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As UCLA Health explores new ways to educate via social networking, the public was invited to follow Brad Carter’s deep-brain-stimulation surgery live on Twitter, with still images and video from the operation posted on Instagram and Vine.

UCLA Medical Group was awarded Gold Level Achievement for clinical quality by the California Department of Managed Health Care.

U.S. News & World Report’s Best Hospital Survey ranks UCLA the No. 5 hospital in the country and Best in the West.

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FAITH & HEALING

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Share Your Thoughts With Us
Like us or hate us, we want to hear from you. Your input is important to us, so please give us your comments and feedback. We also welcome your ideas for future stories and memories of your time as a UCLA medical student. Don’t be a stranger. Write to us. We look forward to hearing from you.

Patient, Advocate for Thyself
By Douglas Yakich

There is a quote from John F. Kennedy that adorns refrigerator magnets, coffee mugs and tote bags: “One person can make a difference, and everyone should try.” It is a simple but important message. I have taken our former president’s words to heart as an advocate on behalf of individuals like me with Crohn’s disease and an ostomy — a surgically created opening for the discharge of body wastes.

I have lived with Crohn’s disease for more than 20 years, and in 2010, underwent surgery at UCLA that left me with an ostomy. While the operation saved my life, it left me scared, frustrated, angry and sad. A most basic aspect of my life, the way I used the toilet, was forever changed. I had no idea how it would affect my life, my relationships or my friendships. I didn’t want to leave the house.

It took the inspiration and encouragement of my wife, who pledged that she would be by my side forever, the comfort of understanding that my family would always love me, and the knowledge that no one else would ever know unless I told them to help me move forward. When I came to these realisations, the fears I had were transformed into more positive feelings. My quality of life, after all, had improved literally overnight as a result of the surgery. No longer would I have to rush to the bathroom again and again. No longer would I avoid traveling or going out because of the lack of restroom facilities.

Still, it took many years for me to build up the courage and to become educated enough to effectively speak about my condition and how other people face similar, or even worse, circumstances. Responding to an ad for a writing contest helped; I wrote a heartfelt message of inspiration to other patients with Crohn’s disease, and then I was recognized for my efforts by being named IBD Icon in 2011.

Now, I am unafraid to speak out. I have visited Washington, DC, several times, talking to senators and representatives about digestive diseases, the importance of continued funding for research and the need to build greater awareness about these disorders. It is estimated that more than 1.4 million Americans are confronted with these diseases and that the annual cost of treating them exceeds $6 billion.

When I came to Washington, I find an overwhelming amount of support — often the response is, “I know someone with Crohn’s disease” or “I never knew it cost that much just to get supplies.” Much of advocacy is teaching highly educated people about a topic they know little about, and once they make a connection to the cause, often after hearing what are very personal stories, they will become supportive.

My advocacy has taken many forms. In addition to meeting with lawmakers to try to garner their support, a petition I started to have the physician and television personality Dr. Mehmet Oz devote a show to digestive disease and ostomies has gathered more than 2,500 signatures. I have written an article for the i.know section of CNN’s website, with the aim of starting a national conversation about these issues in response to the ongoing negative connotations that are attached to patients with digestive diseases and/or an ostomy. These negative comments were made in the media, prime-time television shows, and even made by some in the medical community. Much to my surprise, CNN elevated the story to its homepage.

Through my different efforts, I hear so many personal stories; they motivate me to continue my efforts, and I consistently look for innovative and fresh ideas to use in connecting those patients who seemed lost or forgotten with those who have the ability to change lives. Becoming an advocate does not mean you have to stand up on the national level, like I have done. Simply sharing your story with friends and family, writing a letter to your local government officials or joining a local support group is enough to help build awareness. The medical care I received at UCLA gave me a new life, and I feel that through my advocacy, I can repay that debt in some way.
Many argue that children are the soul of our society and that children’s health and wellness reflect the state of our culture. Relatedly, healthy children become healthy adults, and hence, a commitment to children’s well-being ensures a healthy society. At UCLA, we share this view.

A particular emphasis for the David Geffen School of Medicine at UCLA and UCLA Health System is on keeping children healthy through screening and prevention. Faculty, staff and trainees are providing behavioral and physical wellness to children at remote sites via telemedicine; taking a van to schools and neighborhoods to screen and treat children in their own settings for conditions like asthma; working with families in their communities to change their perceptions of healthy eating; and partnering with schools to educate coaches and parents about prevention and early recognition of traumatic brain injury in children who participate in athletics.

For those times when a child is unwell, we have a 360-degree approach to helping the child and his or her family tide over difficult periods. Comprehensive care is provided within Mattel Children’s Hospital UCLA and, by extension, our Pediatric Transport team, as well as in pediatric offices, pharmacies, schools and social settings. The care provided covers the gamut, from community-acquired infections to gene therapy for blood disorders and immune dysfunction to multiple-organ transplantation. Some of our care is specifically targeted to the needs of more vulnerable populations, such as those with chronic illnesses or those in poverty, where the issues — like malnutrition — facing these children and their families are entirely different from those of the broader population.

To foster innovation in preventions and cures of tomorrow, we established the UCLA Children’s Discovery and Innovation Institute last year. Studies conducted there span the spectrum from the womb through childhood to adolescence. Research at the institute ranges from the basic investigation of stem cells and their role in keeping the lungs and gut healthy in children who suffer from related disorders to a life-course study to determine nutritional elements and environmental toxins that may perturb a child’s well-being to novel diagnostics for therapies and prevention approaches for addressing heart and kidney disease, HIV infection, seizure disorders and cancers affecting children. We are also training the next generation of physicians and scientists who will be local, national and global leaders in child health. Many of our students, residents and fellows currently train in other countries as part of the UCLA Mattel Global Scholar Program.

Yes, the health of children is inextricably intertwined with the health of our society. By maintaining our focus on them, we at UCLA are helping to promote a brighter future for children as well as for our nation and the world.

Too Small to Fail
By focusing on the health of children, we promote a better future for all of society.

A. Eugene Washington, MD, MSc
Vice Chancellor, UCLA Health Sciences
Dean, David Geffen School of Medicine at UCLA
Gerald S. Levey, MD, Endowed Chair
Before he was discharged from the hospital, baby Gaël Villegas received the standard panel of newborn screenings to check for genetic and metabolic diseases and hearing. The results showed a healthy baby. Then, one more screening — a non-mandatory test that Mattel Children’s Hospital UCLA routinely offers — was performed to check for critical congenital heart disease, or CHD.

The test, known as a pulse oximetry screening, detected a problem. Baby Gaël was soon diagnosed with a condition that prevented his blood from flowing properly. At seven days old, he underwent a six-hour open-heart-surgery to repair the defect. Had it been left undetected and untreated, Gaël would have eventually ended up back in the hospital in serious condition.

“Without the screening, we would have taken him home thinking that he was perfectly healthy,” said Gaël’s father, Davis Villegas. “When they did the test and told us about his heart condition, it was hard news to get, but now we see that it was a blessing in disguise. It was better to know about the problem from the beginning so they could fix it.”

While UCLA has been performing pulse oximetry tests voluntarily for the past year as part of its overall program to provide the best methods for early detection and the prompt initiation of appropriate therapies for CHD, recently passed legislation mandates that all babies born in California hospitals be screened for CHD starting July 1. “This test is important because it enables us to discover critical congenital heart disease in some babies at a time when they are not yet showing any other signs or symptoms,” says Jeffrey Smith, MD, professor of neonatology. “If the problem is not detected before discharge from the hospital, these babies are at risk for rapidly becoming seriously ill or even dying at home. Early detection using pulse oximetry screening gives the baby the best chance for a good outcome.”

“As pediatric cardiologists, we see the devastating effect that delays in the diagnosis of congenital heart disease can have on these babies when they present later with problems that could have been prevented,” says Mark Sklansky, MD, chief of pediatric cardiology at UCLA. “Newborn pulse oximetry screening, along with the recent revision of prenatal ultrasound screenings to expand the routine evaluation of the unborn baby’s heart, exemplifies how the field is recognizing the need to move toward earlier detection of heart defects.”

Congenital heart disease represents the most common form of birth defect, as well as the leading cause of birth-defect-related death. Congenital heart defects occur in one out of every 100 live births. Approximately 25 percent of these are classified as critical congenital heart defects, requiring intervention within the first weeks or months of life. Complex congenital heart defects can range from a hole between the chambers of the heart to the absence of one or more valves or chambers.
The nonprofit Alzheimer’s Association projects that the number of people living with Alzheimer’s disease will soar, from 5 million to 13.8 million by 2050, unless scientists develop new ways to stop the disease. Current medications do not treat Alzheimer’s or stop it from progressing; they only temporarily lessen symptoms, such as memory loss and confusion.

Current Alzheimer’s drugs aim to reduce the amyloid plaques — sticky deposits that build up in the brain — that are a visual trademark of the disease. These plaques are made of long fibers of a protein called amyloid beta, or Aß. Recent studies, however, suggest that the real culprit behind Alzheimer’s may be small Aß clumps, called oligomers, that appear in the brain years before plaques develop.

In unraveling the molecular structure of oligomers, UCLA scientists, led by Zhefeng Guo, PhD, assistant professor of neurology and a member of UCLA’s Brain Research Institute and Molecular Biology Institute, discovered that Aß has a vastly different organization in oligomers than in amyloid plaques. Their finding could shed light on why Alzheimer’s drugs designed to seek out amyloid plaques have no effect on oligomers; the study suggests that the drugs failed in clinical trials because they zero in on plaques and do not work on oligomers. Future studies on oligomers will help speed the development of new drugs specifically aiming at Aß oligomers, the researchers say.

Women with severe morning sickness who take antihistamines to help them sleep are significantly more likely to experience premature births or have low-birth-weight babies, a UCLA study has found. Women with this severe form of morning sickness who are considering taking such medications should know the risks, says Marlena Fejzo, PhD, assistant professor of research in obstetrics and gynecology.

The cause of severe morning sickness, called hyperemesis gravidarum (HG), is unknown and the symptoms are intense and can last for several months or throughout the pregnancy. The continuous nausea and vomiting can be so violent that women report suffering from detached retinas, blown eardrums, cracked ribs and torn esophagi.

“It was surprising to find the link between antihistamines and adverse outcomes as these are over-the-counter medications that are used commonly by women with HG during pregnancy,” says Dr. Fejzo.

The six-year study compared pregnancy outcomes in two groups of women. The first was composed of 254 women with HG who were sick enough to require treatment for dehydration with intravenous fluids. The second was made up of 308 women with normal or no morning sickness during pregnancy. The researchers found women with HG had four times the risk of adverse outcomes, confirming a link between HG and adverse outcomes that had been shown in several previous studies.

The study then compared women with HG who suffered adverse outcomes to women with HG who had good outcomes. Researchers looked at whether any of more than 35 medications and treatments commonly used by women with HG were linked to bad outcomes. They found that more than 50 percent of HG patients who experienced adverse outcomes took over-the-counter medications containing antihistamines.

“Some doctors will suggest that their HG patients take antihistamine to help them sleep through their nausea,” Dr. Fejzo says. “Our findings show not only that the use of antihistamines is linked with adverse outcomes, but also that they’re not that effective. Women with HG should be aware of that, so they can make educated decisions on how to treat their HG symptoms.”

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New Clues to Cause of Human Narcolepsy

More than a decade ago, UCLA researchers demonstrated that a lack of hypocretin-containing neurons in the brain contributes to narcolepsy, a disorder characterized by uncontrollable periods of deep sleep. Now, the same team reveals that an excess of another brain-cell type — this one containing histamine — may be the cause of the loss of hypocretin cells in human narcoleptics.

Jerome Siegel, PhD, director of the Center for Sleep Research at the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA, and colleagues found that people with the disorder have nearly 65 percent more brain cells containing the chemical histamine. Their research suggests that this excess of histamine cells causes the loss of hypocretin cells in human narcoleptics.

