When hospitals and physicians invite input from patients and their families, the entire system benefits.
Share Your Thoughts with Us

Like us or not, we want to hear from you. Your input is important, so please give us your comments and feedback. Include your name, email address, city and state of residence and, if you are a UCLA medical alum (MD, PhD, Resident and/or Fellow), your degree(s) and graduation year(s). Letters and/or comments may be edited for clarity and/or length. Don’t be a stranger. Write to us, or post your comments on our social-media pages.

Subscribe letters to:
editormedicine@mednet.ucla.edu

To read U Magazine online, go to:
magazine.uclahealth.org

Cover Illustration: Maria Carte

© Copyright 2016 by The Regents of the University of California. Permission to reprint may be granted by contacting the editor.

E-mail: dgreenwald@mednet.ucla.edu
The Year that Was

From executive-level changes to major advances in research and discovery, a lot can happen over the course of a year.

John C. Mazziotta, MD (RES ’81, FEL ’83), PhD
Vice Chancellor, UCLA Health Sciences
CEO, UCLA Health
Maria de Jesús and Maria Teresa Álvarez, Guatemalan twins who were conjoined at their heads until they were separated in 2002 at UCLA, returned in December 2015 to visit with pediatric patients at Mattel Children’s Hospital UCLA and the medical staff who had cared for them for many months. The girls, who were nicknamed the “two Marias” by hospital staff, now are 14 and live near each other with adoptive families in Southern California.

The twins — Maria de Jesús is now called Josie and her sister Teresita — and a team of volunteers decorated the rooms of several pediatric patients and reunited with the doctors and nurses who cared for them 13 years ago. A tearful reunion took place when a member of the hospital’s housekeeping staff, Yancy Tate, who visited the twins daily during their long hospital stay, met them again, along with Jenny Hull, Josie’s adoptive mother.

Teresita and Josie were born in Guatemala in 2001. With the help of Mending Kids International, they were brought to UCLA and, after months of preparation for the complex procedure, underwent a landmark 23-hour surgery on August 6, 2002. The dramatic story of the “two Marias” captured the world’s attention.

The surgical team, which included more than 40 members, was led by Jorge Lazareff, MD, who was director of pediatric neurosurgery, and Henry Kawamoto Jr., MD, who was surgical director of the UCLA Craniofacial Clinic. Drs. Lazareff and Kawamoto and anesthesiologist Barbara Van de Wiele, MD (RES ’88, FEL ’88), were among the team leaders who welcomed them back.

“The outcome of the twins is a testament to the whole UCLA medical community — nurses, doctors, social workers, therapists, volunteers and more — coming together to help these girls,” Dr. Lazareff said. He also noted the support of benefactors from the Los Angeles Guatemalan community who sent $10 and $20 bills to help cover the girls’ expenses.

Following their successful operation and months of recovery, the girls returned to their parents’ home in Guatemala. Within four months of their return, however, both girls fell ill, with Teresita contracting meningitis. It became apparent to their healthcare providers that neither they nor the girls’ family had the resources to properly manage their fragile medical conditions.

They returned to the United States for treatment, and today they live in Southern California, where they see each other several times a week and Skype regularly with their parents in Guatemala. Josie is mainstreamed in school and is very social. Her favorite activities are swimming and singing, and she has learned to walk using quad canes. Teresita has had to overcome more medical and developmental obstacles than her sister, but she enjoys going to school, where she participates in art, music and computers. She also likes to swim and go horseback riding.

“It is always wonderful for me to see the girls,” Dr. Van De Wiele said. “I was so impressed that it was Josie’s idea to do something for the children who are in the hospital at this time of year. Giving comes full circle.”
The formerly conjoined Guatemalan twins Teresita (left) and Josie Álvarez now live with adoptive parents in Southern California, and they visit each other several times a week and Skype regularly with their parents in Guatemala.

Yancy Tate (center), a member of the hospital housekeeping staff, visited the twins every day they were in the hospital. Jenny Hull (left), Josie’s adoptive mother, calls him “one of the most compassionate human beings on earth.”
Scientists at the UCLA Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research have discovered an important naturally occurring process in the developing human embryo that can be lost when embryonic stem cells are derived in the lab. The finding provides critical information regarding the best method for creating stem cells for regenerative-medicine purposes. The discovery also provides insight into how information that is passed from an unfertilized egg to an embryo may affect the quality of the embryo and, subsequently, the birth of healthy children.

