor and Chairman of the Department of Urology, has been selected to serve as a co-chair for the National Cancer Institute (NCI) Genitourinary Steering Committee. Dr. Thompson was selected as one of three co-chairs for this distinguished leadership position because of his international reputation for prostate cancer research and due to the report of the Clinical Trials Working Group issued in 2004. Thompson is also the prostate study leader in the Southwest Oncology Group (SWOG), a cancer clinical trials cooperative group, which is now part of the UT Health Science Center since the merger with CTRC. With a network of more than 5,000 physicians and researchers located in clinics and in private practice, SWOG is one of the largest cancer clinical trials cooperative groups in the U.S. The SWOG has three regional offices, including the operational and regulatory leadership housed in San Antonio at the Texas Research Park.

The CTRC is one of five sites selected in the U.S. to conduct a Phase III study of active surveillance therapy against radical treatment in patients diagnosed with early prostate cancer. According to study coordinator Dr. Ian Thompson, no other large-scale studies in North America are currently investigating whether active surveillance, often referred to as watchful waiting, fits into the treatment mix. Active surveillance with selective intervention is the close monitoring of prostate cancer with the offer of treatment if there is any evidence of cancer growth. Some medical experts and scientific research suggest that some types of prostate cancer are low risk (not lethal) and may not need to be treated. For some men, the option to wait on treatment may be the best option because it allows them to avoid the risk of treatment side effects. Treatment intervention is either radiation therapy (external beam therapy or brachytherapy seed implant) or surgical removal of the prostate, depending on patient preference.
Drs. Antonio R. Anzueto and Marcos I. Restrepo, of the UT Health Science Center and the Audie L. Murphy Division, are coauthors of a study showing a silver-coated endotracheal tube can reduce the incidence of ventilator-associated pneumonia (VAP) up to 30% by preventing bacterial colonization and biofilm formation. The findings were published in *Journal of the American Medical Association* (JAMA) online August 19. Anzueto and Restrepo are part of the North American Silver-Coated Endotracheal Tube (NASCENT) Study Investigation Group.

Dr. Steven Bailey, Distinguished Chair and Director, Janey Briscoe Center of Excellence in Cardiovascular Research was honored with the 2008 Heroes of the Heart Award by the American Heart Association (AHA). Also newly named as the Division chief of the Janey and Dolph Briscoe Division of Cardiology.

Dr. Lois Bready, Associate Dean for Graduate Medical Education, has been selected to receive the Parker J. Palmer Courage to Lead Award, by the Accreditation Council for Graduate Medical Education (ACGME). She is one of only three people in the country to receive this award. As a part of the award, she will be honored at next year’s ACGME annual convention.

Dr. Charles L. Bowden, a professor of psychiatry who has led 80 research studies of bipolar disorders and mood-stabilizing medications, will receive the NARSAD Falcone Prize for Outstanding Achievement in Mood Disorders Research this week. NARSAD, the world’s leading charity dedicated to mental health research, will hold its 21st annual New York City gala on Friday, Oct. 17. Six scientists including Dr. Bowden will receive their awards at the Waldorf-Astoria Hotel. NARSAD’s 109-member Scientific Council, a volunteer body of leading experts in mental health research, selected the winners.

Dr. Francisco Cigarroa, President, UT Health Science Center at San Antonio and Professor of Pediatric and Transplantation Surgery, was inducted into the Mexican American/Hispanic Physicians Association Hall of Fame to honor his contributions to his profession and to the community.

Dr. Ralph DeFronzo, Professor and Chief of the Division of Diabetes and the South Texas Veterans Health Care System, Audie L. Murphy Division, received the Banting Medal for Scientific Achievement Award, the American Diabetes Association’s most prestigious award.

Dr. Frank Giles, Deputy Director for the Cancer Therapy Research Center was honored as the recipient of the Medtronic Award in recognition of his contributions to the field of health care and medical science at the National University of Ireland Galway Alumni Awards Gala. He was also the recipient of the 2008 Chairman’s Citation for Excellence in Community Service by the South Texas Chapter of the Leukemia & Lymphoma Society for his leadership and contributions to the cure of leukemia and related blood disorders and his recent involvement in the 2nd Annual Texas Forum on Blood Cancers.

The School of Medicine receives largest grant to date: $37M to study small, subcortical strokes.
Dr. Carlos Jaen, Chair, Department of Family and Community Medicine, has been elected Member-at-Large to the Board of Directors of the Association of Departments of Family and Community Medicine (ADFM) until 2010.

Dr. K. Ashok Kumar, Clinical Professor and Director of Medical Education in the Department of Family and Community Medicine was sworn in as President-Elect of the Texas Academy of Family Physicians (TAFP) in the annual session and scientific assembly in Houston this year. He will be President of the organization in 2009-2010.

Dr. Martha Medrano, Professor of Psychiatry, is the 2008 recipient of the Ford Salute to Education Lifetime Achievement Award. Her commitments to supporting excellence in education and to advancing access to education have touched the lives of many.

Roger Perales, MPH, and Assistant Director of the South Texas Environmental Education and Research program (STEER) was selected to make a formal presentation of his field project with aspiring medical students, nursing students and physician assistants at the Environmental Public Health Leadership Institute graduation ceremonies in Atlanta, Georgia.

Dr. Basil Pruitt, Jr., was awarded $100,000 by the King Faisal International Prize for being an innovator in trauma management, including the treatment of burns while caring for thousands of American soldiers.

L. David Hillis, M.D., is the new Chair of the Department of Medicine. He came from UT Southwestern, where he was known as a leading authority on ischemic heart disease and coronary artery disease. He was the director of the cardiac catheterization laboratory for 15 years.

After graduating from the Columbia University College of Physicians and Surgeons, Dr. Hillis was a house officer in medicine at UT Southwestern and served as chief medical resident under Dr. Donald Seldin. He completed his cardiology training at the Peter Bent Brigham Hospital under the tutelage of Dr. Eugene Braunwald. Hillis is the author or co-author of more than 350 original articles, reviews, books and book chapters and serves on the editorial boards of the New England Journal of Medicine and the American Journal of Cardiology, among others. He has received numerous awards in teaching for both medicine and cardiology.

The $50 million Children’s Cancer Research Institute (CCRI) opens to study formation and development of cancer in children and adults.
**A Decade of Commitment**

On June 1, 2008, the Sembradores of San Antonio Educational Foundation presented the School of Medicine with their eleventh annual gift in support of student scholarships during their 47th Installation Ceremony and Awards Presentation.