Narcolepsy is a chronic disorder of the central nervous system that is believed to affect one-in-3,000 Americans. It is characterized by the brain’s inability to control sleep-wake cycles, causing sudden bouts of sleep. It often is accompanied by cataplexy, an abrupt loss of voluntary muscle tone that can cause a person to collapse.

Histamine is a body chemical that works as part of the immune system to kill invading cells. When the immune system goes awry, histamine can act on a person’s eyes, nose, throat, lungs, skin or gastrointestinal tract, causing the symptoms of allergy that are familiar to many people. But histamine is also present in a type of brain cell.

For the study, researchers examined five narcoleptic brains and seven control brains from human cadavers. Prior to death, all the narcoleptics had been diagnosed by a sleep-disorder center as having narcolepsy with cataplexy. These brains were also compared with the brains of three narcoleptic mouse models and to the brains of narcoleptic dogs.

The researchers found that the humans with narcolepsy — but not the animals — had an average of 64 percent more histamine neurons. “Our current findings indicate that the increase of histamine cells that we see in human narcolepsy may cause the loss of hypocretin cells,” Dr. Siegel says.

The study results may also further understanding of brain plasticity, Dr. Siegel notes. While scientists have known of the existence neurogenesis — the process by which the brain is populated with new neurons — it was thought to function mainly to replace existing cells that had died. “This paper shows for the first time that neuronal numbers can increase greatly and not just serve as replacement cells,” he says. “In the current example, this process appears to be pathological with the destruction of hypocretin, but in other circumstances, it may underlie recovery and learning and open new routes to treatment of a number of neurological disorders.”

Exercise after School to Stay Fit

Research has shown that children from low-income neighborhoods are at higher risk of being obese and overweight than children from affluent neighborhoods. In fact, one-third of low-income children enter kindergarten either overweight or obese. In an effort to address this issue, UCLA researchers implemented and evaluated the effectiveness of a pilot after-school health-promotion program that focused on increasing opportunities for physical activity and healthy snacks for students, in grades three through five, at four low-income, diverse elementary schools in Los Angeles County.

After-school staff members were trained by UCLA researchers to implement the evidence-based, sequential nutrition and physical-activity curriculum. Data were collected on students’ nutrition and physical-activity knowledge and behavior, and their height and weight measurements, at the beginning and end of the academic year. Results showed that the proportion of children who were obese or overweight in the intervention group decreased by 3.1 percent by the end of the school year, compared with a 2-percent reduction among children in the comparison group. The study found mixed results regarding diet and physical-activity knowledge and behavior.

The authors conclude that enhancing after-school physical-activity opportunities through evidence-based programs can...
Scientists at the Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research at UCLA have successfully established the foundation for using hematopoietic (blood-producing) stem cells from the bone marrow of patients with sickle-cell disease to treat the illness. The study was led by Donald Kohn, MD, professor of pediatrics and of microbiology, immunology and molecular genetics.

Sickle-cell disease causes the body to produce misshapen red blood cells that form like the crescent-shaped blade of a sickle, which hinders blood flow and deprives the body’s organs of oxygen. Dr. Kohn introduced an anti-sickling gene into the hematopoietic stem cells to capitalize on the self-renewing potential of stem cells and create a continual source of healthy red blood cells that do not sickle. The breakthrough gene-therapy technique for sickle-cell disease is scheduled to begin clinical trials early next year.

Dr. Kohn’s autologous gene-therapy approach is a revolutionary alternative to current sickle-cell disease treatments, which include transplanting patients with donor hematopoietic stem cells. Such transplants offer a potential cure for sickle-cell disease, but due to the serious risks of rejection, only a small number of patients have undergone this procedure, and it is usually restricted to children with severe symptoms.

Dr. Kohn and colleagues found that in the laboratory, the hematopoietic stem cells produced new non-sickled blood cells at a rate sufficient for significant clinical improvement for patients. The new blood cells survive longer than sickled cells, which also could improve treatment outcomes.

More than 90,000 patients in the U.S. have been diagnosed with sickle-cell disease. It is caused by an inherited mutation in the beta-globin gene that makes red blood cells change from their normal shape, which is round and pliable, into a rigid, sickle-shaped cell. Normal red blood cells are able to pass easily through the tiniest blood vessels, carrying oxygen to organs throughout the body. But due to their rigid structure, sickled blood cells get stuck in the small capillaries.

“ß-globin Gene Transfer to Human Bone Marrow for Sickle Cell Disease,” Journal of Clinical Investigation, July 1, 2013

“Improving Overweight among At-risk Minority Youth: Results of a Pilot Intervention in After-school Programs,” Journal of Health Care for the Poor and Underserved, May 2013, Supplement

Illustration: Maja Moden
WALL-E, Meet EVA: Robo-doc Navigates on Its Own

Ronald Reagan UCLA Medical Center was the world’s first hospital to introduce a remote-presence robot into its neurological intensive-care unit in 2005. Now it has introduced the RP-VITA, the first robot able to navigate the hospital on its own.

UCLA staff affectionately dubbed the 5-foot, 5-inch, 176-pound robot EVA, for executive virtual attending physician. Unlike earlier models that physicians steered via a computer-linked joystick, EVA drives on auto-pilot, freeing doctors to devote more time to patient care.

“During a stroke, the loss of a few minutes can mean the difference between preserving or losing brain function,” says Paul Vespa, MD (FEL ’96), director of neurocritical care at Ronald Reagan UCLA Medical Center. “This new advance enables me to concentrate on caring for my patients without being distracted by the need to set up and manage its technological features.”

With a simple push of an iPad button, Dr. Vespa can send the robot gliding down the hall to a patient’s room. Equipped with 30 sensors that enable it to “see” when its route is blocked by a gurney or curious bystander, EVA possesses the intelligence to self-correct and plot a detour to its destination. After the robot reaches a patient’s bedside, Dr. Vespa can examine the patient in real time. A two-way video monitor in EVA’s “face” enables the patient and doctor to see and hear each other. A 120x zoom capacity allows Dr. Vespa to magnify a single word on the patient’s chart or zero in on the patient’s eyes to check for dilated pupils.

Jointly developed by InTouch Health and iRobotCorp, EVA’s software creates a map of the neuro-ICU floor that is integrated with hospital records, informing the robot where to go when a physician selects a patient on an iPad. Saved in EVA’s memory bank, the map constantly refreshes as patients are admitted and discharged. In the neuro-ICU, where “time is brain,” EVA enables neurosurgeons and neurologists to connect with patients and their family members at a moment’s notice, regardless of where they are. The robot also allows specialists to offer lifesaving consultations on complex cases worldwide at hospitals without neurocritical-care expertise. Encrypted patient data and medical images are easily downloaded from a cloud-based network.

“Consumers nationwide are facing long delays in medical delivery, largely because the healthcare system can’t provide enough physicians in enough locations,” Dr. Vespa says. “We need new technologies that revolutionize physicians’ capacity to see more patients and greatly expand patients’ access to specialized care.”

From his office, Dr. Paul Vespa conducts a neurological exam of a neuro-ICU patient through the “eyes” of EVA. Photo: Reed Hutchinson

To view a video of EVA, go to: uclahealth.org/eva
Fat Chance: Scientists Accidentally Discover Stress-Resistant Stem Cells in Adipose Tissue

UCLA researchers have isolated a new population of primitive, stress-resistant human pluripotent stem cells that are easily derived from fat tissue and are able to differentiate into virtually every cell type in the human body without genetic modification. The cells, called multi-lineage stress-enduring stem cells from adipose tissue (Muse-AT), were discovered by “scientific accident,” when a piece of equipment failed in the laboratory, killing all the stem cells in an experiment except the Muse-AT cells.

The UCLA team further discovered that not only are Muse-AT cells able to survive severe stress, they may even be activated by it, says Gregorio Chazenbalk, PhD, associate researcher in obstetrics and gynecology and a scientist with the Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research at UCLA. These pluripotent cells, isolated from fat tissue removed during liposuction, expressed many embryonic-stem-cell markers and were able to differentiate into muscle, bone, fat, cardiac, neuronal and liver cells. An examination of their genetic characteristics confirmed their specialized functions, as well as their capacity to regenerate tissue when transplanted back into the body following their “awakening.”

“This population of cells lies dormant in the fat tissue until it is subjected to very harsh conditions,” Dr. Chazenbalk says. “These cells can survive in conditions in which usually only cancer cells can live. Upon further investigation and clinical trials,” he added, “these cells could prove a revolutionary treatment option for numerous diseases, including heart disease and stroke, and for tissue damage and neural regeneration.”

Purifying and isolating Muse-AT cells does not require the use of a cell sorter or other specialized high-tech devices. The cells are able to grow either in suspension, forming cell spheres, or as adherent cells, forming cell aggregates very similar to the embryoid bodies derived from human embryonic stem cells.

“This research offers a new and exciting source of fat stem cells with pluripotent characteristics, as well as a new method for quickly isolating them,” Dr. Chazenbalk says. “These cells also appear to be more primitive than the average fat stem cells, making them potentially superior sources for regenerative medicine.”

Doctor-Patient Communication about Dietary Supplements Could Use a Vitamin Boost

Nearly half of all Americans take dietary supplements, but they can carry risk, including potentially adverse interactions with prescription drugs. However, a UCLA study has found that when it comes to communicating with patients about supplements, most doctors are deficient.

“This study is the first to look at the actual content of conversations about dietary supplements in a primary-care setting,” says Derjung Tarn, MD (FEL ’05, ’06), PhD, assistant professor of family medicine. “The bottom line was that discussions about meaningful topics such as risks, effectiveness and costs that might inform patient decisions about taking dietary supplements were sparse.”

The researchers analyzed transcripts of audio recordings from office visits by 1,477 patients to 102 primary-care providers between 1998 and 2010. Of those visits, 357 included patient-physician discussions of 738 dietary supplements. The team found that five major topics generally were discussed with regard to supplements: the reason for taking the supplements, how to take them, potential risks, effectiveness, and cost or affordability. Among the findings:

• Less than 25 percent of the five major topics — fewer than two on average — were discussed during the office visits.
• All five topics were covered during discussions of only six of the 738 supplements.
• None of the five major topics were discussed for 281 of the supplements patients told their physicians they were taking.

Given the popularity, availability and potential risks of the supplements discussed, more should be done to improve physician communication about them, the researchers said. “Future studies should examine the relationship between physician-patient discussions on patient decision-making about dietary supplements and investigate whether or not discussions are effective for preventing adverse events and supplement-drug interactions,” the researchers write. “A better understanding about these relationships could inform future interventions to enhance physician-patient communication about dietary supplements.”


“Physician-Patient Communication about Dietary Supplements,” Patient Education and Counseling, February 27, 2013
The new Teaching and Learning Center for Health Sciences will enable students from all medical disciplines to work more closely together.

Rendering: Courtesy of Skidmore, Owings & Merrill LLP

**New Learning Center Will Expand School's Capabilities**

The David Geffen School of Medicine at UCLA was scheduled to break ground in September for a new medical-education building. The $120-million, six-level, 110,000-square-foot Teaching and Learning Center for Health Sciences will enable the medical school to expand its educational programs and improve teaching and learning. The facility also is expected to be a boon for recruiting students, staff and faculty.

“We’re building this center not for just today,” says A. Eugene Washington, MD, MSc, vice chancellor for UCLA Health Sciences and dean of the David Geffen School of Medicine at UCLA. “We’re constructing an edifice we believe will help shape the future.”

The Teaching and Learning Center, which is expected to be completed in 2016, will feature technology-enabled classrooms to facilitate active learning; a clinical-skills training center; innovative and flexible teaching labs that promote collaboration and interaction; as well as spaces for students to relax, room for student organizations to meet and offices for admissions, financial aid, student affairs and other student services.