The research focuses on DNA methylation in the early embryo and in stem cells created from embryos. DNA methylation plays a role in how genetic information is used in the body. Correct DNA methylation of particular genes is critical for normal human development, and it remains critical in maintaining healthy cells throughout a person’s lifespan. It also helps maintain an embryonic stem cell’s ability to develop into any cell in the body.

The researchers discovered that an early-stage embryo, or blastocyst, retains the DNA methylation pattern from the egg for at least six days after fertilization. “We know that the six days after fertilization is a very critical time in human development,” says Amander Clark, PhD, vice chair of molecular, cell and developmental biology. “It’s not clear yet why the blastocyst retains methylation during this time period, but this finding opens up new areas of investigation into how methylation patterns built in the egg affect embryo quality and the birth of healthy children.”

The team also revealed that using a recently adopted method to derive stem cells from embryos in a petri dish depletes methylation. In the early embryo, the blastocyst stage of development lasts for less than five days. The less-mature human embryonic cells that exist at the beginning of blastocyst development are called “naïve” embryonic cells. It is thought that at the time of implantation, these naïve embryonic cells reach a more mature state. They are then called “primed” embryonic cells, able to become every cell type in the body.

In 1998, when the first human embryonic stem cells were derived, scientists used a method that created primed stem cells. This was the standard method until recently, when scientists started using a different method that preserves the naïve stem cell state. “In the past three years, naïve stem cells have been touted as potentially superior to primed cells,” Dr. Clark says. “But our data show that the naïve method for creating stem cells results in cells that have problems, including the loss of methylation from important places in DNA. Until we have a way to create more stable naïve embryonic stem cells, the embryonic stem cells created for the purposes of regenerative medicine should be in a primed state in order to create the highest-quality cells for differentiation.”

A Better Stem Cell for Regenerative Medicine

“Naïve Human Pluripotent Cells Feature a Methylation Landscape Devoid of Blastocyst or Germline Memory,” Cell Stem Cell, January 2016
Our Ancestors Probably Didn’t Get Eight Hours of Sleep a Night, Either

A team of UCLA-led researchers studying sleeping patterns among traditional peoples whose lifestyles closely resemble those of our evolutionary ancestors found that the industrialized world’s sleep habits do not differ much from those of our pre-industrial forebears.

“The argument has always been that modern life has reduced our sleep time below the amount our ancestors got, but our data indicate that this is a myth,” says Jerome Siegel, PhD, professor of psychiatry and biobehavioral sciences.

The researchers monitored sleep patterns among the Hadza, hunter-gatherers who live near the Serengeti National Park in Tanzania; the Tsimane, hunter-horticulturalists who live along the Andean foothills in Bolivia; and the San, hunter-gatherers in the Kalahari Desert of Namibia. It is the first study of sleep habits of people who maintain foraging and traditional hunting lifestyles in the present day. Measurements included length of sleep during the summer and winter, body temperatures, environmental temperatures and the amount of light exposure.

One myth dispelled by the results is that people in earlier eras went to bed at sundown. The subjects of the study stayed awake an average of nearly three-and-a-half hours after sunset. “The fact that we all stay up hours after sunset is absolutely normal and does not appear to be a new development,” Dr. Siegel says.

Most of the people studied by Dr. Siegel’s team slept less than seven hours each night, clocking an average of six hours and 25 minutes. The amount is at the low end of sleep averages documented among adults in industrialized societies in Europe and America. The amount they slept also was found to vary with the seasons — less in the summer and more in the winter.

One recent history suggested that humans evolved to sleep in two shifts, a practice chronicled in early European documents. But the people Dr. Siegel’s team studied rarely woke for long after going to sleep. Dr. Siegel chalks up the discrepancy to a difference in latitudes. The groups of people studied live near the equator, as did our earliest ancestors; by contrast, early Europeans migrated from the equator to latitudes with much longer nights, which may have altered natural sleeping patterns, he says.