Over the past 11 years, Sembradores have grown their namesake endowed scholarship to over $91,000.

Commitment to positively influencing their community has driven this special, international civic organization, whose name means “sowers of friendship,” to continue their annual fundraiser “La Posada” and maintain their yearly scholarship donations.

“An investment in the education of our students is an investment which will yield dividends many times over to our community and our country,” Jesse Garcia, Jr., P.E., past President of Sembradores.

**Champions of Compassionate Care**

Mario Vazquez and Alexandra Davalos, friends of Dr. and Mrs. Mahendra Patel, spearheaded a campaign in 2007 to grow the Patel’s endowed namesake scholarship, the Mahendra and Kirti Patel Endowed Scholarship for Ethics and Humanity in Medical Education. All are pictured below with the first Patel scholarship recipient, Chris Corbitt, and Dr. Cigarroa.

“The Patels’ compassion for their patients, their generosity, and their kindness inspired Alexandra and me to grow this fund. It is but a small effort to honor them, while benefiting deserving scholarship recipients.” Mario Vazquez, campaign co-chair.

The Patels generously established a scholarship in fall of 2006 to honor Urmee Patel, Dr. Patel’s sister, who passed away during childhood from a brain tumor. Their scholarship will fill an important need for medical students, greatly affecting their lives and those of the many patients and their families to whom they will deliver care in years to come.

“I am as thankful as ever for the generous contributions. They have made such a difference in my life,” John Martin, MS IV, and a multi-year Sembradores scholarship recipient.

**A Legacy of Training**

Over 140 friends, colleagues, and former residents attended a special dinner on June 30th to honor Dr. William H. Hadnott, II and to celebrate the initiation of an endowed chair campaign in his name: the William H. Hadnott, II, Endowed Chair in Anesthesiology.

Dr. Hadnott was the first graduate of the Department of Anesthesiology’s residency program, and he served on the faculty, training residents for over 40 years. Generations of anesthesiologists have benefited from his distinguished career in which he modeled professionalism, compassion and steadiness.

“His legacy will live on through the many who have had the privilege to learn from him,” William L. Henrich, M.D., M.A.C.P., Dean, School of Medicine and Vice President for Medical Affairs.

Additional dinner photographs and information on the Dr. Hadnott endowed chair campaign can be found at: http://anesthesia.uthscsa.edu/.
Continuing an Educator’s Passion
When Urology faculty member, Dr. Jack R. Robison, passed away suddenly in October of 1975, a student loan fund was established in his name as a memorial. His son, Jay, a third year medical student at the time was on rotation with him the day he passed.

Now a successful Professor of Surgery at the Medical University of South Carolina, Dr. Jay Robison initiated efforts to change the student loan fund to an endowed scholarship for 4th year students intending to pursue a career in Urology.

“He (Dad) felt strongly that – next to direct patient care – passing knowledge to the next generation was the highest calling. How better to honor his memory than to help the next generation of urologists in training?” Jay Robison, M.D.

Tribute for a Medical Degree
Dr. Thomas P. Miller, (Class of 1975) responded to an alumni appeal by making a commitment to establish an endowed namesake scholarship to benefit students with financial need.

“I tribute the UT School of Medicine for setting me on course for something special they gave me my medical degree.” Thomas P. Miller, M.D.

In the summer of 1973, Miller, a Vietnam War Veteran living in San Antonio, was preparing to move to Lubbock. He had been accepted as a 3rd year medical student there. Before departing, he made a call to then Dean of Admissions, Dr. Carlos Pestana. Not only was he able to make an appointment with Dr. Pestana, he learned there might be two possible openings. While on the road leaving San Antonio, Miller received word that he had been accepted at the UT School of Medicine at San Antonio. That marked the beginning of a wonderful medical career for which Dr. Miller is most grateful. He is creating a scholarship to assist future generations of students on course for a similarly satisfying medical career.

President’s Council – Dean’s Critical Needs
Annual gifts to the Dean’s Critical Needs fund through the President’s Council provide invaluable unrestricted resources for responding to emerging needs. A special thanks to the following individuals:

Professors’ Circle ($5,000+)
Phyllis & Jamie Browning
Drs. Sharon & Edward Rosenthal

Research Circle ($2,500+)
Colette M. Kohler, MD
Mrs. Marie L. Pauerstein

Scholars’ Circle ($1,000)
Aleida & William Allen
Dr. Aaron Angel
Dr. Murthy Badiga
Drs. Virginia & Charles Bowden
Dr. Lois L. Bready & Joseph R. Holahan
Drs. Robin Brey & Stephen Holliday
Dr. & Mrs. Howard A. Britton
Dr. John H. Calhoon & Ms. Sarah Lucero
Dr. Robert A. Clark
Dr. & Mrs. Stephen M. Cohn
Fred G. Corley, Jr., MD
Dr. & Mrs. Robert L. Dickson
Drs. Gerald D. Dodd & Deborah A. Neigut
Dr. & Mrs. Ralph F. Erian
Dr. & Mrs. Wayne A. Fagan
Dr. Maria Elena Falcon
Dr. Marvin & Mrs. Ellinor Forland
Dr. Robert S. Hamilton
Dr. Scotte Hartronft
Dr. & Mrs. William W. Hinchey
Dr. & Mrs. O. Roger Hollan
Dr. & Mrs. Stephen D. Houston
Ming Kang Dennis Hsueh, MD
Dr. & Mrs. Robert W. Huff
Dr. J. Daniel Johnson
Dr. & Mrs. David J. Jones
Dr. & Mrs. Jerry M. Keepers
Mr. & Mrs. Curtis M. Klaerner
Mr. Gerry & Mrs. Ann S. Kruger
Drs. Melinda & James McMichael
Dr. & Mrs. James B. Morrison
Dr. & Mrs. Robert W. Parker
Dr. Stephen H. Ponas
Dr. & Mrs. James E. Prigden
Drs. Deborah & John W. Rasch
Imelda Treviño, MBA
Dr. & Mrs. Raul C. Vela, Sr.
Dr. Simeon H. Wall, Jr.
Ed & Kim Warshauer
Drs. Anne & Ken Washburn
Drs. Jan & Michael Wilson
Dr. & Mrs. Barry D. Winston
Dr. & Mrs. James J. Young

Please contact Kim Warshauer, Director of Development, at (210) 567-0242 or warshauer@uthscsa.edu for more information on any of the campaigns or articles in this section of FUTURE
Dear Alumni,

In 2008, two significant things are happening: one, our School of Medicine will celebrate its 40th Anniversary, and two, I will celebrate my 65th birthday. Hanging in my medical office, dated November 28, 1968, is my letter of acceptance to the entering class of 1969. Can you remember the excitement of first seeing your letter of acceptance? I can. I actually, technically, broke a federal law in seeing mine. On the day in which I learned that I would be a physician, a fellow pre-med student at Baylor University said to me, “Well, I hear you’re going to be a doctor.” I was surprised because I had not received a letter of acceptance. I realized then that my letter must have gone to my previous address. I drove to that house where I knew my letter had to be in the mailbox, but when I got there, I hesitated. Shortly, my eagerness overcame my caution, and I opened the mailbox and removed that wonderful letter. My wife had it framed as a gift.