“We pride ourselves on being innovators in education,” says John C. Mazziotta, MD (RES ’81, FEL ’83), PhD, associate vice chancellor of health sciences and executive vice dean of the medical school. “To really be at the forefront, you also must have state-of-the-art facilities — the best classrooms, the best clinical and teaching centers, the best open spaces in which students can learn and the best equipment.”

The center also will enable students from all medical disciplines to work more closely together — an important feature, given the increasing demand for multidisciplinary, team-based approaches to healthcare. For example, a new year-long seminar for third-year students in medicine, dentistry and advanced-practice nursing will allow them to work in groups of eight, along with two faculty members from the different schools, to address issues relevant to systems of healthcare and collaborative practice.

“The future is really about having doctors and nurses and dentists all together in the classroom much earlier on, so it’s very much about interprofessional education,” Dr. Washington says. “As we try to build a truly patient-centered approach to delivering medical care, that integration, which has been a big theme in medical schools, is going to be vital for our trainees. Our vision is to create world leaders in health, science and education. The environment in which that takes place is very important.”
Once again, UCLA Medical Center is the top-ranked hospital in the West and No. 5 in the nation in *U.S. News & World Report*’s 2013-14 “Best Hospitals” study. And while we’re honored by that recognition, our extraordinary team of doctors, nurses, staff and volunteers understands that our true focus remains, as always, on our patients. From the routine to the most complex, bringing you world-class medical care is our greatest honor. To find a UCLA doctor near you, call us at 1-800-UCLA-MD1 or visit uclahealth.org.
The patient-centered medical home concept has gained traction in recent years amid mounting pressure to eliminate unnecessary healthcare costs and improve the quality of care — particularly for individuals with chronic conditions. The basic principles can be interpreted differently. But the patient-centered medical home focuses on a more coordinated, proactive approach to primary care involving a primary-care physician working with a team of providers and a treatment plan developed with the patient. Health-policy researcher Nadereh Pourat, PhD, has examined the topic of the patient-centered medical home, finding, most recently, that patients with chronic conditions who are in such environments are more likely to receive key preventive services such as an annual flu shot.

Contributing writer Dan Gordon spoke with Dr. Pourat about the potential benefits of the patient-centered medical home, what the evidence shows and its future place in the U.S. healthcare system.

What is meant by the patient-centered medical home?

It’s actually an old approach that has been brought back and is now being applied beyond its original context. As far back as the 1960s, this concept was brought up as a way to better manage children with special healthcare conditions and needs who require complex care. The goal is to manage the patient proactively, rather than providing services on an as-needed basis, which has typically been the approach we have had in the United States. For example, a patient with diabetes who is experiencing a problem comes in; the doctor examines the patient, provides advice, maybe prescribes medication; and the patient goes home until the next time there’s a crisis. The patient-centered medical home turns that approach around by anticipating the kinds of care individual patients will need, teaching patients how to take care of themselves, and having patients serve as partners in their own care as opposed to being given doctor’s instructions that may not work well for them. Now, a number of different interest groups, including physician organizations, have reintroduced this idea as a way of managing populations with chronic conditions, particularly adults.

If I have a primary-care physician who coordinates my care, does that mean I have a medical home?

It is more than that. We used to talk about the usual source of care as being the place you typically go for care where they keep your information, your chart. In the medical home, the provider would do a lot more beyond just waiting for you to show up for your next visit. First of all, a team of experts would be
taking care of you. If you have diabetes, you might have, in addition to your physician, a nutritionist on the team, along with a medical assistant who calls to remind you about upcoming visits to get your blood pressure, cholesterol and blood sugar checked, as well as to ensure you are taking your medications. A nurse might be calling to make sure your feet are being checked for neuropathy. So it is a comprehensive team of providers — some of them operating behind the scenes, some of them in direct contact with the patient — who are helping to make sure patients are being managed appropriately.

Does this concept extend beyond routine office visits?

Yes. The orientation should be the whole person. In other words, the focus is not only on the patient’s condition, but also on the patient’s entire spectrum of needs. A strong element of coordination should exist among the primary-care doctor, specialists, and all of the other potential services that the patient requires, including those that are delivered in the community. The patient might be sent to nutrition classes or social-support services outside of the medical home. Utilization of services should be closely monitored so that a strong focus remains on improving quality of care. If the patient is hospitalized, the hospital and the physician should communicate about the services the patient received and what needs to be done to keep the patient out of the hospital the next time. If the patient is referred to a specialist, that specialist and the medical-home providers need to be in close contact. Much of the quality-assurance focus has to do with infrastructure: a health-information-technology system with information on the patient along with guidelines for the providers on managing that individual.

What is meant by “patient-centered” in this context?

The patient centeredness comes from the individual participating in the decision-making. It’s not just your doctor telling a patient, “This is what I want you to do.” Just telling a patient to change his or her diet and exercise isn’t necessarily going to work; the patient needs to participate in his or her own care and buy into the plan. Being patient-centered means sitting down with patients, asking about their daily routines, helping them develop a plan that they think can work for them, and then adjusting that plan over time. That’s a strategy that’s much more likely to be successful.
Are there specific guidelines determining what constitutes a medical home?
These ideas, when they were introduced, were not fully articulated. Now organizations such as the National Committee for Quality Assurance have specified what this means and are developing implementation steps. Although standards are being developed, the term is still used very loosely. More organizations are offering facilities recognition as a medical home, but it’s voluntary.

What is the advantage of receiving such a designation?
The key advantage will be when payment is associated with being a medical home. Some health plans and other organizations are beginning to think about using the medical home as a basis for structuring reimbursements, and their numbers are probably going to expand under healthcare reform.

Do you think this concept is going to expand?
We have to change how we approach care delivery, particularly in the primary-care setting, if we are to achieve the triple aims of healthcare reform — better quality, better health and lower costs.

Can this approach be beneficial for patients who don’t have chronic conditions?
People who don’t have chronic conditions probably won’t see much change, but it could have positive spillover effects. For example, a medical home should be proactive in making sure patients are receiving their preventive services. Some, such as the annual flu shot, can keep one from developing life-threatening conditions. Other services, such as cancer screenings, aim to catch the disease early. The medical home also can help healthy populations focus on lifestyle and diet changes. If you are overweight or a smoker, you may not have a chronic condition today, but if you continue to be overweight, you will likely develop one over time. If your medical home takes a proactive approach and has additional services aimed at its chronic patients, then you can benefit from those services as well, whether it’s a nutritionist to help you eat better or a smoking-cessation program.

“We have to change how we approach care delivery, particularly in the primary-care setting, if we are to achieve the triple aims of healthcare reform — better quality, better health and lower costs.”
How much evidence supports this approach?

It is early, but it’s starting to build. The early evidence is promising with regard to improving quality by providing the right services — the process measures. Some evidence shows improved outcomes and reduced hospitalizations and visits to the emergency room. But it’s still too early to conclude what aspects of the medical home lead to these improvements.

What, then, are the most pressing unanswered questions?

How are providers implementing the medical home, and which providers are doing it? Is it happening in the private-insurance sector or in the safety-net system where people have fewer resources and often have more uncontrolled chronic conditions? Are those who are implementing the medical home getting results in terms of improvements in health, quality of care and costs?

What was the aim of your study on the impact of medical homes on patients receiving flu shots?

Using data from the biannual California Health Interview Survey, we estimated which Californians with chronic conditions such as diabetes, asthma and heart disease receive three key characteristics of medical-home care. They include: having a regular doctor rather than switching from provider to provider; having that doctor coordinate the patient’s care; and having that regular doctor develop an individual treatment plan for the patient. We used the flu shot as an indicator of whether or not people were receiving important preventive services. And we found that the rate of flu shots was highest among adults with chronic conditions who reported having all three medical-home characteristics, at 59 percent. In comparison, only 26 percent of adults with chronic conditions without any of the three characteristics received the flu shot. We also found that those with all three medical-home characteristics were more likely to have seen their doctor five or more times in the past year and to have called their doctor with a question about their care. They were the most confident about their ability to manage their health.

What lessons can be taken from these findings?

This was data from 2009, which was before efforts to implement medical homes began to intensify, so it allowed us to see the point from which we were starting. These findings suggest that seeing the same doctor over time builds familiarity, trust and confidence. And if that doctor takes a coordinated approach to the patient’s care, there seems to be a big payoff in terms of better health — and cost. In a nutshell, giving patients, especially those with complex conditions, a medical place to call “home” may not only keep them healthier, it also may contribute to keeping our health system solvent.”
Three years ago, Ann Donato was diagnosed with congestive heart failure. The mitral valve that controls the flow of blood between the left atrium and left ventricle of her heart was leaking badly, and she felt like she was “drowning from the inside out.” An implanted cardioverter-defibrillator and surgery to repair the valve didn’t help. She vividly remembers the night when doctors at the local hospital where she was being treated came to her room to tell her there was nothing more they could do for her. A nurse stayed with her all night, through tears and prayers. “I lay in the room at night wondering what would become of me,” Donato recalls. “I was scared and I needed answers.”

She was discharged the next day, but, as sick as she was, Donato did not give up. She reached deep within herself to draw on a faith rooted in her Catholic upbringing to stay strong in the face of new challenges while pursuing other options.

“Faith is very important to me,” says Donato, a 56-year-old mixed-media artist. “God, prayer and hope are the key to what gives me my strength and belief to stay focused on what I face daily — and what is in the positive future. It is what keeps me knowing that it is worth all the fight and that I will see myself as a happy, healthy human being once again.”
“That as you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you attempt to cure the body without the soul.”

– Plato, Charmides, c. 387 BCE

Without her spiritual belief, Donato says, she would have had less fight in her; she might have given up. Instead, Donato believes it was her faith that propelled her to find her way to UCLA, where doctors implanted a lifesaving left-ventricular-assist device and where, in September 2012, she received a heart transplant. Donato recalls waking up after her transplant and seeing a doctor smiling at her. With everything that she had been through during the past two years — the search for answers to her condition, the struggle to cut through the red tape of public insurance, the multitude of tests and medical procedures — smiles like this had been rare. “My spirit had been torn down,” Donato says. “Seeing this doctor smiling at me gave me an immediate feeling of empowerment and strength.”

That smile belonged to Mario C. Deng, MD, medical director of UCLA’s Advanced Heart Failure, Mechanical Circulatory Support and Heart Transplant Program. Dr. Deng and Donato formed an immediate bond. “Dr. Deng reassured me that he was with me and somehow I could reach in and get that spirit that I had lost and build back everything that I had lived for,” Donato says. “I knew I was going to be all right.”
DR. DENG IS CLEARLY A MAN OF SCIENCE, but he also believes strongly that a compassionate and trusting relationship between physician and patient — one that supports both the physical and spiritual needs of the patient as he or she makes often-difficult choices about his or her medical care — is essential to healing. He and his wife, Federica Raia, PhD, an assistant professor of education and information studies at UCLA, explored this concept, which they term Relational Medicine Theory, in their research together into patient-physician relationships.

In practice, Dr. Deng says, Relational Medicine Theory advances a model of medicine that integrates science, technology and humanism within a single framework. “It is a mindful act of kindness, delivered from one human being to another, not from a white coat to a patient,” he explains. Physicians can help their patients to recover by encouraging them to draw from their spiritual well.

“When we go through a crisis in our life, why is it almost universal to say, ‘Oh, God, please help me?’” he asks. “It’s not that we are members of a specific church and we are calling upon a specific god. It is a concept of spirituality that ties into the overall aspect of medicine and healing.”

MORE AND MORE, FAITH IS BEING INTRODUCED into physician training as medicine’s focus shifts toward more holistic treatment of patients. Some schools offer separate courses on spirituality, while others, including the David Geffen School of Medicine at UCLA, weave the topic into related coursework. UCLA’s Doctoring 1 class, for example, which is required for all first-year medical students, includes a segment on conducting a patient-centric interview that takes into account spiritual issues. Students also follow chaplains on their rounds in the hospital.

