Oral History

#070

An Interview with

I. Celine Hanson

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CAITLYN JONES: This is Caitlyn Jones with The oH Project, and I am in Houston, Texas, with Dr. Celine Hanson on September 3, 2019, to record her recollections on the HIV/AIDS crisis in Houston.

Thank you so much for being with us.

CELINE HANSON: You’re very welcome. I’m happy to be here.

CAITLYN JONES: Let’s start with a little bit about your early life. When and where were you born?

CELINE HANSON: I was born in Edinburg, Texas, down in South Texas near the Mexican border. That was on June 27 of 1953.

CAITLYN JONES: What did your parents do for a living?

CELINE HANSON: My dad was a physician. He was one of the first Hispanic physicians in South Texas. His name was Dr. Guerra. My mom was from Tulsa, Oklahoma, and they met while he was training to become a surgeon and she was a nurse.

CAITLYN JONES: So from a medical family.

CELINE HANSON: Absolutely. Lots and lots of exposure and experience.

CAITLYN JONES: Sure. Did you have any siblings?

CELINE HANSON: Yes, five older siblings. That was also a survival skill I learned early, how to make it through being the youngest child.

CAITLYN JONES: What was it like growing up in Edinburg at that time?

CELINE HANSON: Edinburg in 1953 was a very small town, and it was not filled with
lots of activities for youngsters, but we had the normal kind of life in the mid-1950s, with lots of visits to the library and lots of outdoor activities. It was tranquil and fun.

JONES: What were some of the life lessons you learned from your childhood, whether that be from your parents, from your siblings, in school?

HANSON: The area was a farming community for the most part, lots of cotton and also lots of citrus fruit down in South Texas, so people’s income was based on their crops and their cattle and their animals that they raised and how well they did, so relatively poor, but really happy people who enjoyed being with one another and interacting with one another. Football games were huge events because it was the only event that you could go to that was relatively inexpensive and just a lot of fun. That’s kind of funny to say because most of the football players were under 5’5”, being that the population was mostly Hispanic.

JONES: They had to be quick.

HANSON: Yes, they were very fleet of foot, and they tried to catch quick and fall down fast.

JONES: It’s a good game plan. I like that. What were the early inklings you had of your future career? Obviously you were in a household filled with medicine.

HANSON: Yes, that’s true. I grew up in a home where my parents were both in the medical field. My mother, because she had six children, was pretty engaged with being a homemaker, and her nursing career kind of fell to the side to take care of us. But my dad was a very active physician. He was really one of the few physicians who spoke Spanish down there, so he had a very, very big practice. Remember that in the 1950s, in the early 1950s, this small, rural town actually
had no hospital, so our own home served as an evening stop for people who were acutely ill and couldn’t wait until the next day to be seen. They actually came by the house, rang a doorbell, and Dad went downstairs and saw them in a room that was designated for his emergency room, if you will. He also did house calls, so oftentimes we would accompany him in house calls. Obviously for privacy reasons, we stayed in the car with the windows rolled down because it was hot, but had lots of exposure and experience in terms of seeing people who needed care, people who were in pain or who were suffering and were looking for opportunities to get relief as quickly as possible.

JONES: Did that make your dad a cornerstone in the community in that way?

HANSON: Absolutely, and in our family it made him like the God, right, so he was just like the person that everybody wanted to be as they were growing up, all six of us. But Mom was a really bright, very compassionate woman, and it was really interesting to see her.

I remember somebody asked me once, “Didn’t your parents not want you to be a physician?” and I have to say that my parents only wanted me to be happy and succeed, and never, ever did I feel that there was any pressure for me, because of my gender, to follow a more traditional 1950s female role. It was kind of like, “Well, what do you want to be, and is it safe for you?” When I announced that I wanted to be a football player, I was told that that probably would never happen. When I said okay, I would be a doctor or a nurse, that was very acceptable to them.

JONES: After you graduated from high school, you went to college. Where did you go to college?
HANSON: I went to the University of Texas at Austin. My father had gone there, and so I was excited about going, and I found out quickly that being a big fish in a little pond was very different from being a little fish in a huge pond where there were even bigger fish and lots of them swarming. It was a lot of fun, though. I enjoyed my time up there. I was in undergraduate school for three years.