Insomnia was so rare among those studied that the San and the Tsimane do not have a word for the disorder, which affects more than 20 percent of Americans. The reason may have to do with sleep temperature. The people studied consistently slept during the nightly period of declining ambient temperature, Dr. Siegel found. Invariably, they woke when temperatures, having fallen all night, hit the lowest point in the 24-hour period. This was the case even when the lowest temperature occurred after daybreak. The pattern resulted in roughly the same wake-up time each morning, a habit long recommended for treating sleep disorders.

The team was surprised to find that all three groups receive their maximal light exposure in the morning. This suggests that morning light may have the most important role in regulating mood and the suprachiasmatic nucleus, a group of neurons that serve as the brain’s clock. Morning light is uniquely effective in treating depression. “Many of us may be suffering from the disruption of this ancient pattern,” Dr. Siegel says.

“Natural Sleep and Its Seasonal Variations in Three Pre-industrial Societies,” Current Biology, November 2, 2015

Illustration: Maja Moden
In a discovery that may eventually aid in identifying ways to regenerate damaged heart tissue after a heart attack, researchers at UCLA have uncovered two specific markers that identify a stem cell able to generate heart muscle and the vessels that support heart function.

Progress toward Healing Scarred Hearts

The method still is years away from being tested in humans, but the findings are a significant step forward in the use of human embryonic stem cells for heart regeneration. The research team used human embryonic stem cells, which are capable of turning into any cell in the body, to create cardiac mesoderm cells, which generate specific cell types found in the heart. The researchers pinpointed two distinct markers on cardiac mesoderm cells that specifically create heart-muscle tissue and supporting vessels. They transplanted these cells into an animal model and found that a significant number of the cells survived, integrated and produced cardiac cells, resulting in the regeneration of heart muscle and vessels.

Another study recently published by Dr. Ardehali and his team outlines a novel approach to image, label and track transplanted cells in the heart employing magnetic resonance imaging (MRI), a common and noninvasive imaging technique. That study used specialized particles that are easily identified using an MRI. The labeling approach allowed Dr. Ardehali and his team to track cells in an animal model for up to 40 days after transplantation. “Our findings show, for the first time, that specific markers can be used to isolate the right kind of early heart cells for transplantation,” says David Elliott, PhD, leader of the cardiac-development research group at the Murdoch Children’s Research Institute in Victoria, Australia, and a co-author of both studies. “Furthermore, our cell-labeling and tracking approach allows us to determine the viability and location of transplanted cells.”

“CD13 and ROR2 Permit Isolation of Highly Enriched Cardiac Mesoderm from Differentiating Human Embryonic Stem Cells,” Stem Cell Reports, January 12, 2016

“Magnetic Resonance Imaging of Iron Oxide-labeled Human Embryonic Stem Cell-derived Cardiac Progenitors,” Stem Cells Translational Medicine, January 2016
Over the past few years, body mass index (BMI) effectively has become a proxy for whether or not a person is considered healthy, and many U.S. companies use their employees’ BMIs as a factor in determining workers’ healthcare costs. But a new UCLA study has found that using BMI to gauge health incorrectly labels more than 54-million Americans as “unhealthy,” even though they are not.

“Many people see obesity as a death sentence,” says A. Janet Tomiyama, PhD, assistant professor of psychology and director of UCLA’s Dieting, Stress and Health Laboratory. “But the data show there are tens of millions of people who are overweight and/or obese and are perfectly healthy.”

The scientists analyzed the link between BMI — which is calculated by dividing a person’s weight in kilograms by the square of the person’s height in meters — and several health markers, including blood pressure and glucose, cholesterol and triglyceride levels, using data from the most recent National Health and Nutrition Examination Survey. The study found that close to half of Americans who are considered “overweight” by virtue of their BMIs (47.4 percent, or 34.4-million people) are healthy, as are 19.8 million who are considered “obese.”

Given their health readings other than BMI, the people in both of those groups would be unlikely to incur higher medical expenses, and it would be unfair to charge them more for healthcare premiums, Dr. Tomiyama says.