“One of the important aspects that chaplain rounds emphasize is to put the students in a position to have empathy — not just to address a patient’s symptoms but to also ask, ‘How are you doing? How are you coping?’” says Lacey Wyatt, MD ’94, associate clinical professor of family medicine and chair of Doctoring 1. “People draw strength from different support systems, and faith is one of them.”

And faith doesn’t necessarily mean belief in an organized religion, notes Margaret Stuber, MD (RES ’82, FEL ’84), professor of psychiatry and director of the doctoring curriculum. It can be a patient’s sense that everything is going to work out, or that someone — particularly one’s doctor — cares about you. It can mean having faith in the treatment, belief that an individual affliction or disease is curable. Or, it can mean that whatever happens, things are going to be OK. “That sense of confidence and faith is definitely healing; it is the opposite of anxiety or worry or cynicism,” Dr. Stuber says. “I often wish I could just prescribe faith to people.”

As a part of its mandate, Doctoring 1 teaches physicians-in-training to consider spirituality and religious issues as an element of their initial patient assessment. Are there concerns that need to be discussed with a representative of the patient’s faith? Might a person’s religious belief have an impact on treatment considerations? “One of the things that clinicians have to do is become comfortable with, and open to, hearing the beliefs and attitudes of the patient and working with them without feeling they need to argue with them or change them in some way,” Dr. Stuber says.

WHILE STUDENTS TODAY MAY BE taught to consider issues of faith when speaking with patients, the idea that a patient’s spiritual framework might play an active role in his or her healing is not universally accepted. “There’s still a good deal of resistance within mainstream medicine,” notes Harold G. Koenig, MD, director of the Center for Spirituality, Theology and Health at Duke University Medical Center, in Durham, North Carolina. Dr. Koenig,
But many simply don’t believe it is their role to bring these things up. They prefer to keep that part separate from the medical care they deliver. I think, perhaps, it is possible for there to be more of a balance here.”

**UCLA HAS OFFERED SPIRITUAL CARE SINCE 1960**, when several concerned medical staff privately funded the service to pay for a chaplain’s salary. In 1974, the position became an official staff position; today, UCLA’s Department of Spiritual Care includes seven staff chaplains and five resident chaplains.

“In today’s model, the chaplains see themselves as integrated members of the care team,” says the Rev. Timothy Thorstenson, DMin, who manages spiritual care at UCLA Medical Center, Santa Monica. “People respond well when they feel like their emotional self is cared for as they go through a hospitalization. We primarily focus on empowering people to adapt to their circumstances, make meaning out of their experiences by integrating their values and beliefs, and to draw on their faith to face an uncertain future with hope and courage.”

Adds Chaplain Chitra Rao, who attends to the hematology and oncology unit at Ronald Reagan UCLA Medical Center, “I see my role as a spiritual companion, listening to those questions and not necessarily having the answers. Often from these reflections, patients and families are able to access their faith to find peace in not knowing. In their encounter with the limits of medicine, they often sense in a deeper way that faith is indeed about journeying into the unknown.”

**SOMETIMES PATIENTS ARE NOT EVEN AWARE** of their own spiritual needs until they are confronted with the stress of an illness, says Edith O’Neil-Page, a palliative-care clinical nurse specialist. “By exploring their own spirituality, they come to terms with the fact that no one is responsible for what is happening to them,” O’Neil-Page says. “That’s a very important part of dealing with illness and recovering from illness.” O’Neil-Page tries to facilitate that process whenever possible by sitting with the patient and listening. Other times, she will draw upon the resources of physicians, social workers or chaplains. “The spirituality and spiritual assessment of our patients and their families is an intrinsic part of what we do for patients. That is the core of nursing,” she says. “It’s the combination of putting the physiological disease process together with all of the aspects of human need, including spirituality.”

Kim Kronfeld, 62, was diagnosed three years ago with a marginal zone lymphoma in her left tear duct. Kronfeld, a resident of Florida, spent months going from one doctor to another until she received her initial diagnosis. Then she was also diagnosed with dermatomyositis, an uncommon inflammatory disease that causes muscle weakness and a distinctive skin rash. After much research, she found a specialist at UCLA, and now she travels every few months to Los Angeles for treatments for the dermatomyositis. (Her lymphoma is in remission.) During that time, she often talks with the nurses or meets with Chaplain Rao. “It’s easy to get into the, ‘Poor me, poor me, I have this chronic illness that’s never going away,’” Kronfeld says. “But knowing Chitra has been absolutely one of the most wonderful things. She has really been instrumental in helping me through some things.”

Kronfeld, who describes herself as spiritual but not religious, says that she believes one needs faith in order to take risks and succeed. “I see faith in terms of being on a boat during a dark night somewhere on the Long Island Sound. It is totally dark and suddenly the moon comes up and you feel better,” she says. “But you also feel better when the GPS and radar are working. So faith for me is both the moon and the radar. I don’t think faith is unrealistic; I believe that you can’t have healing without it.”

When surgeons opened Brad Carter’s skull to perform a delicate operation to calm his tremors, they invited the public to watch at #UCLAORLive. The patient even contributed to the social-media broadcast with a short musical performance.
There came an extraordinary moment about a third of the way through the brain operation being performed on Brad Carter when the 39-year-old actor and musician was woken up, handed a guitar, and he proceeded to play a couple of songs he had written called *Henrietta* and *Drunken Again*.

With his shaven head immobilized in a metal brace and draped in a blue surgical towel and plastic, he finger-picked the box-shaped handmade instrument and sang, while the operating-room staff worked around him.

“You take my hand/we’ll go runnin’ crazy/down in Dixieland. We will dance and sing/we won’t ever worry/worry ‘bout a thing.”

As he played and sang — and throughout the six-hour-long procedure this past May — the progress of Carter’s surgery, as well as images of him in the OR, were tweeted around the world.

That Carter was awakened in the midst of the operation and directed to perform specific tasks was not unique (though playing a guitar was); his was the 500th operation of this type performed at UCLA, a so-called deep-brain-stimulation surgery to implant electrodes in his brain (which would be followed a couple of weeks later by a pacemaker-like device) to calm his tremors. But it was the first time that UCLA Health invited the general public into the OR via social media to observe such a procedure as a way to educate people about deep-brain stimulation. In addition to live-tweeting, with Carter’s permission, UCLA posted Instagram photos and six-second video clips of the operation via a Twitter application called Vine. The event went viral, landing in the news feeds of millions of Twitter users and attracting widespread attention from conventional news media. While other institutions have live-tweeted surgeries in the past, this was the first time in the United States that a procedure had been broadcast with video clips.

The power of social media is well-recognized by healthcare institutions, and more and more UCLA Health has taken steps to tap into that audience. “The idea of live-tweeting a surgery was something we had wanted to do, but we were waiting for the right opportunity,” says Ashley Dinielli, social-media and Web strategist for UCLA Health, who sent out the tweets, videos and photos throughout Carter’s operation. “It’s not every day that a patient plays guitar in the OR,” Dinielli notes. “This was a chance to let people see something unusual, while at the same time educating them about the surgery.”

For Nader Pouratian, MD ’03, PhD ’01, director of UCLA’s Neurosurgical Movement Disorders Program and the surgeon who performed Carter’s operation, such a development is “a sign of the times.” But at the same time, Dr. Pouratian says, “this is an extension of what we do at UCLA. As a teaching institution, we’re used to having medical students, residents, fellows and visitors from other
parts of the country and around the world observe our surgeries and learn from us. We thought this would be a great opportunity to bring the world into the operating room and teach people about deep-brain stimulation.”

There were two target audiences that Dr. Pouratian wanted to reach. The first was the general public and the many people who are intrigued by the idea of brain surgery, particularly when the patient is awake. But he considered the second audience even more important — potential candidates for the surgery. Dr. Pouratian hoped that by tweeting Carter’s operation, others with similar movement disorders, such as essential tremor or Parkinson’s disease, would see that there could be another option for them. And for those who knew of the procedure but were afraid, he hoped seeing it might alleviate their apprehension. “Our thought was that bringing them into the operating room to see what it’s like would demystify the procedure, showing them that it’s not as anxiety-provoking as they might imagine it to be, so that they might benefit from a therapy we know can help people,” he says.

**DEEP-BRAIN STIMULATION FUNCTIONS LIKE A HEART PACEMAKER.** But instead of going to the heart, the electrodes are strategically positioned in the brain. The pacemaker itself includes a chest-implanted generator that sends continuous pulses to the electrodes to correct the abnormal patterns of activity in the brains of patients with neurological disease. In Carter’s case, the abnormal activity and the involuntary movement they caused were the result of essential tremor, which he first noticed in 2006, beginning in his hands and eventually progressing to the point where he could no longer do many of the things he loved most, like play the guitar.

Since it was first performed about 20 years ago (it was approved for use in the United States in the late 1990s by the U.S. Food and Drug Administration), some 100,000 people have undergone deep-brain-stimulation surgery throughout the world. While most often used for patients with Parkinson’s disease or essential tremor, it is also FDA-approved for a third movement disorder, dystonia, which is characterized by sustained involuntary muscle contractions, as well as for obsessive-compulsive disorder.

In the U.S., an estimated 10-million people have essential tremor, and 1 million have Parkinson’s disease. Although tremors are a characteristic of both conditions, for Parkinson’s they occur predominantly at rest, whereas people with essential tremor tend to experience their symptoms when they hold out their arms or are engaged in an activity. (Parkinson’s disease is also characterized by other symptoms that patients with essential tremor don’t experience, such as stiffness, rigidity and slowness of movement.)

There is no cure for either condition. “This procedure doesn’t change the underlying disease,” Dr. Pouratian stresses. “It doesn’t change the time course or the progression; it’s purely symptomatic.” Medications can also serve to relieve symptoms, and they are the first option. But for patients who either don’t get satisfactory benefits from their drugs, experience complications from them that can’t be managed or have intolerable side effects, deep-brain stimulation can become an attractive option.

“We are fortunate in our field to have very good studies — randomized controlled trials — that show this to be an excellent therapy,” says Dr. Pouratian. “There is significant improvement in quality of life with the surgery, well beyond what patients get from the available medications. It’s not a cure, but it’s quite clear that they spend much more of their day in a better condition — able to participate in many more activities and to enjoy their lives more. One of the most powerful comments I hear from many patients is that they wish they had done it earlier.”

**AN INVOLUNTARY TREMOR WOULD BE UNWELCOME for anyone; for Carter, a native of Georgia who moved to Southern California a decade ago to pursue his acting career (you might have seen him as a forlorn customer in a Progressive Insurance television commercial or on an episode of House MD or CSI: New York), it was a particularly cruel stroke. In addition to acting, Carter supplements his income as a photographer; he also holds an art degree and does sculpting. Then there is his first love, music. Carter describes himself as a professional-grade guitarist who writes songs, has performed live and, until the tremors overwhelmed him, planned to record albums. Moreover, he describes his guitar-playing style as that of a “finger-picker” — heavily reliant on precise movements for his craft.**
Brad Carter is asked to provide feedback by performing specific tasks, such as drawing a spiral, touching his nose and speaking some tongue-twisters. The exercises help the surgical team to precisely position the electrodes.

"The person I am is so wrapped up in activities that I do with my hands," Carter says. "Where am I without that? This has been like slowly feeling my personality being taken away. To say that it's frustrating is an understatement. It's heartbreaking."

Carter first noticed shakiness in his right hand in the summer of 2006, and his symptoms gradually worsened. "The more finite the movement, and the more precise it has to be, the worse it is for me," he says.