JONES: What was school like at that time? You mentioned a lot of people. Was it a competitive atmosphere?

HANSON: I didn’t feel the competitive atmosphere in undergraduate school. I did in medical school, but not in undergraduate school. I was so excited that I had moved from a small town that, really, everything was a wonder. Everything that I had an opportunity to be exposed to was so different. Different cultures, people of different skin color. There were very few, if any, Asians in South Texas when I was growing up, and we had one family that lived in our community who was African American, so I really had no idea what other cultures were like. So I really enjoyed, actually, the opportunity to see other cultures and try and understand what they were about and how it worked. The school was just terrific. It was a huge campus at the time. More people were on my college campus than my city that I grew up in, so that was a phenomenal opportunity. I told you I wanted to be a football player when I was growing up, so I actually picked the school because I thought it had a good football team.

JONES: Hook ’em Horns. I like that.

HANSON: It’s a theme during this interview you’ll hear.

JONES: Gotcha. After you spent those three years in undergrad, you went to medical school. What was that like?
HANSON: I did. I went to — at that time it was called Southwestern. It’s now the University of Texas Health Science Center at Dallas, quite the mouthful. I picked that one because, number one, they accepted me, but also because I loved the Dallas Cowboys, and my cousin actually played for the Dallas Cowboys, so I was very excited that I would get to go to all of the games. Little did I know that I would be studying my tail off and what I would be doing is learning how to be a physician.

Medical school was very competitive. Weeded from the 40,000 kids I went to school with was a very small handful, some of them I recognized from college, some I did not, and so it was daunting to start that class and realize there were 200 of us and only 20 of us were women. It was such a very different setting, and it was very serious. Nobody took it lightly. Everybody wanted to make sure that they took on the responsibility of knowing that they had taken a competitive slot and that they were going to take it to fruition and complete their training and not have it be given to them for naught.

JONES: Right. At what time were you in medical school? What years?

HANSON: I think that would have been 1974. 1974 to 1978 is when I went to medical school.

JONES: You mentioned that out of 200, there were only 20 women. Were there any sort of gender roles that you dealt with in medical school as far as any sort of sexism or anything?

HANSON: I think that there was evidence of sexism. What was interesting is when I first began to experience sexism was during the interview process for medical school. Interviewers would ask very peculiar questions like, “How often do you
date?” and I would think what does that have to do with my professional training? Then I realized that there was a slant in the minds of the interviewers that because I was a female, I wouldn’t take a medical position seriously. As I continued to matriculate through medical school, I continued to feel that to a certain extent from the male professors. The female professors were amazing, but many of them were very hardened, and they were almost as difficult as some of the males in terms of the gender issues, and instituting a kind of a rite of passage. “I made it through, and it wasn’t easy, so I’m not going to make it easy for you.” But I have to say in general at my medical school, people were really interested in having us all be successful, and I could say that they were equal opportunity offenders from that perspective, and gender played less of a role. Their position was more about completing the task, “You took somebody’s slot. You really need to pay attention to that.” It was a message driven home often and quickly.

JONES: You mentioned that you had some family issues when you were in medical school. Your father?

HANSON: Yes, in my second year of medical school, my father developed lung cancer. He made his own diagnosis. You live in a small town, you’re the only doctor, you take your own X-ray, figure it’s not tuberculosis. He put his own TB [tuberculosis] skin test on and then went to the surgeon and said, “I think this is lung cancer. I smoke,” and sure enough, that’s what it was. He got his care at MD Anderson. He got his surgical care in South Texas where we lived, and then he got his radiation treatment at MD Anderson. That was the recommended therapeutic course for people with lung cancer. It developed an affinity for me to Houston, and so when I started looking at my pediatric residency, then I was very
interested in looking at that part of the country because it meant I could continue
to be a part of my dad’s care and help my mom out a bit.

JONES: What drew you to pediatrics?

HANSON: I always loved kids. I’m the youngest of six, and my oldest sister is 13 years
older than me, so by the time she was 20 and had her first child, I was only 10, so
I always enjoyed being around children, and so I thought what better job could
you have than to take care of kids who were sick? Not only are they a joy when
they’re well, they also can be unbelievably — what is the word? They’re so full
of life all the time, even when they’re losing their lives, that they’re inspiring.