As I turn 65 this year, I am engaged as the CEO of a multiple-specialty practice which treats a very large group of geriatric patients. We also manage an IPA for which I serve as President and Medical Director. Now being eligible for the same Medicare Advantage health plan which I have managed for 13 years, I look forward to participating with my patients in a continuing effort to improve their healthcare and to do it in a way which is sustainable.

This memory of my acceptance to Medical School and my becoming a member of a Medicare Advantage healthcare plan are bookends of my excitement about the Alumni Association of our School of Medicine. The continuing challenge to excellence in the practice of medicine, which I experience in being associated with the School of Medicine, is sustained by my memories of a 40-year relationship with the School. My pride in our School is enhanced by a founding Dean and a current Dean who shared and shared a vision and a passion for excellent in medical education and practice.

As you read the FUTURE, I hope that your past experiences and your anticipation of new ones will cause you to engage with the University of Texas Health Science Center at San Antonio School of Medicine, indeed, with your School of Medicine. I can assure you that pride in your education and in your career will only be enhanced by that relationship. Welcome to the FUTURE. Welcome back to the foundation of your medical career.

James L. Holly, M.D.
Class of 1973
President, Alumni Association
www.setma.com

---

Alumni; [u-uhm-ni], Derived from the Latin alere which means to bring up, to nourish.

Alumnus  Masculine singular graduate or former student, can also be used for feminine singular.
Alumni  Plural for alumnus Masculine plural, also used for groups composed of both sexes
Alumna  Feminine singular graduate or former student
Alumnae  Plural for alumna Female plural
Alum  An alumna or alumnus

---

Calendar of Events 2008

November 22, 2008
MSI-MSII Annual Powderpuff Football Game

In Memoriam
Robert L. Schelper, M.D. ’75
Pathology
Manlius, New York
February 28, 2007
Larry E. De Volld, M.D. ’76
Radiology
Canyon Lake, Texas
August 24, 2007

---

Alumni Updates

The CTRC merges with the University.
Dept. of Neurology is established.

Dr. Francis Giles becomes Director of the Institute for Drug Development (IDD).
The School of Medicine turns 40!  

**Clinician Ceremony**

On Wednesday, July 2, the Class of 2010, along with family and friends, gathered in the auditorium for the Student Clinician Ceremony. This ceremony marks the passage into the final two years of medical school and signifies the much-anticipated venture in the hospitals as a student clinician. Armed with their new clinician badge and oath card and gifts from the School of Medicine Alumni Association, students excitedly and nervously await the beginning of their first rotation. Several years ago, to help with the transition into the clinician year, fourth year students were asked to submit a “letter” to the third year students filled with advice and nuggets of wisdom learned during their previous year. This tradition has continued over the years and remains as one of the highlights of the Clinician Ceremony. Students were welcomed into their third year with a video keynote address by Dr. William Henrich, Dean of the School of Medicine. In addition to the “Letters to a 3rd Year” booklet from the Class of 2009 and the Office of Academic Enhancement, students received *Powerful Medicines: The Benefits, Risks and Costs of Prescription Drugs* by Dr. Jerry Avorn, courtesy of the Arnold P. Gold Foundation and the *Sanford Guide to Antimicrobial Therapy 2008* by Dr. David Gilbert, a gift from the Office of Academic Affairs.

Noting the importance of having great teachers, the Arnold P. Gold Foundation also sponsors the Resident Excellence in Teaching Award each year. During the fourth year, students are asked to think back to their third year and nominate a resident they felt exemplified the qualities of a great teacher – someone who led by example and inspired the students and staff around them. This year’s winners were:

- Yadira Anca, MD – Obstetrics and Gynecology
- Joseph Love, DO – Surgery
- Marc Simpao, MD ’05 – Internal Medicine
- Laudino Castillo, MD – Internal Medicine
- Ashley Parker, MD ’07 – Obstetrics and Gynecology
- Christiane Ueno, MD – Urology

**2012 Welcome Reception**

On Wednesday, July 25, over 50 alumni and current residents gathered to welcome the incoming Class of 2012 with a reception at Cha-Cha’s Restaurant. This gathering, part of the Alumni Association’s “Connect the Docs – Happy Rounds” series, is an annual party sponsored by the Alumni Association to give students, alumni and current residents a chance to mingle and get officially welcomed to the School of Medicine.

**CTRC is recognized as a Center of Excellence by the Myelodysplastic Syndromes Foundation.**
It started with a phone call in the summer of 2003. Dr Jim Peake, the U.S. Army Surgeon General (now Secretary, Veterans Affairs) called and invited me to join military medical colleagues deployed in Iraq in an outreach effort to meet face to face with Iraqi physicians. Immediately after the invasion, the fall of 2003 offered an excellent opportunity with reasonable security and social order to move about the country and personally engage with Iraqi doctors.

We used U.S. Army resources, U.S. governmental liaison, and Iraqi physician leaders to meet with small groups of physicians across all specialties of medicine and throughout the country, from the Kurdish Region to large southern cities. These informal, sometimes skeptical relationships, in an extremely precarious period for the Iraqi physician community, revealed several key facts. Our Iraqi colleagues value international alliances through mutual specialty societies. They eagerly seek face-to-face engagement for contemporary, clinically-relevant CME and they were most excited to have unabridged personal connections abroad for the first time in decades.

This introduction evolved to the development of the Medical Alliance for Iraq (MAI), an independent, unincorporated, nongovernmental (NGO) association of volunteer U.S. and U.K. physicians united with our Iraqi colleagues. The Alliance was initiated with a Medical Specialty Forum in Baghdad in 2004 including 500 Iraqi physicians, joined by two dozen civilian U.S. physicians representing (unofficially) every major medical specialty. It was sponsored by USAID, the Coalition Provisional Authority, and the Iraqi Ministry of Health.