Medications for essential tremor are often ineffective, and for Carter they also came with undesirable side effects, including moodiness. "My quality of life was not what I wanted," he says. "All the things I worked so hard at doing — I'm just on the cusp of getting what I want, but I haven't achieved my dreams yet." Worst of all was what the symptoms did to Carter's guitar skills. After putting himself through school playing original music as a singer/songwriter, he had placed his music aspirations on hold to focus on acting. But he'd planned all along to one day record an album, and he continued to play live shows until a year ago, when his handicap became too debilitating.

Carter began discussing deep-brain stimulation with Dr. Pouratian, and as the surgery date approached, he asked if it would be OK to play his guitar during the surgery, so that he could see how his skills were affected by the placement of the electrodes. Dr. Pouratian thought it was a great idea. When he subsequently relayed UCLA Health's interest in live-tweeting the surgery, Carter had no qualms. "I didn't think anything of it," he says. "Honestly, I didn't think anyone would care to watch this. I had no idea it would become so big."

Fueled by the popularity of the six-second Vine videos, the #UCLAORLive hashtag appeared on the streams of nearly 1-million Twitter users. Dozens of mainstream news outlets picked up on the story, generating more than 3,200 shares on Facebook, nearly 4,000 tweets and more than 1,700 shares on other social networks and emails. More than 250 blogs posted information about the story.

Dr. Pouratian admits that he misjudged the impact sharing the surgery via social media would have.

"I didn't think it was that big of a deal before we did it, but the response made me realize what an amazing opportunity this was," he says. "People appreciated being able to come into the operating room, and it gave us a chance to educate them about this surgery."

DEEP-BRAIN-STIMULATION SURGERY IS MOST COMMONLY performed as an asleep/awake/asleep procedure: The patient is anesthetized and asleep during the first part, as a hole is being drilled in the skull; once the potentially uncomfortable phase is over and the brain is exposed, the patient is awakened and asked to provide feedback that helps the team precisely position the electrodes, before being put to sleep again as the skull is closed. Since there are no pain receptors within the brain, patients experience no discomfort while awake during the operation.

"This is a surgery whose goal is to improve function and quality of life," explains Dr. Pouratian. "The best way to ensure that we are achieving that goal is to actually test the patient during surgery, when we first put the electrode in, and make sure we're getting the benefits from the stimulation while limiting the side effects. If it's not in the optimal position, that's our opportunity to move the electrode."

For essential tremor, that step means working with the patient to test the extent to which the stimulation is suppressing the unwanted movement. Patients are asked to hold their hand straight in front of them, do pointing exercises, draw in spirals, hold a cup and pretend they are drinking — and in Carter's case, to play the guitar.

Both before the surgery and during the awake phase, after the surgical team had given him the other tests to optimize placement of the electrodes, Carter played original songs on an instrument that had been handmade for him by a friend.
Both songs involved extensive finger picking. After the brain-stimulation portion of the surgery, Carter’s dexterity on the guitar was much improved.

Images of his improved guitar playing were sent throughout the world, but Carter didn’t see an instant turnaround; in fact, as with all deep-brain-stimulation patients, his recovery will be measured in months. Carter returns regularly for programming sessions — a fine-tuning process in which Dr. Pouratian and colleagues adjust how the patient’s brain is stimulated. “It’s a slow ramping process,” says Dr. Pouratian. “This is not a one-time surgery that makes your life better overnight. We’re putting an object in the brain, and it needs time to recover and adjust. It can take two-to-three months of programming until patients see the benefits in a consistent manner.”

But if Carter needs inspiration during his recovery process, there is no shortage of success stories. Richard Rothenberg was only 37 when he was diagnosed with Parkinson’s disease in 2004, and the Century City banking executive’s symptoms quickly progressed to the point that they were having a substantial impact on his quality of life and ability to perform his job. Rothenberg’s neurologist, Jeff Bronstein, MD ‘88, PhD ‘88 (RES ‘92), director of the UCLA Movement Disorders Program, told him he was a good candidate for deep-brain-stimulation surgery, but for several years Rothenberg resisted. “The idea of an open-brain surgery — it was just so major,” Rothenberg explains. “And it also meant admitting that I was aggressively degenerating with my Parkinson’s disease.”

By 2011, Rothenberg found he could no longer deny the impact of his disease. The medication he was taking, levodopa, provided relief for a few hours, but he had to take increasingly higher doses as his body built a tolerance, and too much levodopa in his system brought on the side effect of dyskinesia — paralyzing stiffness emanating from his head through his body, recurring several times a day as the therapeutic effects of his medication wore off — he would hide in his office.

One day he realized he didn’t want to continue this way. As the symptoms began, Rothenberg called his father — the chairman at the bank — and asked him to sit in his office with him during the downward spiral as Rothenberg waited for his medication to take effect. At the end of the 45-minute period, Rothenberg’s father suggested that his son consider the surgery Dr. Bronstein had been recommending. “I said ‘Yeah, it’s time,’” Rothenberg recalls. “And soon my life turned around.”

Two years after his surgery, Rothenberg says he feels like a new person. He still takes levodopa, and still feels the effects of his disease on a daily basis. But the symptoms come far less frequently, for a much shorter duration, and are significantly less severe. The dyskinesia is completely gone. Rothenberg has returned to working full-time and is able to become a much more active participant in the lives of his teenage children. After the surgery, he remarried, and Rothenberg now has twin girls with his new wife. “I had been unable to drive, unable to work functionally, unable to have relationships,” he says. “I was completely checked out from the aggressiveness of the Parkinson’s disease. Now I have a new life. It’s incredible.”

Carter has similar hopes for his future. “It’s an unbelievable experience,” he says. “I’m not quite sure how I am changed by it quite yet, but I am changed by it.”

For all of the people like Rothenberg and Carter who opt for deep-brain stimulation, there are countless others who could benefit but are either afraid or don’t know about the surgery. Moreover, deep-brain stimulation is being studied for its potential to help in a number of other conditions — including chronic pain, post-traumatic stress disorder, Alzheimer’s disease, obesity and depression.

“This is a technology that’s extremely underutilized,” says Dr. Pouratian. “Just taking into account patients with movement disorders, it has the potential to help many more people if they just knew about it and had the right information. That’s why we wanted to get the word out, through this powerful tool of social media.”

Dan Gordon is a regular contributor to U Magazine.

To read Twitter feeds and see video clips of Brad Carter’s surgery, go to: uclahealth.org/uclathonlive

For more information about UCLA’s Deep-Brain-Stimulation Program, go to: dbs.ucla.edu
Among the myriad characteristics to admire about the nation’s 77-million-member Baby Boom generation is how they’re aging. Not content to fade into irrelevance or boredom, many Boomers are using their senior years to continue working, babysit the grandchildren, climb Half Dome or surf Oahu’s North Shore. But while the mind is willing, the body often isn’t. And so a steady stream of Americans ages 50 and older seek joint-replacement surgery to help them stay in the game.

Since 2000, the number of total-hip-replacement surgeries performed in the United States has nearly doubled while total knee replacements have more than doubled. According to the American Academy of Orthopaedic Surgeons (AAOS), hip replacements will increase by 174 percent and knee replacements by 674 percent by 2030. Today, about 645,000 total knee replacements are performed annually in the U.S., at a cost of about $9 billion, according to a 2012 analysis in the Journal of the American Medical Association. About 306,000 people undergo total-hip-replacement surgery annually.

As the Baby Boomers age, knees and hips are blowing at record rates. Surgery is a salvation for many, but in this era of cost containment, is the price tag too high?
“We have seen a progressive increase year after year,” says Benjamin Bengs, MD (FEL ’07), assistant professor of orthopaedic surgery. “It’s an amazing number. And when we add to that the population getting older, we will see a continued increase.”

Numerous studies show knee- and hip-replacement surgeries are reliable, durable and produce wide-ranging benefits to patients and society. But the cost of the operation, along with the rising demand, has made joint-replacement surgery Exhibit A in the often-contentious national dialogue on controlling healthcare costs. The authors of the JAMA paper noted that while the benefits of the surgery are clear, “the increase in [total-knee-replacement surgery] can also be viewed as yet another source of strain on government, insurers, individuals and businesses struggling with unremitting growth in healthcare spending.”

“People single out joint-replacement surgery because it lends itself to being singled out,” says Tom Rosenthal, MD, chief medical officer for UCLA’s hospitals. “It’s an expensive part of the healthcare system, although it’s a small percentage of the overall system. And, it’s discretionary. It’s not life-saving, like treating cancer.”

Moreover, the passage of the Affordable Care Act (ACA) has refocused national healthcare leaders — insurers, policymakers, medical professionals and consumers, too — on the issue of cost. “The idea behind the ACA was to expand coverage and move to universal coverage,” Dr. Rosenthal says. “The central question was how are we going to pay for it? Healthcare costs had not been talked about for the last 10 years, even though healthcare costs continued to rise. The ACA was the trigger for suddenly recognizing, ‘Oh my, we have never really addressed cost.’”

With more Americans than ever flocking to have a discretionary surgery that costs around $20,000, UCLA administrators and physicians are rethinking the logistics of joint-replacement surgery. From research on preventing arthritis to negotiating price cuts with medical suppliers, they say costs can be held down without limiting access to a surgery that dramatically improves lives.

A PATIENT CHECKING IN FOR TOTAL-KNEE-REPLACEMENT SURGERY — also called knee arthroplasty — generally is middle-aged or older, hobbling on crutches or sitting in a wheelchair or walking stiffly with bowed legs and a pained...
A REAL LIFE CHANGER
Personal Effects of Joint-Replacement Surgery

Most patients can **resume** their normal activities **in as little as three-to-six weeks**.

Knee pain disappear for more than 90 percent of patients.

Look. Typically, arthritis has eroded the cartilage that cushions the bones of the knees, leaving bone rubbing against bone. During the roughly two-hour operation, the surgeon makes a five-inch incision in the front of the knee and moves the kneecap to the side to expose the joint. The damaged cartilage at the ends of the femur and tibia bones is removed, along with some gentle trimming and shaping of the underlying bone. Metal replacement components are affixed into the space to recreate the joint. A plastic spacer is inserted between the metal components to create a smooth gliding surface. In some cases, the kneecap is cut and resurfaced with a piece of plastic. Before closing the incision, the surgeon tests the components by moving the knee through a range of motions.

Several days of hospitalization follow, and then a longer recovery and rehabilitation period at home begins. Most patients can resume normal activities in three-to-six weeks. Although the operation doesn’t restore a knee to a pre-arthritis function, for more than 90 percent of patients, knee pain disappears, and they are able to partake in many common activities, including recreational sports.

Claire Beaumon, 53, emerged from surgery at UCLA on June 12, 2012, with a new right knee and a much brighter future. The Burbank woman, a lifelong sports enthusiast, had worked as a physical-therapist assistant but had gone on disability due to numerous orthopaedic problems that had plagued her since adolescence, including a bad knee that was severely damaged by a post-operative infection in the 1980s.

“My knee was pretty much destroyed after that infection,” she says. “I just lived with it. I tried to stay active. I continued going to the gym, but I stopped biking and I stopped running. But my knee was getting so much worse. I went to doctors, but they said they would never operate on me because I had had a post-op infection. I basically gave up.”

Three years ago, however, Beaumon, now beset by constant pain, consulted with Dr. Bengs. “I’d had 14 procedures on that right knee prior to reconstruction. I told him I’d had this infection and all of these problems,” she says. “But Dr. Bengs said: ‘I can do it. I’m not scared.’ I said, ‘OK, well, I am scared.’”

The operation was uneventful and Beaumon devoted herself to rehabilitation. She continues to work out at the gym and has resumed swimming.

“It was painful and it was hard,” she says. “But I kept going. I finally got my full knee extension back around November.”

She still has health problems, including a circulatory disorder and spinal stenosis. But, she says, “To have that one huge, painful disability gone is amazing. The surgery is worth every penny if the patient is good about the rehab.”