JONES: Tell me a little bit about your residency.

HANSON: I did my residency at Baylor College of Medicine in Houston. That was a
three-year program. I had just unbelievably wonderful mentors, Dr. Feigin and
Dr. William Shearer. Working with them was just amazing. They were great role
models. Lots of women in medicine and lots more women in pediatrics than there
were in medical school for sure, so that felt a little more comfortable, especially
having come from a small town where you didn’t meet doctors often and you
definitely didn’t meet females very often. I enjoyed my residency. It was really
hard work.

A funny story is that my dad had told me my residency would be the best
time of my life, and I spent the first day of work on a Saturday at the local
indigent hospital peering into a microscope reading my patients’ urine analysis
and performing and interpreting their stool smears and looking at cell counts on
CSF [cerebrospinal fluid]. I called my Dad the next day and said, “You lied. It
was awful.” It was hard work, but it was good.
JONES: After your residency, you were sort of at a crossroads in life?

HANSON: That’s right, and many young people eventually begin to try and make decisions about their personal lives, and they put a lot on hold or on a back burner while they’re doing their training. I was going to move forward and actually get married, and those plans kind of imploded on me, so I took a little bit of time and worked as a general pediatrician here and then found out that one of the mentors that I mentioned, Dr. Shearer, had an opening in his section for Allergy and Immunology as a fellow in training. I liked being a general pediatrician, but I wasn’t terribly challenged by it. I felt like my nurse was as well-educated in the field as I was, and I wasn’t feeling too much like I was giving something back. So I thought I’ll try this and see how it works, and so that launched me into this career of allergy and immunology, which I had never really thought of as an option, but it turned out very good for me.

JONES: What did your father say when you told him about allergy and immunology?

HANSON: My dad did not think that allergy and immunology was actually really in the medical field and thought maybe that it was a little bit magical, kind of like dermatology, he told me. I reminded him that no, they are actually medical fields, and I would be doing some good work here, so he was fine with it. My mom was sure that I would make great inroads into the medical field, as she was about all of the things that I took on. She was quite the wonderful cheerleader.

JONES: She was very supportive.

HANSON: Yes.

JONES: When did you start your fellowship?

HANSON: I started my fellowship training actually in 1983. I had just finished my
pediatric residency in 1981, took a year or two to kind of get my bearing, and then started my training in 1983. It was soon after I started my fellowship training that David, the bubble boy, actually had received his transplant from his sister. It was kind of a benchmark because people were not doing a lot of what we call haploidentical half-matched transplants, and he was 12. Most children with severe combined immune deficiency, which is what he had, didn’t survive to that time without some sort of intervention, and since he lived in that bubble, he effectively avoided and efficiently avoided all infections, but he wanted an opportunity to have a real life and not be so isolated. Remember, his mother had never touched him. His mother had never held him. She had had previous children with immune deficiency, and so when this boy was born, they knew he was likely to have it, and he became isolated right away.

After transplantation, he initially did very well but then became sick. My mentor at the time, Dr. Shearer, asked me to become actively engaged and join his care team. That was quite an honor because I was the only person who wasn’t the head of a department. In, effect, I was the youngster on the block. I knew I would learn a lot and that it would be a turning point in my life.

JONES: What was it like to be part of a team that got quite a bit of media attention?

HANSON: For me, not so bad, because nobody wanted to talk to the young girl in the corner who was mostly busy and quiet. But for Dr. Shearer, I think it must have been a very difficult job because every step of David’s healthcare was delivered under the microscope. Typical of Dr. Shearer, he rose to the occasion and provided his care with compassion for the adolescent and his family.

For me, David, the patient, was my biggest challenge at the time as he was
a bit distrustful of my youth. When I first met him, he was very curious about me because I was probably the only healthcare provider under 25 involved in his care.

I remember his team asked me to draw his blood while he was in the bubble, and David’s response to my assignment was, “Have you ever done this before?” I had never had a 12-year-old actually question me professionally and grill me before I did any kind of a procedure.

I said, well, no, I hadn’t.

He picked out a nurse in the room and said, “Put the gloves on, draw her blood, and if you can do it, then you can draw my blood.”