While focusing on clinical dialogue with specialty design, the Forum set out a course for the charter and propagation of national specialty societies and the adoption of international standards and commissions for the accreditation of CME, and the maintenance of licensure and specialty certification.

Subsequent strife and chaos in 2005 and 2006 limited our engagement to Middle East regional meetings and sponsored visits of Iraqi physician leaders to U.S. specialty organization meetings, notably orthopedics, anesthesia, ENT, psychiatry and ophthalmology.

With improved security in December of 2006, we met with 200 Iraqi medical leaders and the Ministers of Health and Higher Education in Erbil, Iraq. We gathered to endorse the emerging Iraqi Medical Specialty societies and to set a course for a face-to-face CME schedule to be conducted initially in the safer Kurdish region. 2007 featured our alliance with International Medical Corps (IMC), a remarkably enduring health care NGO that operates in all provinces of Iraq. Monthly week-long visits of volunteer physicians from orthopedics, pediatrics, obstetrics, psychiatry and plastic surgery highlighted the 2007 schedule in Kurdish Iraq with the Iraqi Ministry of Health setting the clinical priorities.
The Iraqi physician and governmental response encouraged our State Department to provide a mission-sustaining grant thru 2009. IMC and Project HOPE have been our NGO allies, and IMC currently manages administration to include travel, visa, accommodations and security. The face-to-face CME structure originally limited to the northern provinces due to security needed a wider dimension, and we affiliated with WiRED, a telemedicine consortium, and the Swinfen Charitable Trust, an email teleconsultation service, both of whom were well installed and trusted in Iraq. We have also allied with many of the United Kingdom Royal Colleges for adjunct volunteer faculty. Physicians from San Antonio and the UT Health Science Center’s School of Medicine’s community who have traveled and taught, listened and learned, including Drs. John Howe, Harold Timboe, Richard Holt, Robert Ferry, Craig Manifold and Kaye Wilkins. The reception we have received in Iraq has been magical. Medical Alliance for Iraq remains “doctors with borders” implying that we directly relate to the U.S. State, Defense and Health and Human Service Departments and coordinate with IMC and the Health Attaché in Baghdad to collaborate with Iraqi health authorities. We remain committed to the development of independent, respectfully nongovernmental, Iraqi medical specialty societies and continue to champion the cause of continuing professional development through face-to-face CME and distance learning. Most important, we have maintained trusting personal and professional relationships with our Iraqi physician friends.

Michael W Brennan, M.D.
Chairman, Medical Alliance for Iraq
mbrennan1@triad.rr.com

Brennan, class of 1978, is an ophthalmologist practicing in Burlington, North Carolina.
Stephen D. Houston, MD, Austin, TX

After my Internal Medicine Internship at Bexar County Hospital, I finished my dermatology residency at Baylor College of Medicine in Houston in 1977. I immediately moved to Austin, my home town, and set up a solo practice of Dermatology. Eventually, I specialized in Dermatologic Surgery, primarily Mohs surgery for skin cancer, establishing the Southwest Skin & Cancer Clinic, PA.

R. A. Moore, MD, Dallas, TX

Greg Moore, MD - graduate of UTHSCSA; Natalie Roberts - Attorney; Children - Michael Moore - 1st year medical student at UTHSCSA

Hardy Morgan, MD, Hamilton, TX

I was in the class of 1973 and retired as of Thanksgiving 2007. My time in medicine was spent as a Family Practitioner roughly 10 years each in Hico, Texas, San Angelo and Dallas Texas. The last 10 years were exclusively in end-of-life care primarily in nursing homes and Medical City Dallas Hospital. It is a neglected field, but very fruitful for those that take the time to see patients.

David G. Morgan, MD, Spokane, WA


Fred H. Olin, MD, San Antonio, TX

No change since last time - except that now I am semi-retired. I do surgical assisting, occasional locum tenens assignments and enjoy life.

Philip B. Plattner, MD, Seattle, WA

Psychiatric Residency, Department of Psychiatry and Behavioral Science, University of Washington School of Medicine, 1975-1978 Diplomate, American Board of Psychiatry and Neurology, 1982 Clinical Associate Professor, Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, 1985 Philip and Peggy’s son, Will Haney Plattner, was born March 1995 Graduate of Seattle Institute for Psychoanalysis, 1996

In July 2004, Plattner’s, M.D.’s work was recognized with a Letter of Commendation for outstanding and dedicated service by the combat veterans of Washington state. In 2007, Dr. Plattner wrote “Getting a Fair, Thorough and Accurate VA Disability Evaluation: Guidelines for Veterans” to help the many men and women who have served our country, and their families. (www.courageafterfire.com and www.ptsdhelp.net).

Brian E. Hayes, MD, Roseburg, OR

I’m retiring out of orthopedics to do some easy things; logging, ranching, furniture building.

Michael W. Brennan, MD, Burlington, NC

1993 - President, NC Soc of Eye Physicians and Surgeons 2008 - President Elect, American Academy of Ophthalmology 2008 - Chairman, Medical Alliance for Iraq Editor’s note: See article

Deborah D. Douglas, MD, Burnet, TX


Nima A. Grissom, MD, San Francisco, CA

Breast oncologic surgeon at CPMC San Francisco, California.

James J. Leech, MD, El Paso, TX

I am retiring from the Army on July 31, 2008 and will be joining Al Hernandez, MD (Class of ’82) in private practice in El Paso.

Alan L. Parks, MD, San Marcos, TX

Recently retired (semi) to devote time to family and to start an organization called “Americans for a Balanced Budget Amendment” in order to help get this country back onto a sound financial footing. Happily married in San Marcos, Texas - 3 great kids, aged 12, 10, 8.

Joel Tsevat, MD, Cincinnati, OH

Past-President, Society for Medical Decision Making, 2002-2003 Distinguished Alumnus Award, UTHSCSA School of Medicine Alumni Association, 2007 Over 90 peer-reviewed publications

Steven B. Buckley, MD, San Antonio, TX

I married Siobhain Anders. We have two red-headed girls (Diana, 13 and Ireland, 10). My office is across the street from the Health Science Center. I now have 5 partners in Alamo Maxillofacial Surgery Associates.