FOR ALL OF THE ANGST ABOUT THE PRICE TAG OF JOINT-REPLACEMENT SURGERY, few operations are more supported by data showing their cost-effectiveness and impact on quality of life. In a 2012 analysis published in the journal *Best Practice & Research Clinical Rheumatology*, researchers at Brigham & Women’s Hospital in Boston conducted a cost-effectiveness review of seven studies on total-knee arthroplasty and six studies on total-hip arthroplasty. The paper concluded that the operations are highly cost-effective.

In another analysis, published in March in the journal *Cost Effectiveness and Resource Allocation*, Timothy M. Dall, a health economist and managing director of the IHS Healthcare Consulting Practice, argued that musculoskeletal disorders impose a huge burden on society and that scant attention has been paid to the economic benefits of treatment. He studied economic and employment data on more than 185,000 Americans participating in the National Health Interview Survey. The survey also assessed the...
severity of their physical limitations. Dall found that improved physical function is associated with a higher likelihood of employment, higher household income, fewer missed days of work and reduced likelihood of receiving supplemental security income for disability.

In a statement, AAOS President John R. Tongue, MD, noted that the ACA charges Americans with becoming better stewards of healthcare funds. But he argued that a missing piece of the debate is the indirect costs of illness. “The policy arguments to date have focused narrowly and relentlessly on the simple cost of procedures to patients and payers, which skews the picture,” he wrote, arguing that the definition of value can’t be based on “the sticker price of the orthopaedic procedure or treatment.”

Joint-replacement surgery “is one of the few procedures that consistently is shown to be cost-effective,” notes Dr. Bengs. “It’s been measured time and time again. It saves money per year by decreasing pain, increasing function, increasing participation in employment and activities, decreasing visits to doctors. That’s why it’s done, because it’s so cost-effective.”

Joint-replacement-surgery expenditures should be compared to the cost of not treating the patient, says Bert Thomas, MD (RES ’84), chief of the joint-replacement service at Ronald Reagan UCLA Medical Center. While medications and physical therapy are recommended for arthritis — and must be attempted before insurers will agree to pay for arthroplasty — they rarely alleviate the problems associated with severe joint damage.

“The alternative if you did not take care of the knee with surgery would be to have the patient live with arthritis. The cost of that is much higher than treating the condition with surgery,” he explains. “A patient who has severe arthritis in the hip or knee oftentimes, in addition to living in constant pain, will be unable to carry on normal work activity, will miss work or will go on disability. Society and the employer will wind up paying disability payments indefinitely. The only true cure for arthritis is surgery.”

The dramatic improvement in patients’ lives is one reason why more Americans are having joint-replacement surgery at younger ages. But that trend has ignited a fresh round of scrutiny over the costs of the procedure. The widening scope of patients seeking the procedure drives up overall costs. Moreover, while today’s artificial joints can last as long as 20 years before wearing out, a person getting a new knee at age 50 is likely to need a second surgery, called a revision surgery, later in life.

Revision surgeries are increasing, with more than 60,000 such operations reported in 2012. Of the 4.7 percent of Americans age 50 and older who have had total knee replacement, about one-third are in their 50s and 60s, according to a study by Elena Losina, PhD, co-director of the Orthopaedic and Arthritis Center for Outcomes Research at Brigham & Women’s Hospital. Demand for the procedure, which costs about $27,000, among people 45 to 64 has tripled in the past 10 years.

“The concern over costs related to revisions is very valid,” Dr. Bengs says. “But we’re seeing an improving quality of surgery and increased longevity of the components, too. That is part of the reason why we’re more comfortable doing the surgery in younger patients. We’re seeing 50-year-olds with debilitating arthritis. Rather than telling them to come back when they’re 60 and deconditioned and with illnesses related to a sedentary lifestyle, why not take care of it now?”

DESPITE THE SUPPORT FOR PROVIDING SURGERY TO PATIENTS IN NEED, responsible healthcare leaders constantly look for ways to curtail costs. For example, says Dr. Rosenthal, healthcare organizations, including Medicare, are attempting to look at why the cost of joint-replacement surgery can vary widely around the nation.

"The policy arguments to date have focused narrowly and relentlessly on the simple cost of procedures to patients and payers, which skews the picture. The definition of value can’t be based on the sticker price of the orthopaedic procedure or treatment."
“The popularity of the procedure tells me that it’s very successful. These hip and knee replacements are the most successful procedures in the history of surgery.”

Nationwide, Dr. Rosenthal says, doctors “should be able to do the surgery on large numbers of patients without a lot of variation. Reducing variation will be good. It will end up improving care because people are following best practices, and that ends up reducing the cost of care.”

UCLA and the other University of California medical centers are addressing the issue of internal cost containment, Dr. Bengs adds. For example, each medical center performs surveillance to decrease waste. The university system is also negotiating better prices with the joint-replacement manufacturers.

“We are constantly trying to improve efficacy and quality and decrease waste,” he says. “UCLA and the other UCs are very sensitive to cost.”

The medical center is also working on improving the biomaterials used in implants so they will last even longer. UCLA and Los Angeles Orthopaedic Hospital created a new plastic that has been shown to be more durable, perhaps for as long as 30 years, Dr. Bengs says.

They have also made advances in how the new joint is inserted. The standard approach is to affix the prosthesis to the body with bone cement. But the cement can deteriorate, he says. UCLA has helped pioneer an approach that adds proteins called growth factors to the implant “so there is a living interface with bone growing into the prosthesis,” Dr. Bengs says. UCLA also has assisted in the development of partial-knee-replacement surgery and resurfacing hip arthroplasty, less extensive and less costly surgeries “that we think will help conserve bone,” Dr. Thomas adds.

Currently, little can be done to help prevent the severe tissue damage that ultimately leads to the need for joint replacement. But UCLA researchers are studying potential preventive strategies, says Dr. Thomas. Obesity, for example, is a major contributor to deteriorating joints. Helping patients lose weight and maintain a healthy weight pays off.

UCLA researchers are also investigating the causes of arthritis — a term that encompasses a number of different diseases that attack joints — in an attempt to discover a technique to interrupt the disease or treat it. One investigative group is in the early stages of research on trying to regrow cartilage.

“Our goal would be, if we can get a good-enough understanding of the arthritis process, to have specific therapies to cure the disease,” Dr. Thomas says. “Right now, the only cure is surgery.”

But, he notes, that’s not such a bad thing. “The popularity of the procedure tells me that it’s very successful. These hip and knee replacements are the most successful procedures in the history of surgery. The results are so dramatic. You’re taking someone from crutches and wheelchairs and within days having them walking through the community.”

Shari Roan wrote about medicine and healthcare for the Los Angeles Times.

**REVISION SURGERIES BY THE NUMBERS**

- **3x**: increase in the demand for the procedure
- **20 Years**: Today’s artificial joints can last as long as before wearing out
- **$27,000**: average cost of revision arthroplasty surgery in 2012
- **60,000**: The number of revision surgeries reported in 2012
Voted Best in the West / 150 neighborhood offices

From our extensive network of primary care offices and specialty clinics to our four renowned hospitals, UCLA has you covered throughout the entire L.A. area. Consistently ranked Best in the West by U.S. News & World Report, the world looks to UCLA for leading-edge medicine. But you need only look around the corner.

- Brentwood
- Malibu
- Manhattan Beach
- Marina del Rey
- Northridge
- Pacific Palisades
- Pasadena
- Porter Ranch OPEN SOON
- Redondo Beach OPEN SOON
- Santa Clarita (Valencia)
- Santa Monica
- Simi Valley
- Thousand Oaks
- Torrance
- Westlake Village
- West Los Angeles
- Westwood

Scan to find a doctor near you
Multitasker

By Kim Kowsky

While some oft-cited labor statistics suggest that the average American worker will have as many as seven careers over his or her lifetime, many jobs researchers say that number is implausibly high. UCLA’s James I. Ausman, MD, PhD, however, has come close.

In the past 50 years, Dr. Ausman has made his mark as a neurosurgeon, medical educator, business consultant, lecturer, online publisher and television producer. All of his endeavors, he says, are based on one guiding principle that he learned from his father, a physician, and his mother: “The patient comes first.”

“It is a fundamental principle in medicine,” Dr. Ausman says. “It’s all about helping people.”

At age 75, Dr. Ausman currently spends one week a month in the operating room. A specialist in complicated surgeries of the brain, he now focuses on spine surgery, vascular surgery and tumor surgery. The rest of his time is divided among a host of other enterprises, each of which is a career in itself. With a lecture schedule this year that includes Finland, Korea, Pakistan, Peru, Panama and Israel, Dr. Ausman serves as chief executive officer of Future Healthcare Strategies, a neuroscience and neurosurgery consulting company he founded. He also is editor-in-chief of Surgical Neurology International, a free online journal of neurosurgery and neuroscience that he began in 2010. The journal reaches some 20,000 readers each month in more than 200 countries, offering scientific papers, live video tutorials and other educational content. “It’s all about helping people,” Dr. Ausman says.

He and his wife of 53 years, Carolyn, also have a production company that currently is assembling its third season of a successful public-television series called The Leading Gen, which draws on his extensive research in geriatrics, cognitive psychology, physiology, aging and brain imaging to help baby boomers and older people achieve longer, healthier lives.

Dressed in his signature white jeans, white shirt, white coat and white cowboy boots — a pristine ensemble he wears daily to convey fastidiousness to his patients — Dr. Ausman cuts a striking figure of health and vitality. Each day, he rises at 4:30 am to read 10 politically diverse online newspapers, medical journals, books and other publications. He also spends an hour a day playing tennis and swimming.

Dr. Ausman earned his MD from The Johns Hopkins University School of Medicine, a master’s in physiology from State University of New York, Buffalo, and a PhD in pharmacology from George Washington University. After completing his neurosurgery residency at the University of Minnesota, he worked at the National Institutes of Health for three years, where he developed the nation’s first pharmacological model for brain-tumor therapy. He also was on the board of directors of a biomedical company that he helped found, which sold a product he and his colleagues developed to measure brain-oxygen content.

Before he came to UCLA in 2004, he headed two departments of neurosurgery — Henry Ford Hospital in Detroit and the University of Illinois in Chicago — growing both into top-ranked programs and cementing his reputation as a “turnaround specialist.”

Dr. Ausman’s strategy for creating The Leading Gen and the production company that launched it in 2007 speaks volumes about his intellectual curiosity and prowess, as well as his tendency to take on controversial topics. When he came to Los Angeles, he began treating a large number of formerly high-powered executives who saw their cognitive and language abilities decline after retirement — a condition he describes as both a syndrome and a disease precipitated by retirement. He felt particularly frustrated by the widely accepted view that people are born with brain cells that are destined to decrease throughout life. Research, he says, shows that the number of brain cells actually increases when properly stimulated. “If you exercise your body and
As an author and journalist, Dr. Ausman has created their own production company and began writing, shooting and editing a series of interviews with people representative of the U.S. population. The show has been broadcast on 214 public-television stations nationwide.

Dr. Ausman takes his own research into aging to heart. He and Carolyn are currently working on a personal “strategic plan” to help guide what they will do in the next chapter of their lives. “We’re looking at new careers and new challenges. The 21st century is going to be a phenomenal period in human history. We want a plan so we can enjoy it,” he says, adding “It’s going to be all about helping people.”

Kim Kowsky is a freelance writer in Los Angeles.

Awards/Honors

Dr. Cathy Alessi, professor-in-residence of geriatric medicine and director of the Greater Los Angeles Veterans Administration’s Geriatric Research Education and Clinical Center, was named president of the American Geriatrics Society.

Dr. Robin Clarke (RES ’10), medical director for quality for the UCLA Faculty Practice Group and assistant clinical professor of general internal medicine, received a UC Health Fellowship.