That’s how we set it up, and fortunately I was very good at procedures, so it worked out, and he allowed me to draw his blood and thought I was okay with him and earned his trust.

JONES: You passed the test.

HANSON: I passed the test, that’s right.

JONES: This was the early 1980s. Were you starting to see cases of kids coming in with HIV at the time?

HANSON: Everything I was doing clinically at the time was actually immune deficiency, and so yes, little by little we began to see children coming to Allergy and Immunology Service for us to rule out immune dysfunction or immune abnormalities. Some of them wound up later to be determined to have HIV infection, but in the beginning we were looking to see if they had things more like what my patient David had, primary immune deficiency. David developed an oncologic process driven by Epstein-Barr virus infection and we learned about the impact of a viral infection on the immune system. His care unfortunately
documented for the medical community the link between infections and evolution of immune defects.

We began to see this population of children in the early 1980s with immune problems and recurrent infections but no congenital immune problem. Their cells seemed to be fine at birth but became less and less functional over time; they had an acquired or what we call a secondary immune deficiency, like you might have if you got a burn and lose cells in fluid lost from your burn and lose lymphocyte numbers and start getting sick. It turned out those children actually had HIV infection and were, over a very short period of time, losing their immune systems and beginning to get the kinds of infections that children like with primary immune deficiency like David.

JONES: What were you able to do for those kids at the time if you weren’t quite sure what they had?

HANSON: In the 1980s it was very difficult because we didn’t even know what HIV infection was. We knew about a cohort of individual adults who were having similar sorts of symptoms thought to be caused by a sexually transmitted infection, but we did not know if it was a virus or a bacteria or anything about it. It didn’t make sense from an epidemiologic standpoint for that same symptom complex to be occurring in children.

I remember actually calling somebody at the CDC [Centers for Disease Control] and saying, “I think I want to get that HIV test done on one of my little kids here.” The guy laughed at me and said, “No, children don’t have HIV. It’s not spread in that way.”

Well, later I worked at the CDC and I met that individual, and he laughed
and he said, “I’ve been waiting for the day to run into you because I remember our interaction on the phone, and I remember you telling me, ‘I think I’m right, and I’m going to prove it to you someday.’”

JONES: When did you guys start figuring it out?

HANSON: About 1985, HIV infection, the virus itself, was isolated and a serologic assay became available for us to try and look at. It was hard in children to do too much with that because we thought that they were infected perinatally; that their mother had transmitted it to them either in utero or as they were traveling out of the birth canal. So we knew when we measured early in life that serologic test, we were actually testing the mother because it was her residual antibody, not the baby’s, but it still gave us a marker to know they had been exposed.

About that time, we really began to then understand that this new cohort of either kids who’d gotten transfusions, who had sickle cell disease or other sorts of diseases that required them to get transfusions and had HIV infection from a contaminated blood supply, or youngsters born to women at risk, were in fact getting this disorder and then succumbing to it, because in terms of therapeutic interventions, except for identifying the disease and trying to prevent infections, we had nothing to treat the disease yet with.

JONES: What was the stigma around that disease at this time?

HANSON: The obvious stigma around HIV infection in the 1980s was participation in homosexual practices. Most of the reported HIV-infected adult male cases occurred in men who had sex with men, but that transmission risk didn’t make sense in children. There was less stigma for children regarding transmission risk but grave concern about their ability to spread HIV to others, especially other
children. The young women who were having babies that were HIV infected were very much thought to be anomalies and surely must have had relationships with men who had sex with men. Then as we understood more about the blood supply being contaminated with HIV, then the transmission risk of HIV acquisition from infected blood or needle was better understood epidemiologically, and then there was a lot of stigma regarding on whether women with HIV-infected children weren’t themselves IV [intravenous] drug users or in relationships with drug users. The role of heterosexual transmission was the last risk to be understood and in good part explained the pediatric perinatal HIV epidemic.