David L. Phillips, MD, Austin, TX

My highlights (and lowlights) have been few. I’ve steadily become a busy and reasonably well respected private practice urologist. I’ve enjoyed a clinical faculty position with the local F.P. residency and have been a Texas Monthly “Super Doc” since that began. Our small uro group has recently combined into a much larger group, Urology Austin, which has finally begun this year. My 2 boys Beck, 8 and Dawson, 5 keep Sara and I busy and happy.

Marla R. Schick, MD, Tampa, FL

I completed a radiology residency in San Antonio and then was in private practice in North Carolina. I was at the University of South Florida for 10 years at Moffitt Cancer Center and recently moved to the James A. Haley VA in Tampa, Florida. I still enjoy traveling with my family to various destinations in the US and abroad.

Wayland H. Dillard, MD, Carl Junction, MO

Have busy Internal Medicine practice. Named Emergency Department Director at McCune-Brooks Hospital in Carthage, MO.

Chanda H. Kewalramani, MD, Houston, TX

After residency, there was a group practice in San Antonio, then locum tenens where I combined medicine with travel, and now private practice in Houston. Traveling has been my favorite pasttime; various exotic places in India, including the Himalayas, Rajasthan, Kashmir, Kerala, Kanya Kumari, Goa, as well as Bombay, and Delhi. Throughout the US including Alaska, Hawaii and Native American country. In Europe, Asia and Central America. In addition, I became a Fellow with the American Academy of Family Physicians.
Carla D. McKelvey, MD, Coos Bay, OR
Distinguished Alumni - University of Texas at Arlington
Speaker of the House of Delegates - Oregon Medical Association
Appointed by Governor to Health Services Commission

Jeffrey A. Leslie, MD, Helotes, TX
Completed fellowship in Pediatric Urology at Indiana University.

Amy E. Rogers, MD, McKinney, TX
Back in 1999, I decided I wanted to stay home with my son, Luke. I've been at home with him and his 2 sisters, Peyton and Romy since then. Bud started his own company in 2002 and we homeschool, so we're all home together a lot. We enjoy traveling and Bud and I have recently started to do short-term international mission work. Life is really good, but quite different than we imagined in 1998!

Douglas G. Harrison, MD, Milledgeville, GA
Enjoyed UTHSCSA and San Antonio tremendously.

Elizabeth H. Tichy, MD, San Antonio, TX

Michael E. Frey, MD, Helotes, TX
I am currently a Lieutenant Colonel in the Army and I am stationed overseas in support of our nation’s operations in Iraq. I am assigned as the Task Force Surgeon of Task Force ODIN, a 600 personnel unit located just outside Tikrit, Iraq.

Ty Ann Heath, MD, Knoxville, TN
Since finishing Anesthesiology residency in 2006 I've joined a private practice here in East Tennessee. My partner and I are currently restoring a 110 year old Victorian house, enjoying our 8 year old son and traveling as much possible. Our last European trip was with fellow UTHSCSA classmate and anesthesiologist, Blake Leche. Would love to hear from other classmates.

Ana M. Rojas, MD, Houston, TX
I completed my pediatric residency in Lubbock, TX where I met my husband Michael Montanez, Jr. We have been blessed with a wonderful son, Matthew, who is about to be three years old. I am currently finishing my fellowship in Neonatology at UT Houston. We are planning to move back to Lubbock, which will be our home.

Dale Yoo, MD, Atlanta, GA
Tanya and I have been living in Atlanta since graduating from UTHSCSA. Tanya finished her pediatrics training at Emory and has continued on to completing her pediatric Heme/Onc fellowship as well as a Masters in Science of Clinical Research. After completing my Internal Medicine training at Emory, I remained at Emory and just finished my clinical cardiology fellowship in June. I am now working in an Emory/Georgia Tech biotech facility working on various projects in Cardiac Electrophysiology and will complete my EP fellowship in 2011.

Laura E. Berry, MD, Covington, LA
Laura Eileen McRea married Captain Jacob Ellis Berry, USMC, on 3/29/08 in New Orleans, LA.

Read more at www.SAmedAlum.com
The Class of 2008 celebrated Match Day at Floore’s Country Store in Helotes, Texas. This was an emotional celebration when fourth year medical students found out where they would spend their residencies. The festivities gave graduates a time to share laughs and tears with their fellow classmates as many of them part ways to continue their medical education. Congratulations, doctors!

**Doctor of Medicine Degrees Conferred December 2007**

Vivian J. Caraveo, Transitional Residency, Fort Sam Houston, Texas  
Olawale A. Igun, Internal Medicine, University of Miami – Atlantis, Florida

**Candidates for the Degree Doctor of Medicine**

Nadia Hannah Abboud, Psychiatry, Austin Medical Education Programs  
Adebimpe Olubusayo Adewusi, Pediatrics, St. Christopher’s Hospital, Philadelphia  
Grace Milchak Akinyi-Joseph, Internal Medicine, UT Health Science Center SA  
Anysa M. Aldape, Psychiatry, Texas A&M – Scott & White, Temple, Texas  
Lisa Cristina Alvarez, Internal Medicine, McGaw Medical Center, Chicago  
Rudy Alvarez, Pathology, Indiana University School of Medicine, Indianapolis  
Jamie Rachelle Avila, Pediatrics, The University of Texas Health Science Center at Houston  
Kristen Nicole Baker, Pediatrics, The University of Texas Southwestern Medical Center at Dallas  
Melissa Marie Batt, Psychiatry, University of Colorado School of Medicine, Denver  
Laura Ashley Beech, Emergency Medicine, Case Western University Hospitals Cleveland  
Ritha Mary Belizaire, General Surgery, University Hospital, Cincinnati  
Adam Stone Bellinger, General Surgery Internship, Barnes Jewish Hospital, St. Louis  
Monica Marie Benavides, Internal Medicine, UT Health Science Center SA  
Jamie M. Berger, Internal Medicine, California Pacific Medical Center, San Francisco