Dr. Tomiyama found in previous research that there was no clear connection between weight loss and health improvements related to hypertension, diabetes and cholesterol and blood-glucose levels, and she was surprised at the magnitude of the numbers in the latest study. “There are healthy people who could be penalized based on a faulty health measure, while unhealthy people of normal weight” — more than 30 percent of those with BMIs in the “normal” range, or some 20.7-million people, according to the study — “will fly under the radar and won’t get charged more for their health insurance,” she says. “Employers, policy makers and insurance companies should focus on actual health markers.”

Jeffrey Hunger, a doctoral candidate at UC Santa Barbara and co-author of the study, says the research shows that BMI is a deeply flawed measure of health. “This should be the final nail in the coffin for BMI,” he says. Hunger recommends that people focus on eating a healthy diet and exercising regularly, rather than obsessing about their weight.

A proposed Equal Employment Opportunity Commission rule would allow employers to charge higher insurance rates to people whose BMI is 25 or higher. A BMI between 18.5 and 24.99 is considered normal, but the study emphasizes that normal BMI should not be the primary goal for maintaining good health.

UCLA scientists have discovered that an overlooked region in brain cells houses a motherlode of mutated genes previously tied to autism. The finding could provide fresh drug targets and lead to new therapies for the disorder.

“Our discovery will shed new light on how genetic mutations lead to autism,” says Kelsey C. Martin, MD, PhD, professor of biological chemistry and psychiatry and biobehavioral sciences and interim dean of the David Geffen School of Medicine at UCLA. “Before we can develop an effective therapy to target a gene, we must first understand how the gene operates in the cell.”

Earlier studies have linked mutations in Rbfox1 to an increased risk for autism, which makes Rbfox1 an especially important gene to study. To better understand how Rbfox1 functions, Dr. Martin teamed up with Douglas Black, PhD, professor of microbiology, immunology and molecular genetics. The two blended a cell-biology approach with powerful DNA-sequencing technology to reveal the identities of the genes controlled by Rbfox1. “Our results turned up an exciting new set of genetic connections,” Dr. Black says. “We found that where Rbfox1 was located in the cell determined what genes it influenced.”

Ji-Ann Lee, PhD, a postdoctoral research fellow in Dr. Martin’s lab, compared Rbfox1’s function in the cell’s nucleus, or command center, to its function in the cytoplasm, the gel-like fluid that surrounds the cell’s nucleus. “Scientists used to think that Rbfox1 worked primarily in the nucleus to allow genes to make multiple proteins. We were surprised to see that Rbfox1 also controls more than 100 genes in the cytoplasm,” Dr. Lee says. “A majority of these genes encode proteins critical to the brain’s development and have been tied to autism risk.”

Furthermore, the genes controlled by Rbfox1 in the cell’s nucleus were completely different from those it controlled in the cell’s cytoplasm. The UCLA team’s separation of these two functions revealed that the genes targeted by Rbfox1 in the cell’s cytoplasm were highly enriched in proteins vital to the developing brain. Autism risk increases when these genes go awry. “While some experts have hinted at the role of cytoplasmic gene control by Rbfox1 in autism risk, no one has systematically explored it in nerve cells before,” Dr. Martin says. “Our study is the first to discover that dozens of autism-risk genes have special functions in the cytoplasm and share common pathways in regulating the brain cells.”

**“Cytoplasmic Rbfox1 Regulates the Expression of Synaptic and Autism-related Genes,”** *Neuron*, January 6, 2016

**Untapped Brain-cell Region Offers Goldmine of Drug Targets for Autism Treatments**

An average of 30 years had passed since the traumatic events that had left them depressed, anxious, irritable, hypervigilant, unable to sleep well and prone to nightmares. But for 12 people who were involved in a UCLA-led study — survivors of rape, car accidents, domestic abuse and other traumas — an unobtrusive patch on the forehead provided significant relief from post-traumatic stress (PTS).

**Electric Patch Holds Promise for Treating PTS**

TNS harnesses current from a 9-volt battery to power a patch that sends a low-level current to cranial nerves that run through the forehead.

Photo: Reed Hutchinson
New Strategy to Fight Ovarian Cancer

UCLA scientists have developed a promising novel method to treat gynecologic tumors. The approach focuses on a protein called p53, which is commonly mutated in women who have high-grade serous ovarian cancer, the deadliest form of reproductive cancer. In many women with the disease, the cancer is very advanced by the time it is diagnosed and is therefore difficult to treat.