JONES: As far as schools and public spaces, how were they reacting to these children?
HANSON: Once we better understood the virus and its mode of transmission, then it gave us a real opportunity to begin to socially educate the community and reach out to them and have them understand what the pediatric risks for acquisition of the virus were: how a child would become infected with HIV and how their family were perceived. The latter impacted not just infected children but unfortunately even exposed uninfected children with family-related stigma: Your mother must be a prostitute, or your parents are drug users, or your mother is a bad person and you have that disease, and you’re a bad person, and I don’t want to be near you. Believe me, if that’s what the child thought, that’s definitely what their parents thought. We had quite a mountain to climb to try and better educate our community and especially our educational system and even my colleagues and peers in medicine about how people who were in contact with folks with HIV infection could or could not acquire the infection.
JONES: As far as the amount of things that you were able to do for these early kids, it wasn’t a lot, so you probably saw a lot of death and things like that. What was the emotional toll like for you?

HANSON: It was a very difficult emotional toll for everyone, to be honest, because sometimes as we identified an HIV-infected child in the hospital with an opportunistic infection, we would be diagnosing not only that child but also an HIV-infected family for the first time, and that family because of social stigma didn’t have anybody to talk to. Parents weren’t comfortable telling grandparents. They didn’t want to tell family. Sometimes they didn’t want to tell their spouse, especially if that child wasn’t necessarily that man’s child, because now all of a sudden they have a spouse who’s at risk for HIV infection.

It was very trying for these families and completely isolated them. For many of the families that we met, we sometimes lost parents before we lost the child, and that was very hard to deal with because you were trying to find a safe house for that child at the time that their parents were dying in the hospital. It was so very hard for the family, unbelievably difficult for them, but also really tough on the caregivers because without a cure, without a good intervention back in the mid-1980s, there was very little to offer except your sincere support and any little positive thing you could try and do to keep them out
of pain, out of the hospital, and to have as comfortable a life as they could.

I think we all banded together, and we did it, of course, as a lot of people do who like to help other people, we did it in the names of those children, but actually we were the beneficiaries of everything we did, too. So we established things to try and make sure that they could have other people to interact with, but it gave us the opportunity then to be the people who took them to that so then we could all interact with one another and begin to get some comfort out of just being with each other and supporting each other through the tough times.

That didn’t happen just at a local level. That actually happened at a national level, too. You went to every single meeting you could because you wanted to learn everything you could so you could offer the best opportunity for the people you came back to, to try and help.

I’ve always been very public health minded. I think growing up in a small community helped. You were just tired of seeing the same thing over and over again, so you tried to find a root cause and cut it out or cut it off so that it no longer affected the population. What can we do to not only take care of this particular child, but make sure that this mother does not have another affected baby and she has a quality of life that lets her be a mother? How do we keep that system intact? We were all depending on one another to find the intervention, the cure, the public-health intervention that would allow us to identify kids before they got sick and were dying.

JONES: What was the turning point for you guys at the hospital, in terms of recovery?

HANSON: I think one of the biggest turning points was development of a serologic test and then identification of therapeutic interventions. The first was back in the
very, very early 1980s, as soon as the serologic test was available, the state of Texas actually passed a law that said that women who were going to have babies all needed to have HIV testing. That was a banner day because it gave us an opportunity to let women know that they had a risk for transmitting this disease, let families know that they had some risks and we could work on some prevention interventions at that time.

Once we knew that we could identify women when they were pregnant, then it gave us an option later, when we found an intervention to interrupt transmission from mothers to babies, to get the kids off the hook, and then they might be born to an infected mom but they wouldn’t themselves be affected. That was an unbelievable step in the right direction.

Those small steps were really important, but then as we understood more and more how HIV and how that virus replicated and what it was susceptible to and finding treatments that made it a chronic illness as opposed to a death sentence was just like a miracle. The fact that we have some of the characters out in our community who are well known with HIV infection who continue to survive and do well — the Magic Johnsons of the world — is a remarkable feat, and it was a remarkable opportunity that we were able to translate that not to just rich, famous people, but actually to communities as a whole to try and intervene and interrupt transmission.

[END OF AUDIO PART 1]

JONES: You stepped away from Houston for a while.

HANSON: I did.