Karri Mireille Bernal, Anesthesiology, UT Health Science Center SA  
David Benjamin Blomstrom, Jr, Family Medicine, Jackson Memorial Hospital, Miami  
Katherine Claire Bolt, Ob/Gyn, Methodist Hospital, Houston  
Stephanie Anne Bouvier, Anesthesiology, Vanderbilt University Medical Center, Nashville  
Gregory Cain Bratton, Family Medicine, John Peter Smith Hospital, Fort Worth, Texas  
Erin Marie Brockway, Anesthesiology, Vanderbilt University Medical Center, Nashville  
Heather Brooks, Psychiatry, University of Colorado School of Medicine, Denver  
Erin Leigh Brown, Anesthesiology, Stony Brook Teaching Hospitals, Stony Brook, New York  
Kristin Brozena, Ob/Gyn, UT Health Science Center SA  
Javier Castillo, Ob/Gyn, John Peter Smith Hospital, Fort Worth, Texas  
Tracey Chantell Cawthorn, Psychiatry, Loyola University Medical Center, Maywood, Illinois  
Jessica Cayce, Psychiatry, Texas A&M – Scott & White, Temple, Texas  
Tira Chaicha, Internal Medicine, University of Illinois College of Medicine, Chicago  
Annie Yen-Yi Chan, Transitional, Riverside Regional Medical Center, Newport News, Virginia  
Aruna Ambat Chandrasekhar, Medicine, Rhode Island Hospital – Brown University, Providence  
Stephen Ken-Wei Chao, Family Medicine, UT Health Science Center SA  
Mehee Choi, Transitional, Mayo School of Graduate Medical Education, Jacksonville, Florida  
Leonard Hoyin Chow, Internal Medicine, The University of Texas Medical Branch at Galveston  
Anne Carroll Cioletti, Medicine-Primary, George Washington University, Washington, D.C.  
Cristina Colmenares, Internal Medicine, Baylor College of Medicine, Houston  
Christine Ann Contreras, Internal Medicine Internship, Neurology, UT Health Science Center SA  
Lane Joseph Cooper, Anesthesiology, University of Louisville School of Medicine, Kentucky  
Beatriz Cornelius, Pediatrics, Driscoll Children’s Hospital, Corpus Christi, Texas  
Craig Michael Couvillon, Internal Medicine, University of Oklahoma College of Medicine
Scott Crabtree Jr, Internal Medicine, San Antonio Uniformed Services Health Education Consortium, LAFB, Texas
Ali Daftarian, Internal Medicine Internship, Texas A&M – Scott & White, Temple, Texas
Benjamin Dow Daggett, Internal Medicine, Tripler Army Medical Center, Hawaii
Mary Louise Davidson, Psychiatry, UT Health Science Center SA
Jana Davis, Transitional, San Antonio Uniformed Services Health Education Consortium LAFB, Texas
Joshua Adam Delavan, Transitional, Colorado Health Foundation, Denver, Colorado
Gwen A. Denton, General Surgery Internship, University of South Alabama, Mobile
Stephanie Ellen Deter, Ob/Gyn, University Hospitals Case Medical Center, Cleveland
Nicolette Deveneau, Ob/Gyn, Medical College of Wisconsin Affiliated Hospitals, Milwaukee
Dinesh Dhanaraj, Orthopaedic Surgery, New York University School of Medicine, New York
Michael J. Diamond, Family Medicine, Medical Sciences Area Health Center, Texarkana, Arkansas
Candice Nicole Dubose, Orthopaedic Surgery, Univ. of Florida College of Medicine, Gainesville
Marquinn D. Duke, General Surgery Internship, UT Health Science Center SA
Natalie Lorraine DuMont, Pediatrics, University of Texas Southwestern Medical Center at Dallas
Shaina Rose Eckhouse, General Surgery, Medical University of South Carolina, Charleston
Jami Marie Eidem, Anesthesiology, McGaw Medical Center of Northwestern Univ., Chicago
Joseph Carlos Elizondo, Internal Medicine, The University of Texas Medical Branch at Galveston
Sara J. Emslie, Pediatrics, San Antonio Uniformed Services Health Education Consortium, LAFB

Joey Ann England, Ob/Gyn, The University of Texas Medical Branch at Galveston
Vida Esfandiari, Ob/Gyn, The University of Texas Medical Branch at Galveston
Charisse Estess, Internal Medicine, University of Maryland Medical Center, Baltimore
Matt Douglas Fay, Internal Medicine, UT Health Science Center SA
Maeva Walton Felle, Ob/Gyn, University of Colorado School of Medicine, Denver
Kathryn Lee Fick, Ob/Gyn, Louisiana State University Health Science Center at Shreveport
Susanne Elizabeth Francis, Internal Medicine, Naval Medical Center, Portsmouth, Virginia
Sandra Giovanna Frasser, Pediatrics, UT Health Science Center SA
Jennifer Jean Freeman, General Surgery, University of Nevada Affiliated Hospitals, Las Vegas
Steven Garza Garcia, General Surgery Internship, Baylor College of Medicine, Houston
Briana Garcia McGrath, Emergency Medicine, Texas Tech Univ. Affiliated Hospitals, El Paso
Angel Joel Garcia Vera, Family Medicine, Texas Tech University Affiliated Hospitals, El Paso
Sarita Gayle, Internal Medicine, University of Illinois College of Medicine, Chicago
Semhar Ghebremichael, Anesthesiology, The Univ. of Texas Health Science Center at Houston
Summer Bell Gibson, Neurology, University of Utah Affiliated Hospitals, Salt Lake City
Cara Marie Govednik-Horny, General Surgery, Texas A&M – Scott & White, Temple, Texas
Paul Barringer Gravel, Internal Medicine, UT Health Science Center SA

Katie P. Green, Pediatrics, University of Arizona Affiliated Hospitals, Tucson
Adam Griffith, General Surgery Internship, Neurosurgery, Univ. of Texas Southwestern Medical Center at Dallas
Nancey Mae Hahn, Ob/Gyn, Texas A&M – Scott & White, Temple, Texas
Nicholas David Harrel, General Surgery Internship, Maricopa Integrated Health System, Phoenix
Rachel Aubrey Hassan, Pediatrics, San Antonio Uniformed Services Health Education Consortium, Fort Sam Houston, Texas
Ann Thien Hau, General Surgery Internship, Baylor College of Medicine, Houston
Andrea L. Haws, Pathology, Baylor College of Medicine, Houston
Jennifer Lynn Helander, Pediatrics, Nationwide Children’s Hospital, Columbus, Ohio
Deborah Ann Hendryx, Ob/Gyn, Baylor College of Medicine, Houston
Fernando Hernandez, Family Medicine, David Grant Medical Center, Travis AFB, California
Judith Hernández, Internal Medicine, UT Health Science Center SA
Lynda M. Hernandez, Ob/Gyn, Methodist Health System, Dallas
Vivian Maria Herrero, Pediatrics, University of New Mexico School of Medicine, Albuquerque
Rachel Hollander, Family Medicine, University of California Davis Medical Center, Sacramento
Brett Horn, Emergency Medicine, Louisiana State Univ. Health Science Center at Shreveport
Philip Thomas Houser II, Anesthesiology, University of Louisville School of Medicine, Kentucky
Match Day 2008