The discovery was the result of a three-year study co-led by David Eisenberg, DPhil, professor of biological chemistry and a member of the UCLA-DOE Institute, and Sanaz Memarzadeh, MD (RES ’00, FEL ’03), PhD, associate professor of obstetrics and gynecology and director of the G.O. Discovery Laboratory at UCLA’s Eli and Edythe Broad Center of Regenerative Medicine and Stem Cell Research. The findings ultimately could lead to new targeted therapies for many other types of cancer carrying similar p53 mutations.

P53 is known as the “guardian of the genome.” It prevents damaged cells from reproducing by stopping their growth until the damage is repaired or, if the damage cannot be reversed, promotes cell death. But mutations, which are found in 96 percent of patients with high-grade serous ovarian tumors, can cause p53 to form clumps, or “aggregates,” which impair the protein’s normal function. As a result, the damaged cells are able to multiply uncontrollably, which can lead to cancer.

The UCLA scientists developed and tested a peptide called ReACp53, which penetrates cancer cells and prevents mutated p53 from clumping together. The technique restores normal p53 function, causing the death of the ovarian-cancer cells. “Our lab has worked for 15 years on the protein aggregates that cause amyloid diseases such as Alzheimer’s and Parkinson’s,” says Dr. Eisenberg. “These aggregates are organized as fibers that are 500 times smaller than the width of a hair, which is quite a challenge.”

“Tumor organoid treated with ReACp53.”
A section of a mini-tumor treated with ReACp53, resulting in extensive cancer-cell death.

This approach was originally developed for neurodegenerative diseases, and we now are applying it to cancer therapy,” says Alice Soragni, PhD, a postdoctoral scholar in Dr. Eisenberg’s lab and first author of the study. The scientists identified the sticky segments of p53 that cause the protein to clump by using a computer algorithm, determined their structure and then designed ReACp53 to block this process. “This can keep the protein from clumping so it can do its job and kill cancer cells,” Dr. Soragni says.

The researchers isolated tumor cells from patients and grew them to reproduce small tumors in the lab dish. The “mini-tumors” are extremely useful for drug development because they faithfully replicate several features of the original cancer. “The results were remarkable, with significant shrinkage in patient-derived tumors,” Dr. Memarzadeh says. She added that the approach produced no obvious side effects in a physiological model and that ReACp53 was very well-tolerated.

More than 80 percent of women with advanced-stage high-grade serous ovarian cancer experience relapses even after repeated surgeries and multiple rounds of chemotherapy, and this effective new approach to treat the disease could be a major step forward in preventing this cancer from returning. More than 15,000 women a year in the U.S. die from all types of ovarian cancer.

“Tumor organoid treated with ReACp53.”
A designed inhibitor of p53 aggregation rescues p53 tumor suppression in ovarian carcinomas,” Cancer Cell, January 11, 2016

“We’re talking about patients for whom illness had almost become a way of life,” says Andrew Leuchter, MD (RES ’84, FEL ’86), director of the neuromodulation division at the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA. “Yet, they were coming in and saying, ‘For the first time in years, I slept through the night,’ or, ‘My nightmares are gone.’ The effect was extraordinarily powerful.”

The research revealed the first evidence that trigeminal nerve stimulation, or TNS, holds promise for treating chronic PTS. “Most patients with PTS do get some benefit from existing treatments, but the great majority still have symptoms and suffer for years from those symptoms,” Dr. Leuchter says. “This could be a breakthrough for patients who have not been helped adequately by existing treatments.”

TNS is a new form of neuromodulation, a class of treatment in which external energy sources are used to make subtle adjustments to the brain’s electrical wiring to drug-resistant neurological and psychiatric disorders. While the patient sleeps, a patch, powered by a 9-volt battery, sends a low-level current to cranial nerves through the forehead to signal parts of the brain that help regulate mood, behavior and cognition, including the amygdala and medial prefrontal cortex, as well as the autonomic nervous system. Prior research has shown abnormal activity in those areas of the brains of PTS sufferers.