JONES: You moved to Atlanta, correct?
HANSON: I did. Like married couples sometimes do, one person’s career is going along well, and another needs a little bit of their day in the sunshine. We moved to Atlanta, and I first took a job at Emory, but then there was an opening in the HIV world up there at the Centers for Disease Control, and I couldn’t ignore it. Even though I thought I was stepping away from HIV infection, I stepped right back into it. I really enjoyed that. It was my real love of public health that made me want to do that. Also I learned pretty quickly that resources for healthcare are dependent upon your ability to understand the disease, treat the disease, but also understand its fiscal needs over a larger population.

I was very excited and took a job as a medical epidemiologist in the pediatric HIV group, and my job was to develop a tool so that we could identify who these kids were, what their clinical illnesses looked like, and then what it cost to take care of them. That way, as time moved forward — because remember, at that time when I moved to Atlanta, we actually did not have these wonderful treatments that we have now. We still needed to figure out how do we get those treatments to people? What are those treatments? Where are kids hiding that can’t get access to them?

I very much enjoyed that opportunity. It was an unbelievable learning experience, and I was handed the baton and I ran, and they had to find me.

JONES: What time frame was this when you were working there?

HANSON: That would have been 1990 to 1993–1994.

JONES: As you were working with the CDC, you had some deaths in your family.

HANSON: I did. We loved Atlanta. I really enjoyed the work. My husband was really enjoying his work at a higher level in the company he worked for. Unfortunately,
I had a number of deaths in my family, and so it pulled us back to Texas. My second-oldest brother actually passed away with HIV infection, and that was just a terrible blow for me, but I also lost my mother and father within a 12-month timeframe, so it was very difficult to be so far away from a very big, noisy family and not be around them to try and help.

We moved back to Texas, and I got lucky, and my mentors, Dr. Shearer and Dr. Feigin, heard that I was coming back and said, “Great, come back. We have a spot for you. Here it is.”

JONES: As far as your brother’s death, obviously you’ve looked at a bunch of issues with HIV from a medical perspective, so what was it to look at it from a familial perspective?

HANSON: Perhaps having to deal with this infection in my own family made me have a better understanding of the social impact of the disease and made me less clinical and more compassionate. I think I had always given myself pretty good credit for understanding what it was like for our poor little patients and their parents, but oh, my goodness, losing my brother was very, very difficult, especially as a physician. And especially as a physician who took care of people with HIV infection, it was a very big loss and sense of failure.

The timing of his immune dysfunction and symptoms has just been a tragedy to me because if his disease had started only 10 years later, he’d be here. But medicine did not have options for my brother at the time of his passing. The drugs that are available now or even were available three years after his death could have been so helpful. It was very difficult for me personally.

JONES: Did he have to deal with the stigma that you were talking about that you saw
with the homosexual community?

HANSON: Absolutely, absolutely, yes, he did, he did. My brother was gay, and he grew up in a small town, we were Hispanics, and so he had lots of things going against him from the beginning. He was very handsome, very bright, lots of energy and talent and lots of love of life. Unfortunately, he didn’t get to love life for too long, but his family tried to comfort him and let him have the most fun he could in his life.

JONES: How long was it from his diagnosis until his death?

HANSON: About two years.

JONES: Wow. When you got back to Texas, did you feel sort of — renewed is maybe not the right word, but had a different outlook on things when you got back?

HANSON: I did. Certainly I had lost some really important people, and I had lost a brother to HIV infection. When I had been at the CDC, it had been a passion. Now it became kind of like, “Oh, hell no, this is not going to continue,” so it really made me want to work with as many people as I could to try and figure out how to help at more than just the level I had been helping before. How could I help all humans affected by this virus, not just a selected population?

I trained in pediatrics, so I didn’t have the wherewithal to take care of adults with HIV infection. But we did take care of the women that had HIV infection, and they were adults, and so I began to focus a little bit more on women and the transmission. In fact, when I came back, one of the studies that we started was the WITS study. That’s the Women and Infants Transmission Study. It gave us an opportunity not only to look at infants, but also to look at women and how it impacted their lives. I had a renewed interest in understanding what happened to
adults when they got this infection? How did it impact their lives?

JONES: When you came back, did you come back in the same position that you had
when you left, as far as the hospital goes?

HANSON: You leave places, come back with different experiences. They’re kind.
They give you promotions and things like that, but I came back to the same
section, to Allergy and Immunology.

JONES: How long were you there before your next step?