Claire Hoverman, Ob/Gyn, East Tennessee State University, Johnson City, Tennessee
Melissa S. Hu, Otolaryngology, Louisiana State University Health Science Center at Shreveport
Lisa Marguerite Hunt, Anesthesiology, The Univ. of Texas Health Science Center at Houston
Glen Hybarger, Internal Medicine, Baylor College of Medicine, Houston
Sara Ann Jackson, Emergency Medicine, University of Arizona Affiliated Hospitals, Tucson
Tyler Scott Jorgensen, Internal Medicine, University of North Carolina Hospitals, Chapel Hill
Jason Paul Jundt, General Surgery, Oregon Health and Science University, Portland
Joseph Alan Koch, Family Medicine, McLennan County Family Medicine, Waco, Texas
Rebekah Wright Koch, Psychiatry, Texas A&M – Scott & White, Temple, Texas
Katherine O’Brien Kohls, Anesthesiology, UT Health Science Center SA
Kattayoun Kordy, Pediatrics, University of Texas Southwestern Medical Center at Dallas
Stuart Krein, General Surgery Internship, Rush University Medical Center, Chicago

Scott Larson, Internal Medicine, Mayo School of Graduate Medical Education, Rochester, Minnesota
Christina Yi-Shen Lee, Internal Medicine Internship, Univ. of New Mexico School of Medicine, Albuquerque
Angie Li, Ob/Gyn, New York Downtown Hospital, New York
Nicholas Te Hao Lin, Family Medicine, Austin Medical Education Programs, Austin, Texas
Stephen Andrew Lopez, Internal Medicine, Virginia Mason Medical Center, Seattle, Washington
Jason Gene Lozano, Internal Medicine, Naval Medical Center, Portsmouth, Virginia
Kristina M. Lozano, Family Medicine, Riverside Regional Medical Center, Newport News, Virginia
Aojing Lu, Anesthesiology, The University of Texas Medical Branch at Galveston
Christina Lumbreras, Emergency Medicine, The Univ. of Texas Health Science Center at Houston
Naveen Mann Mangat, Internal Medicine, UT Health Science Center SA
Heather C. Martin, Pathology, Dartmouth – Hitchcock Medical Center, Lebanon, New Hampshire
Neha Mathur, Internal Medicine, Rush University Medical Center, Chicago, Illinois
Braden Kent Mayer, Orthopaedic Surgery, Duke Univ. Medical Center, Durham, North Carolina
Stephanie Mayer, Orthopaedic Surgery, Duke Univ. Medical Center, Durham, North Carolina
Casey Elizabeth McCain, Family Medicine, Memorial Hermann Hospital, Sugar Land (Houston)
Megan McCoin, Ob/Gyn, Women and Infants Hospital, Providence, Rhode Island
Tiffany Lee Milner, Pediatrics, University of Utah Affiliated Hospitals, Salt Lake City
Erica Amanda Montes, Ob/Gyn, University of Texas Southwestern Medical Center at Dallas
Aaron Thomas Moon, Internal Medicine Internship, Radiology, UT Health Science Center SA

Betty Graham, Dr. Nan Clare and Jennifer Sandlin deliver the envelopes with each student’s results.

Rebecca Lynn Morrison, Anesthesiology, Texas A&M – Scott & White, Temple, Texas
Michael David Mrzek, Psychiatry, George Washington University, Washington, D.C.
Lucinda T. Myers, Internal Medicine Internship, Univ. of Utah Affiliated Hospitals, Salt Lake City
Shelley Leanne Naiser, Pediatrics, UT Health Science Center SA
Brett C. Norman, Internal Medicine, University of Washington Affiliated Hospitals, Seattle
Dennis David O’Banion, Jr, Pediatrics, Oregon Health and Science University, Portland
Nekeshia Oliphant, Psychiatry-Family Medicine, University of Pittsburgh Medical Center
Ifeoma Obiageli Onuorah, Internal Medicine, Johns Hopkins Hospital, Baltimore
Elizabeth Anne Osborne, Internal Medicine, University of Michigan Hospitals, Ann Arbor
Mahdieh Parizi, Internal Medicine Internship, Radiology, UT Health Science Center SA
Ankur Piyush Patel, Internal Medicine Internship, Univ. of California San Diego Medical Center
Matthew Pattillo, Internal Medicine, Univ. of Texas Southwestern Medical Center at Dallas
Christopher Benjamin Patton, Transitional, Maryland General Hospital, Baltimore
Lauren Therese Phillips, Neurology, University of Texas Southwestern Medical Center at Dallas
Jennifer M. Pierce, Emergency Medicine, Univ. of Texas Southwestern Medical Center at Dallas
Thomas J. Pillion, Psychiatry, University of North Carolina Hospitals, Chapel Hill, North Carolina
Salman S. Purbondarwalla, Transitional, Reading Hospital Medical Center, Reading, Pennsylvania
Jeremy A. Porter, Pediatrics, Florida State University – Sacred Heart Hospital, Pensacola