Dr. Edward M. De Robertis, Norman Sprague Professor of Biological Chemistry, a Howard Hughes Medical Institute investigator and a member of UCLA’s Jonsson Comprehensive Cancer Center, was elected to the National Academy of Sciences.

Dr. Susan Edelstein, founder and director of UCLA TIES for Families and adjunct assistant professor of pediatrics, received an Advocate Award from RaiseAChild.US for her work on behalf of foster children and the families who raise them.

Dr. Rita Effros, professor of pathology and laboratory medicine, was elected president of the Gerontological Society of America.

Dr. Jason Ernst, assistant professor of biological chemistry, received the National Science Foundation’s CAREER Award, which recognizes outstanding junior faculty.

Dr. Janet C. Frank, assistant director for academic programs in the Multicampus Program in Geriatric Medicine and Gerontology, was named president of the Association of Gerontology in Higher Education.

Dr. Patricia A. Ganz, MD ’73 (RES ’76, FEL ’78), distinguished university professor in the David Geffen School of Medicine at UCLA and director of cancer prevention and control research at the Jonsson Comprehensive Cancer Center, received the European Institute of Oncology Breast Cancer Therapy Award.

Dr. Luisa Iruela-Arispe, professor of molecular, cell and developmental biology and director of the Cancer Cell Biology Program Area in UCLA’s Jonsson Comprehensive Cancer Center, received the Gold Shield Faculty Prize in recognition of extraordinary accomplishment in undergraduate teaching, research and creative activity, and service to UCLA.

Dr. Roger S. Lo (RES ’06), assistant professor of medicine in the Division of Dermatology and the Department of Molecular and Medical Pharmacology, has received the 33rd Annual American Association of Cancer Research Award for Outstanding Achievement in Cancer Research.

Dr. Marshall Morgan (RES ’72, ’74), chief of Emergency Medicine at Ronald Reagan UCLA Medical Center, was installed as the 142nd president of the Los Angeles County Medical Association.

Dr. Warwick J. Peacock, professor of surgery, received the newly created Distinguished Service in Education Award from the David Geffen School of Medicine at UCLA.

Dr. Shlomo Raz (FEL ’75), chief of UCLA Urology’s Division of Pelvic Medicine and Reconstructive Surgery, was honored by the Confederacion Americana de Urologia, an organization of 8,000 urologists from Central and South America, Mexico and Spain, with the establishment of the Shlomo Raz Medal and Prize, to be awarded annually to a deserving urologist who works to further the mission of the organization. Dr. Raz was the honorary first recipient of the eponymous award.

UCLA Medical Group has earned a four-star ranking, the highest achievement possible, in the California Association of Physician Groups’ (CAPG) seventh annual Standards of Excellence survey.

UCLA Mobile Clinic Project, a student-run program that provides medical care to the homeless, received a 2013 Leadership Award from the Los Angeles Business Journal.

Dr. Ernest M. Wright, professor in Medicine, was elected to the National Academy of Sciences.

“In you exercise your body and brain throughout your life, you’re continuously making chemical products that will keep your brain functioning at a high level...”

In Memoriam

Dr. David H. Solomon, who led a major expansion of the UCLA Department of Medicine and created the campus’s geriatrics program, died July 9, 2013. He was 90 years old. Dr. Solomon was recruited to the new UCLA School of Medicine in 1952; he became the first board-certified endocrinologist in Los Angeles and led the development of the Division of Endocrinology in the new Department of Medicine. During his tenure as executive chair of medicine, Dr. Solomon led a major expansion of the Department of Medicine. He also recognized the need for a new medical specialty, geriatric medicine. After stepping down as chair of medicine in 1981, he created the Multicampus Programs in Geriatric Medicine and Gerontology. From 1991 to 1996, he devoted most of his energy to developing the UCLA Center on Aging, now known as the UCLA Longevity Center, a campus-wide organization dedicated to helping older people live better and longer with improved quality of life through research, community education programs and patient care.
In Her Own Words: Laura Pacha, MD ’98

Laura Pacha, MD ’98, is a lieutenant colonel in the U.S. Army. She serves as manager of the Disease Epidemiology Program in the Army Public Health Command, located at the Aberdeen Proving Grounds in Maryland. On April 4, 2007, Dr. Pacha sent an email from Iraq, where she was deployed, to the UCLA Medical Alumni Association (MAA,) which became the inspiration for a program to collect medical texts for medical school libraries in war-torn areas of the Middle East. The program was recognized as a Daily Point of Light in 2009.

It’s exciting, and even overwhelming, as I reflect on what has happened since I emailed the MAA during my deployment in Iraq six years ago. From my request, the MAA created Books Without Borders, which is now known as Operation Medical Libraries (OML). Scrolling through the OML blog entries literally brings tears to my eyes. The postings represent a truly grassroots effort and reflect the generosity of so many — from an 18-year-old student who wants to become a doctor to corporate and university support.

OML’s continued success in providing medical books and other support to under-resourced, even war-torn, medical facilities and schools around the world shows how individuals coming together can do amazing things and assist those in need — a welcome contrast to the events that typically make international news.

I am filled with tremendous pride and appreciation for the MAA. Six years later, the project continues to send books overseas. To date, medical-education resources valued at some $2.5 million have been donated and distributed to 20 countries. OML has exceeded my expectations.

It has been said that the pen is mightier than the sword. OML is certainly one example of the truth in that statement. On behalf of the patients and practitioners who have benefited from this program, I offer my sincere thanks and appreciation to all those in the UCLA medical enterprise who have embraced this effort.

For more information, go to the OML blog: operationmedicallibraries.blogspot.com

Postcard from Tijuana, Mexico

Efrain Talamantes, MD ’08, completed a residency in internal medicine at UC Davis, earned an MBA degree at the Goizueta School of Business of Emory University and is currently a Robert Wood Johnson Clinical Scholar at UCLA and the Department of Veterans Affairs in West Los Angeles. His research focus is on improving health access for vulnerable populations. Dr. Talamantes serves as the medical advisor for the newly established UCLA chapter of Flying Samaritans. Its mission is to provide healthcare for underserved communities, specifically the rural community of Colonia Margarita Moran, just outside of Tijuana, Mexico.

As an internal-medicine physician, I have a goal to find ways to improve the health of patients, who lack access to basic healthcare services, through collaborative efforts like the UCLA Flying Samaritans. Every third Saturday, we team up with a group of physicians and other healthcare-provider preceptors and pre-health students in order to drive to Tijuana, Mexico. With the help of translators, the student volunteers busily triage adults and children to various health stations. Together, we see each patient and develop a plan of care. There are countless teaching moments to deliver quality care in a resource-limited environment. My role as medical advisor is also to ensure that the patients get the care they need or to refer them to any available local resources.

To learn more about UCLA Flying Samaritans, go to: flyingsamaritansatucla.org
C. Gregory Albers, MD ‘87, FACG, was in private practice for seven years before his passion for research and teaching brought him back to the Division of Gastroenterology (GI) at UC Irvine, where he had completed a GI fellowship in 1993. Today, he has been at UCI for almost 13 years, and he is professor of clinical medicine, medical director of Diagnostic GI Services at the H.H. Chao Comprehensive Digestive Disease Center and an associate in the Inflammatory Bowel Disease Center. His interests include colorectal cancer screening, chemoprevention research and capsule endoscopy.

On our wedding day, I gave my wife, Francie, my heart. Twenty-four years and one day later, I gave her my left kidney. For Francie and me, our 24th wedding anniversary will always be the most special because it will be known as the “kidney anniversary.”

It was a love story right from the start. I met Francie in the early ’80s. I was attending medical school at UCLA and was active with UCLA’s Catholic Center, playing guitar with the music group for several masses every weekend. Francie showed up (with another guy, I might add) at a “Punk and Preppie” dance that the center hosted one Friday night. I was part of a rock band performing and had dyed my hair blue to go with the punk theme. I was impressed with Francie right away, and, luckily, she saw past the blue hair and said later that I made a great impression on her. I suspect that was divine intervention! As time went on, we got to know each other, and, during one of our conversations, Francie told me about her autosomal polycystic kidney disease. I knew even before we started dating that someday I might gladly donate my kidney to her. We were so happy to be married at UCLA on February 4, 1989.

On February 5, 2013, I returned to UCLA, where I donated my left kidney to Francie via a living-donor transplant performed at Ronald Reagan UCLA Medical Center. Life had come full circle at UCLA. Through the expertise and knowledge of the wonderful surgeons, nephrologists, coordinators, and other healthcare professionals, along with lots of prayers and faith, a miracle occurred. Francie went into surgery with approximately 10-percent kidney function, and two days post-op her function was 100 percent. The procedure was a great success. As for me, I was home within 24 hours and back to work in four weeks.

“Our” kidney is doing great, and so are we. Francie and I owe the success of this surgery first of all to our Heavenly Father; the amazing pre-, intra- and post-operative care we received at UCLA; and the outpouring of love, support, prayers and help of families, friends and colleagues. It is awesome to think what God has in store for Francie with the renewed energy and vigor that a healthy kidney is bringing her. This kidney donation was one of my life’s purposes, and Francie feels incredibly blessed and joyful for the gift of renewed life. I feel certain that God brought us together at UCLA so many years ago, so I could someday donate my kidney to her.

On May 31, 2013, Lt. Col. Carlos Ayala, MD ’99, retired from the U.S. Air Force and U.S. Navy after 29 years of service — 20 of which were active duty — in a ceremony at Nellis Air Force Base in Nevada. He received a letter of appreciation from President Barack Obama for his commitment and service to the country. Dr. Ayala’s military career included deployments in Afghanistan, Cuba, Germany and Puerto Rico. He received 20 awards and decorations, including Meritorious Service, Joint Service Commendation Medals, National Defense Service Medal with one Bronze Star and the Afghanistan Campaign Medal with two Bronze Stars.

Dr. Ayala opened Ayala ENT & Facial Plastic Surgery, and he joined fellow UCLA medical alums Vincent Honrubia, MD ’90, and Dynio Honrubia, MD ’96, at Doctors Hospital at Renaissance in McAllen, Texas, the largest physician-owned facility in the nation. Dr. Vincent Honrubia was one of the initial founders of Doctors Hospital.
Golden Portal Awards

More than 250 guests attended the Second Annual Golden Portal Awards on June 23, 2013, benefiting the UCLA Brain Tumor Program, led by Linda Liau, MD, PhD ’99. The event raised more than $180,000, which will help take UCLA’s personalized brain tumor vaccine — already in a Phase III clinical trial in 50 sites throughout the world — to the next phase of research. The vaccine will be coupled with an immune-system booster to determine possible increased effectiveness for patients with brain cancer.

The Golden Portal Awards, recognizing the art and science of film and medicine, was held at the home of Ted Gagliano, president of feature post production at 20th Century Fox. Gagliano, the mastermind behind the event concept and its inaugural launch in 2012, believes in the convergence of motion-picture science and innovative medical technologies that utilize advances in light and sound. This year’s award honorees were:

• Best Film Science: Life of Pi
• Innovation: Dolby Atmos
• Tenacious Discovery: Rob Prins, PhD, UCLA Brain Tumor Program
• Tenacious Bravery: Barry Socher and Jutta Thorne, brain-tumor survivors

The Sunday brunch awards event featured a Life of Pi theme, and included a Bollywood dance performance and a silent auction of original artwork featuring molecular images of the UCLA brain-cancer vaccine at work. Sponsors included 20th Century Fox, Deluxe, Dolby, Adobe, We Can Pediatric Brain Tumor Network, Hydraulx, FotoKem, Technicolor, iGuide, Stereo D and catering sponsor Taste.