HANSON: I kind of get a seven-year itch, and so I would say each of these places, I’ve
been there about seven years, but I always keep coming back to Texas Children’s.
It’s a home plate.

JONES: After you did that for a little while, you went to work for the state health
department; is that correct?

HANSON: I did. What happened is, a lot of the arenas and a lot of the study of the
transmission of HIV became clearer, and the transmission rate had dropped
significantly such that it was well under 1 percent in the pediatric arena, so it
appeared to me that maybe my job in that arena was done and I no longer needed
to actually be part of that role. My husband had just gotten a job in Austin, and so
we moved to Austin and I started working with the health department. That was
in, I think, the year 2000. I decided I would not take a job in HIV infection and
instead took a job in infectious disease, which I had always liked and had in fact
wondered about being an infectious disease doctor, but I didn’t really want to do
that because my perception, real or not, was that you didn’t see patients on a
consistent basis; you just saw them at intervals in their lives.

I worked with the TB department there, and I worked with the veterinary
department there, and I worked with foodborne illnesses and things like that. It was the veterinary experience that actually was the most engaging and amazing because they were seeing all sorts of interesting animal-borne or vector-driven disorders. They were seeing all sorts of infectious illnesses.

I was there working at the health department during September 11, and all of the concern thereafter in this country was driven by our nation’s anxiety around other kinds of threats, including airborne infectious threats. That was a very interesting time.

We got through that piece of this country’s history, and I was approached by the folks in HIV at the health department. They said, “Come and help us. The person that was leading in HIV prevention and therapy just left. Can you come and help us out with some problems that we have?”

I returned to HIV to address a resource issue of acquisition of therapeutic interventions. At this time, many wonderful drugs were available to people with HIV infection, but they were very costly, and the allocation of funding from the State for those drugs to be delivered to people in Texas, if they didn’t have insurance, had not kept up with the cost of the drug. It was our team’s task to work to find $16 million to meet the needs of HIV-infected individuals in Texas. It was a wonderful opportunity to learn how the pharmaceutical business works and how the state works contractually with different agencies. We were able to realize that gap and actually translate our solution over to something that actually helped Medicaid in the State of Texas. I enjoyed the challenge and our success.

My family moved back to Houston to take a public health job at the Regional level for counties without health departments. In time, I transitioned back to
Texas Children’s Hospital to conduct clinical care and research.

JONES: What did you do when you came back this time?

HANSON: When I came back, I did primary immune deficiency, restarting the journey I had begun in the very beginning with my patient David. I was lucky to work with colleagues across the state and passionate advocates and agencies to pass, in January of 2012, screening for severe combined immune deficiency [SCID] in the Texas Newborn screening program. The screening for severe combined immune deficiency has allowed physicians in Texas to identify affected children early and when applicable provide interventions and counseling for parents. It’s funny that you’re interviewing me today, because I just got off the phone with a patient I just saw last week whom I cared for 12 years ago during his transplant for SCID at nine months of age. The long-term care for such youngsters is so very nice.

Fortunately similar relationships with past patients are not a reality for HIV infections. I keep in touch with a really wonderful young woman that I picked up when she was six months of age with HIV infection. Her mom and dad both died with HIV infection. She is in her late 30s and is doing really beautifully and has a career and is quite well with HIV infection, now a chronic illness, and
living a full life. It’s very nice to think I played a small role in getting her to where she is.

JONES: It all kind of came full circle for you.

HANSON: It does come full circle for me, yes.

JONES: Tell me a little bit, because you’ve worked in the financial and you’ve seen the politics play out over healthcare, what do you think the political and institutional support is like today versus when this first happened in the early 1980s?

HANSON: I’m not sure that it’s horribly dissimilar, and that’s a real misfortune that it is still — there are minds to be opened and hopefully opportunities to have people understand that paying attention to healthcare and paying attention to prevention is actually worthwhile. I remember going to a small city in Texas and talking to a group of individuals, and a physician came up to me and said, “HIV prevention is really expensive. Why don’t we just treat them as best we can and let them die?”