Dr. William Henrich congratulates each graduate.
Norman C. Quesada, Internal Medicine, Univ. of California Irvine Medical Center, Orange, California
Jonathan Charles Ramirez, Internal Medicine, Texas A&M – Scott & White, Temple, Texas
Daima Fanaka Ratcliff, Family Medicine, Texas Tech Univ. Affiliated Hospitals, Abilene, Texas
Rachel Anne Rebecca, Psychiatry, University of Washington Affiliated Hospitals, Seattle
Erin Adaire Reese, Internal Medicine, Baylor University Medical Center, Dallas
Brett Nathan Robin, Orthopaedic Surgery, Texas A&M – Scott & White, Temple, Texas
Marisol Loredo Rodriguez, Pediatrics, Eastern Virginia Medical School, Norfolk, Virginia
Holli Tyshawn Sadler, Internal Medicine, The University of Texas Medical Branch at Galveston
Rebecca Linn Schaub, Pediatrics, UT Health Science Center SA
David Roger Schmit, Internal Medicine, UT Health Science Center SA
Donald A. Schultz, Transitional, San Antonio Uniformed Services Health Education Consortium, Fort Sam Houston, Texas
Ruchi Sharma, Anesthesiology, University Hospitals Case Medical Center, Cleveland, Ohio
Andrew D. Shedd, Emergency Medicine, Advocate Christ Medical Center, Oak Lawn, Illinois
Seema K. Sheth, General Surgery Internship, New York Presbyterian Hospital – Weill Cornell Medical Center, New York
Weiwen Vivian Shih, Pediatrics, Stanford University Programs, Stanford, California
Shailee Shukla, Anesthesiology, New York Presbyterian Hospital – Weill Cornell Medical Center New York,
Kathryn Ruth Allen Sickorez, Psychiatry, University of Massachusetts Medical School, Worcester
Stephanie M. Sims, General Surgery Internship, Vanderbilt Univ. Medical Center, Nashville, Tennessee
Kristen Lyn Sorensen, Ob/Gyn, University of Tennessee Graduate School of Medicine, Knoxville
Shaum Sunder Sridharan, Otolaryngology, New York University School of Medicine, New York
Garrett Daniel Starling, Anesthesiology, UT Health Science Center SA
Dylan Eldon Stentiford, Medicine-Primary, Boston University Medical Center, Boston, Massachusetts
Colin Exall Stewart, Psychiatry, University of California San Francisco
Selena Juarez Stuart, Internal Medicine, University of Alabama Medical Center at Birmingham
Joshua David Sultz, Internal Medicine, UT Health Science Center SA
Shelby Elizabeth Sutton, Internal Medicine, UT Health Science Center SA
Elizabeth Sweeney, Pediatrics, University of Colorado School of Medicine, Denver
Rebecca Nonalee Staggs Tapia, Physical Medicine and Rehabilitation, UT Health Science Center SA
Lauren Eleanor Tarbox, Internal Medicine, UT Health Science Center SA
Tiffany Nicole Thomure, Psychiatry, UT Health Science Center SA
Sadie Ann Trammell Velásquez, Internal Medicine, UT Health Science Center SA
Frank Traupman, General Surgery Internship, Univ. of Massachusetts Medical School, Worcester
Crystal Jean Trujillo, Pathology, The University of Texas Health Science Center at Houston
Annie Chan, Kristiina Lozano and Jason Lozano at Match Day Celebration.

Vivian Maria Herrero receives her match day result.

Korie Lee Turner, Anesthesiology, Vanderbilt University Medical Center, Nashville, Tennessee
David K. Vakey, Emergency Medicine, Vanderbilt University Medical Center, Nashville
Nichole Jeanetta Van de Putte, Ob/Gyn, UT Health Science Center SA
David Allen Vance, General Surgery Internship, Univ. of Arizona Health Science Center, Tucson
Marco Antonio Vega, Psychiatry, The University of Texas Medical Branch at Galveston
Elizabeth Ventura, Pathology, Baylor University Medical Center, Dallas, Texas
Celina Villa, General Surgery, UT Health Science Center SA
Andrew J. Wall, Transitional Internship, Anesthesiology, Stanford Univ. Programs, Stanford, California
Brian Weatherford, Orthopaedic Surgery, McGaw Medical Center of Northwestern Univ., Chicago
Jennifer Marie Welch, Internal Medicine, Barnes Jewish Hospital, St. Louis, Missouri
Joy E. Wheat, Ob/Gyn, St. Louis University School of Medicine, St. Louis, Missouri
Rebecca C. Whitesell, Orthopaedic Surgery, Univ. of Alabama Medical Center at Birmingham
Dustin Blake Williams, Emergency Medicine, Indiana University School of Medicine, Indianapolis
Clarence Joseph Wolinski III, Internal Medicine, Baylor University Medical Center, Dallas
Shehnaz A. Zaman, Internal Medicine Internship, McGaw Medical Center of Northwestern Univ., Chicago
Symeon Vasilios Zannikos, Orthopaedic Surgery, New England Medical Center, Boston
The School of Medicine Celebrates 40 Years!

Faculty, alumni, and friends of the University were invited to celebrate the 40th Anniversary of the School of Medicine at The University of Texas Health Science Center’s 2nd annual gala, September 20th. More than 1,300 people attended to enjoy an evening of food and music – as well as receive great news for women in South Texas.

The evening’s special honoree, former Texas Governor Dolph Briscoe Jr., announced he is giving $5 million in support of Cardiology and Women’s Health. Governor Briscoe has now donated more than $9 million to the Health Science Center for cardiovascular disease research to honor the memory of his wife.

“I will always be grateful to the doctors who took care of my beloved wife Janey, especially Dr. Steven Bailey, the head of cardiology at the Health Science Center. You cannot put a price tag on having more time with your loved one,” said Governor Briscoe.

The gift, which will advance heart disease research and care of women in Texas, augments $600,000 raised at the gala. In appreciation, the University will name the division of cardiology “The Janey and Dolph Briscoe Division of Cardiology.”

“There is no way to express what this gift means to us. Certainly it will further critically important research in cardiology, which will save lives. We thank Gov. Briscoe and his entire family,” said Francisco G. Cigarroa, M.D., president of the UT Health Science Center.

“We are on a journey to the highest medical excellence. Our plans are ambitious. Our goals are lofty,” said William L. Henrich, M.D., Dean of the School of Medicine, “San Antonio will be in the vanguard of scientific discovery. Our city will be the destination for the very best medical education and the very best health care available.”

The Briscoe gift will support the four cornerstones of the Health Science Center mission: teaching, healing, research and service. “This gift will make lives better for women and their families,” Dr. Cigarroa said.
Our bold vision for the FUTURE requires the efforts of many. Please consider a gift to support the School of Medicine 40th Anniversary Fund. Your contribution will assist future generations through our education, research and community outreach programs.

All benefactors to this special fund will be recognized on a permanent plaque in the new Medical Arts and Research Center (MARC) building to open in 2009.

To make your gift online, visit http://www.uthscsa.edu/development

Dr. James L. Holly, President, Alumni Association & Dr. William L. Henrich, Dean School of Medicine

For specific MARC naming opportunities or non-online gifts, please contact Kim Warshauer in the School of Medicine Development Office at (210) 567-0242 or warshauer@uthscsa.edu.
Ours is a story of discovery. Compassion and joy. Commitment, vision and inspiration. We engage our minds and talents, and give from our hearts, to help and heal. We touch the lives of thousands, to serve those in need, here and around the world. And, through it all, we work to make lives better. Thank you for all you do to make our story so remarkable. You’re the reason we’re able to write the next chapter.

www.uthscsa.edu

ADDRESS SERVICE REQUESTED

Moving? Help us with your new address. Send the mailing address printed on this page with your new address and ZIP code to FUTURE at the above return address.