Awards/Honors

On May 9, 2013, members of Today’s and Tomorrow’s Children Fund, part of UCLA Children’s Discovery and Innovation Institute, presented $242,000 to support three extraordinary research projects that will have a profound effect on children treated at Mattel Children’s Hospital UCLA and around the globe. Dr. Satiro De Oliveira, clinical instructor in the Division of Pediatric Hematology/Oncology, received the grand prize for his work on the development of an immunotherapy protocol with persistent anti-leukemic activity. Dr. Andrey M. Mazarati, adjunct professor in the Division of Pediatric Neurology, earned an award for his research on infection during pregnancy as a risk factor for the development of autism-associated epilepsy in children, and Dr. Kara Calkins, clinical assistant professor in the Division of Neonatology, received an award for her work on prevention and treatment of intestinal failure-associated liver disease in newborns. Since its inception in 2006, Today’s and Tomorrow’s Children Fund has raised more than $1.75 million to support the research of 16 faculty members, helping to ensure a brighter future for children.
When the 4th of July Pacific Palisades Parade kicked off, UCLA Health’s People-Animal Connection was leading the way with volunteer/dog teams in uniform. UCLA Health was a parade co-sponsor.

UCLA alumni Sherri and John Fogelman have established the Elsie and Isaac Fogelman Chair in the Division of Pediatric Neurology in the Department of Pediatrics. The chair — named in memory of John’s grandparents — will help advance the Pediatric Epilepsy Program by providing the flexibility to recruit, retain and support the career development of exceptional faculty in the field. The Fogelmans have been loyal to UCLA for many years, beginning as hardworking students. Sherri received her Bachelor of Arts and master’s degrees from UCLA, and John received his MBA from the UCLA Anderson School of Management. From 2004 to 2012, John served as a member of the Board of Advisors for Mattel Children’s Hospital UCLA. His father, Dr. Alan Fogelman, who met his wife, Judith, while both were UCLA undergraduates, currently serves as executive chair of the Department of Medicine. John’s brother, James, received his Juris Doctor degree from the UCLA School of Law. The Fogelman Chair allows the family’s deep connection and commitment to UCLA and the Pediatric Epilepsy Program to grow and positively affect countless patients — for which Mattel Children’s Hospital UCLA is truly grateful.

A comedy-night fundraiser on April 24, 2013, raised $40,000 to benefit ovarian-cancer research at UCLA. The Third Annual “Happily Ever Laughter” at The Comedy Store was presented by The Ovarian Cancer Circle/Inspired by Robin Babbini. Each year since the comedy fundraiser’s inception, attendance and awareness have grown — $8,000 raised in 2011, followed by $20,000 last year. When Robin died at age 20 from ovarian cancer, her mother and Circle president, Paulinda Schimmel Babbini, dedicated her life’s work to increasing awareness of ovarian cancer, particularly among young women. Robin would have been 27 this year.

UCLA supporters Carol and James Collins honored retiring UCLA geriatrician James W. Davis, MD, widely revered as a pioneer in the field of geriatrics. The Collins family has provided major gift support to the UCLA Alzheimer’s and Dementia Care Program, one of the many programs championed by Dr. Davis throughout his career. The couple celebrated Dr. Davis at his retirement party, which featured a tribute video, jazz trio and a commendation from Los Angeles Mayor Eric Garcetti.

The Wilder Family Trust has bequeathed $6.25 million to the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. In honor of Billy and Audrey Wilder, $2 million has been allocated to establish the Billy and Audrey Wilder Endowed Chair in Psychiatry and Neuroscience. The chair will be awarded to a senior neuroscientist in the Semel Institute who holds an academic appointment in the Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine at UCLA. The recipient will be an individual of national and international reputation with proven leadership in the development of innovative programs of education, research and clinical care. The purpose of the chair is to yield investigative advances that will translate into optimum care for patients. The endowed chair continues a legacy of generosity and impact from the Wilder family. After Mr. Wilder’s death in 2002 at the age of 95, his wife, Audrey, donated $5 million to the Hammer Museum at UCLA for the Billy Wilder Theater. After fleeing Nazi Germany in the 1930s, Mr. Wilder became a highly regarded writer and director in Hollywood, winning six Academy Awards. Mrs. Wilder was an actress at Paramount Pictures. She died in 2012 at the age of 89.
Gifts

The California Community Foundation awarded a grant of $500,000 to the Center for Health Services and Society in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. The gift will be used to coordinate with community partners to provide screening and care for depression among underserved populations in the Centinela Valley under the direction of Dr. Bowen Chung.

Occidental Petroleum Corporation made a multi-year commitment of $750,000 to the UCLA Division of Digestive Diseases. With this gift, facilitated by Dr. Ray Irani and Ghada Irani, the Division can seize new opportunities each year that will have a lasting impact on unparalleled care, innovative research and exceptional commitment to establish the Melvin and Bren Simon Digestive Diseases Center. Under the direction of Dr. Mary Jane Rotheram-Borus in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. Funds can include psychological support and counseling, spiritual care, and integrative medicine for one year.

Todd and Randy Katz wanted to honor the philanthropic work of their parents, Ronald and Maddie, — the founders of UCLA Operation Mend — and also set an example for their own children and the community about the importance of compassion and gratitude through giving. Along with their own families, Todd and Randy made a multimillion-dollar gift to create the Ronald A. Katz Center for Collaborative Military Medicine at UCLA. In May, Ronald Katz was honored by the Iraq and Afghanistan Veterans of America (IAVA) with the 2013 IAVA Community Leadership Award.

The Melvin and Bren Simon Charitable Foundation made a commitment to establish the Melvin and Bren Simon Digestive Diseases Center. Under the direction of the UCLA Division of Digestive Diseases’ Co-Chiefs Drs. Gary Gitnick and Eric Esrailian, the multidisciplinary center has already made an impact in advancing innovative diagnoses, treatments and therapies. Bren Simon’s gift is made in appreciation for the care her late husband, Melvin, received at UCLA.

UniHealth Foundation awarded $549,329 over two years to fund the Partnership for Community Wellness: Psychosocial & Behavioral Summer Camp Program. The program is under the direction of Dr. Mary Jane Rotheram-Borus in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. Funds will be used to create a culturally tailored, multi-dimensional summer-camp program for K-5 underserved Latino and Korean students at Robert F. Kennedy Community Schools in Pico-Union/Koreatown. This community-outreach and pilot program is aimed at being a first step in creating therapeutic summer camps for children with chronic illnesses, particularly mental health and behavioral disorders.

In Memoriam

Donald A. Adams, MD ’55 (RES ’59), passed away on May 27, 2013 — four days before his 87th birthday — due to complications from prolonged illnesses. Dr. Adams was a member of the first class of the new UCLA School of Medicine and had the unique distinction of being the first graduate from the medical school in 1955. He was born in Hollywood and lived in West Los Angeles throughout his life. He attended Santa Monica High School, where he played varsity basketball. Two days after his high school graduation, in 1944, Dr. Adams joined the Navy, where he served for two years. After the military, he attended UCLA, earning his bachelor’s and master’s degrees. Dr. Adams had a private practice specializing in Internal Medicine and Nephrology in West Los Angeles for more than 31 years. During this time, he was active in many medical associations, including the California Medical Association, American Medical Association, the Society of Internal Medicine, and the National Kidney Foundation. He served as chief of staff at Santa Monica UCLA Hospital and received numerous awards, including the Professional Achievement Award from the UCLA Medical Alumni Association in 1996.

Barbara Marion Ajello passed away on May 1, 2013, from brain cancer at her home in Fallbrook, California. She was 73 years old. Mrs. Ajello was born in 1940 in Boston, Massachusetts, and grew up in Dallas, Texas, and Arcadia, California. She graduated from UCLA in 1962 with a bachelor’s degree in Spanish and master’s degree in education. Mrs. Ajello met her husband of 47 years, Joseph M. Ajello, at a dance in 1965. They married in North Hollywood the following year. Their son, Michael, was born in 1971. They moved to Fallbrook in 2004, after living in Arcadia for 32 years. Mrs. Ajello and her husband loved traveling together around the world and once lived for a year in Paris, France. Mrs. Ajello taught Spanish for the Los Angeles Unified School District. During her career, while teaching in Arcadia, she was selected as Teacher of the Year. Upon retiring from teaching after 30 years — having touched the lives of more than 1,000 students — she became a certified physical-fitness instructor at 24-Hour Fitness and the Paradise Club. A long-time volunteer, Mrs. Ajello was active in several organizations, including AAUW, Rally for Children and the Angel Shop. Mrs. Ajello is survived by her husband, Joseph M. Ajello, PhD, three sisters-in-law and five brothers-in-law. Two graduate-level fellowships are being established in Mrs. Ajello’s name for brain cancer research at UCLA and UC San Diego.
Patient, Advocate for Thyself

By Douglas Yakich

There is a quote from John F. Kennedy that adorns refrigerator magnets, coffee mugs and tote bags: “One person can make a difference, and everyone should try.” It is a simple but important message. I have taken our former president’s words to heart as an advocate on behalf of individuals like me with Crohn’s disease and an ostomy — a surgically created opening for the discharge of body wastes.

I have lived with Crohn’s disease for more than 20 years, and in 2010, I underwent surgery at UCLA that left me with an ostomy. While the operation saved my life, it left me scared, frustrated, angry and sad. A most basic aspect of my life, the way I use the toilet, was forever changed. I had no idea how it would affect my life, my relationships or my friendships. I didn’t want to leave the house.

It took the inspiration and encouragement of my wife, who pledged that she would be by my side forever, the comfort of understanding that my family would always love me, and the knowledge that no one else would ever know — unless I told them — to help me move forward. When I came to these realizations, the fears I had were transformed into more positive feelings. My quality of life, after all, had improved literally overnight as a result of the surgery. No longer would I have to rush to the bathroom again and again. No longer would I avoid traveling or going out because of the lack of restroom facilities.

Still, it took many years for me to build up the courage and to become educated enough to effectively speak about my condition and how other people face similar, or even worse, circumstances. Responding to an ad for a writing contest helped; I wrote a heartfelt message of inspiration to other patients with Crohn’s disease, and then I was recognized for my efforts by being named IBD Icon in 2011.

Now, I am unafraid to speak out. I have visited Washington, DC, several times, talking to senators and representatives about digestive diseases, the importance of continued funding for research and the need to build greater awareness about these disorders. It is estimated that more than 1.4 million Americans are confronted with these diseases and that the annual cost of treating them exceeds $6 billion.

When I was asked to speak at the Crohn’s and Colitis Foundation of America’s iReport section of CNN’s website, with the aim of starting a national conversation about these issues in response to the ongoing negative connotations that are attached to patients with digestive diseases and/or an ostomy. These negative comments were often the media, prime-time television shows, and even made by some in the medical community. Much to my surprise, CNN elevated the story to its homepage.

Through my different efforts, I hear so many personal stories; they motivate me to continue my efforts, and I consistently look for innovative and fresh ideas to use in connecting those patients who seemed lost or forgotten with those who have the ability to change lives. Becoming an advocate does not mean you have to stand up on the national level, like I have done. Simply sharing your story with friends and family, writing a letter to your local government officials or joining a local support group is enough to help build awareness. The medical care I received at UCLA gave me a new life, and I feel that through my advocacy, I can repay that debt in some way.
Drawing upon spiritual strength often helps patients to cope with serious illness.

As UCLA Health explores new ways to educate via social networking, the public was invited to follow Brad Carter’s deep-brain-stimulation surgery live on Twitter, with still images and video from the operation posted on Instagram and Vine.

Photo: Reed Hutchinson

UCLA Medical Group was awarded Gold Level Achievement for clinical quality by the California Department of Managed Health Care.

U.S. News & World Report’s Best Hospital Survey ranks UCLA the No. 5 hospital in the country and Best in the West.

UCLA Health
David Geffen School of Medicine
FALL 2013

GOLD
ACHIEVEMENT

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Photo: Reed Hutchinson