That’s a very hard thing to hear as a physician from another physician. Not only does it lack compassion, it’s like, “Did you go to medical school? I mean, what happened to your compassion? Where did it go?” That was very discouraging to hear, but sometimes I feel like that mentality still exists and especially exists at levels where people make decisions about resources. It’s very disheartening to see that although we’ve come a long way in treatment and in prevention, that we still have that mind-set.

It is more expensive to prevent disorders because you’re dealing with a whole population and not just an affected population. The reality is that it is the right thing to do. It is the appropriate thing to offer people options for prevention. They’re adults. They’ll make their own decisions, but when their decisions
impact other, smaller people who can’t make choices, like children, as a pediatrician I have to stand up and say, “I’m their advocate. You have to think about this. You can’t just ignore them. You can’t not vaccinate your child because you’re worried about vaccines and then let them die of measles when they’re in college. It’s illogical. I know you love your child. You had him. You took him all the way through school. You paid for his education. How can you do this? How can you let him down at the most important moment, over something as simple as a vaccine?” But it happens. It can be very discouraging, but you just keep marching forward at whatever level you can to try and open doors and maybe have people see things a little better.

JONES: What support have you seen from other agencies? The hospital? Community groups? Anything like that?

HANSON: In general, the hospitals early in the epidemic of HIV infection, because they didn’t know what it was, I think were very nervous about liability risks. Especially once it was understood that the blood supply was contaminated, a lot of liability issues came to the forefront until finally people recognized, “Wait a minute. Wait a minute. Wait a minute. It’s just a virus. There are lots of things that contaminate the blood supply. We have to be reasonable about this.” I think that they moved forward then in a more compassionate way. Certainly Texas Children’s has been, as an example, unbelievably supportive of all of the efforts related to HIV. A lot of the work that Dr. Kline initiated outside of this country was so well supported by Texas Children’s Hospital and by medical agencies, but especially this institution.

I think in terms of government groups, really, the pendulum swings. As
soon as there’s an outbreak of something, then everybody really gets on the boat and they want to have a party and they want to do fundraisers and they want to get you everything they can. Once the sun sets and the party is cleaned up and there’s no more disease, people kind of forget about it and figure it’s not anything they should worry about, when in fact it’s still there. The virus still exists. It still has the capacity to infect individuals and to be spread.

I think it’s important to maintain vigilance, so I’m always very enthusiastic about the work of public health and supportive about the people in public health because those guys are working long hours, not getting very much credit for what they do, and yet some of their vigilance is what keeps us all on the right road. I always laugh and tell people, “Do you enjoy your water? Somebody made sure it wasn’t going to make you sick.”

JONES: Exactly. Are there any new obstacles that we’re facing in terms of HIV?

HANSON: I think the biggest obstacle may actually be that people think it’s over; that we don’t have to worry about HIV anymore. We do still have to worry about this infection and what it might mean for people in the future. We have wonderful drugs that currently help us once people have acquired the disease, but I think that it would be important to really begin to continue the hard work of identifying people when they’re at risk and preventing them from having HIV infection. Interestingly enough, there are wonderful drugs that do that now, too. If you think you’ve had a relationship with somebody or intercourse with somebody that had HIV infection, you have a mechanism to consider actually taking that would prevent you from acquiring the infection. Those kinds of things I think we need to still be vigilant about and try to promote.
JONES: Do you think that we’ll see a cure in our lifetimes?

HANSON: I’m optimistic, and I’m hopeful for a cure. Some of that hope comes from some of early data revolving around stem cell transplantation of those with acquired HIV infection. It would be a very expensive endeavor to try and look at it only from that perspective, but even the best therapy that we have now is palliative. It keeps the virus under control so that it won’t disturb the immune system so that you can lead a life. The eradication of HIV infection would be phenomenal, and it’s one of a host of diseases that, as a globe, we would benefit from eradicating.

As I have been talking to you, for the most part I’ve been talking about my national experience. It’s very different when you go to other countries and you still see HIV that’s rampant in the poor, in people with our remarkable resources.

JONES: Thank you so much for meeting with us, Dr. Hanson. I really appreciate you taking the time to share your story.

HANSON: It was my pleasure. It was my pleasure to share my story with you, and thank you for your persistence in making sure I got here.

JONES: Thanks.

[END OF AUDIO PART 2]

[INTERVIEW CONCLUDED]

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