The researchers recruited people with chronic PTS and severe depression who were being treated with psychotherapy, medication or both. While continuing their conventional treatment, the volunteers wore the patch while they slept. Before and after the eight-week study, the study subjects completed questionnaires about the severity of their symptoms and the extent to which the disorders affected their work, parenting and socializing. The severity of participants’ PTS symptoms dropped an average of more than 30 percent, and the severity of their depression dropped an average of more than 50 percent. In fact, for one-quarter of the study subjects, PTS symptoms went into remission.

To ensure that they receive proper care after surgery, patients are frequently referred by hospitals to inpatient facilities such as skilled-nursing homes or inpatient rehabilitation centers or to receive home healthcare and other outpatient services. This type of care, called post-acute care, now accounts for some $62 billion in annual Medicare spending.

Yet spending on post-acute care varies widely across different parts of the U.S., suggesting that medical centers in some areas may be using these services too infrequently and others may be using them more than necessary. A recent report by the Institute of Medicine found that the primary driver of regional variations in Medicare spending is the differences in the costs of post-acute care. But little has been known about why those variations occur.

A new study by UCLA researchers finds that some hospitals refer fewer than 3 percent of their patients to inpatient facilities while others refer up to 40 percent. Similarly, some hospitals prescribe home healthcare for just 3 percent of patients; others refer as many as 58 percent of patients — a finding that prompted the researchers to investigate whether or not the wide variation correlated with differences in the overall quality of care delivered by the hospitals.

They found no association between how often hospitals used post-acute care and the number of recorded postoperative deaths or complications. But the study did discover a relationship between “indirect” measures of hospital quality — metrics like length of stay and readmission rates — and use of post-acute care. Specifically, hospitals that tend to refer patients to inpatient facilities more often also tend to have shorter lengths of stay and higher readmission rates.

“These findings suggest that some hospitals may be using post-acute care as a substitute for inpatient care,” says Greg Sacks, MD, a resident in general surgery at UCLA and a Robert Wood Johnson/Veterans Affairs Clinical Scholar. “This might lead to patients being discharged from the hospital prematurely, which then results in higher readmission rates.”

Dr. Sacks says surgeons and hospitals have virtually no guidelines to help them determine the best post-acute-care services for their patients — and that better recommendations could help reduce some of the variation in how the services are used and the costs associated with them.

The researchers analyzed data for 112,620 patients treated at 217 hospitals in 39 states. They drew information from a national surgery registry and Medicare claims, as well as from American Hospital Association annual surveys from 2005 through 2008. They calculated the correlation between post-acute-care usage rates and hospital quality measures such as mortality rates, complications, readmissions and lengths of stay.

In addition, hospitals that referred patients to inpatient facilities most often were likelier to readmit patients within 30 days (24.1 percent) versus those who referred patients to inpatient facilities least often (21.2 percent). The study did not find a similar correlation between referrals to home healthcare and hospital readmission. The paper suggests that healthcare-payment policies that create financial incentives for hospitals to discharge patients prematurely could be driving hospitals’ post-acute-care decisions.
Companies advertise BPA-free plastic as a safer version of products ranging from water bottles to sippy cups to toys. Many manufacturers stopped using bisphenol A, a chemical that is used to strengthen plastic, after studies linked it to early puberty and a rise in breast and prostate cancers. However, bisphenol S, or BPS, a common replacement for BPA in plastics, also has been linked to health risks. New UCLA-led research demonstrates some of the mechanisms that make BPS just as harmful as BPA. The study found that BPS speeds up embryonic development and disrupts the reproductive system in animals.

“Our study shows that making plastic products with BPA alternatives does not necessarily leave them safer,” says Nancy Wayne, PhD, professor of physiology and associate vice chancellor for research. “The findings are frightening. Consider it like the canary in the coal mine.”

Dr. Wayne and her colleagues found that when zebrafish were exposed to either BPA or BPS at low levels — equivalent to the traces found in polluted river waters — their physiology at the embryonic stage changed in as quickly as 25 hours. “Egg-hatching time accelerated, leading to premature birth,” Dr. Wayne says. “The embryos developed much faster than normal in the presence of BPA or BPS.”

The research team studied zebrafish because their transparent embryos make it relatively easy to “watch” cell growth as it occurs. Using fluorescent-green protein tags, the researchers tracked the development of the animals’ reproductive endocrine brain cells, which control puberty and fertility. They discovered that the number of endocrine neurons increased up to 40 percent, suggesting that BPA overstimulates the reproductive system. “We saw many of these same effects with BPS found in BPA-free products. BPS is not harmless,” Dr. Wayne says.

The researchers also were surprised to find that both BPA and BPS exert their effects partly through an estrogen system and partly through a thyroid-hormone system. “Most people think of BPA as mimicking the effects of estrogen,” Dr. Wayne says. “But our work shows that it also mimics the actions of thyroid hormone.”

Thyroid hormone has a significant influence on brain development during gestation, so the research could have important implications for understanding general embryonic and fetal development, including in humans. Researchers have proposed that endocrine-disrupting chemicals may be contributing to the rise in premature human births and early onset of puberty over the past couple of decades in the U.S. “Our data support that hypothesis,” Dr. Wayne says. “If BPA is affecting a wide variety of animal species, then it’s likely to be affecting human health.”

BPA can leach into food and beverages, particularly under heat, from cans, baby bottles, food-storage containers and plastic tableware. It also can be found in contact lenses, eyeglass lenses, compact discs, water-supply pipes, cash register and ATM receipts and dental sealants and composites. One study published in 2010 projected that by 2015, the U.S. and Europe would be manufacturing more than 5-million tons per year of products containing BPA.
Happy Feet, Happy Hearts

Foot ailments plague many of the homeless in Los Angeles. But a group of David Geffen School of Medicine at UCLA/PRIME students and UCLA undergrads are working to make it better for residents of the city’s streets. Through the Happy Feet Clinic, the students set up day-long podiatry clinics at such locations as the downtown Union Rescue Mission, Ocean Park Community Center in Santa Monica and New Image Emergency Shelter in South L.A. Visitors to the clinics get a foot wash in a tub of warm, soapy water, followed by a foot exam. Students work alongside faculty mentors to check for everything from fungal infections to diabetes. Some foot ailments are remedied immediately, and often simple services prevent major foot problems from developing. A medical “education station” provides fresh socks, shoes and other essential foot-care products.

For more information, go to: uclahappyfeetclinic.org

Photos: Courtesy of Happy Feet Clinic
Ranked No. 3 in the nation / Over 150 neighborhood offices

With a busy life, we give you one less thing to worry about. World-changing medical care with a personal touch is just around the corner with our extensive network of primary and specialty care offices, plus our four renowned hospitals.

Ranked No. 3 in the nation and consistently ranked Best in the West by U.S. News & World Report, UCLA Health offers care you can count on — no matter how busy your schedule may be.
Healing the Invisible Wounds

For nearly 10 years, UCLA’s Operation Mend has been helping to repair the physical injuries suffered in combat in Iraq and Afghanistan. Now, it has launched a program, under the direction of Jo Sornborger, PsyD, that is focused on the psychological traumas of war and the repercussions of mild traumatic brain injury.

In March 2016, UCLA’s Operation Mend, which since 2007 has provided free specialty medical and surgical care to post-9/11-era service members wounded in combat or training, launched a new program to address the psychological damage of war. With a three-year, $15.7-million grant from the Wounded Warrior Project, the Operation Mend Intensive Treatment Program joins Emory Healthcare in Atlanta, Massachusetts General Hospital in Boston and Rush University Medical Center in Chicago to form the Warrior Care Network. The Intensive Treatment Program at UCLA, directed by Jo Sornborger, PsyD, is based on multiple cohorts of 10 veterans, each accompanied by a family member or caregiver. The participants spend three weeks at UCLA, followed by three weeks at home connected via video teleconferencing.

Dr. Sornborger spoke with U Magazine contributor Lyndon Stambler about Operation Mend’s new mental-health program.

How does the Intensive Treatment Program differ from the services you have been delivering through Operation Mend?

Dr. Sornborger: Operation Mend has, since 2007, been providing medical and surgical care to wounded warriors. In 2009, we embedded a psychological-health program that focuses on how families are functioning under the stress of a war-related injuries and provides psychological-health screening and sessions focused on the patients’ pre- and post-surgical care, with follow-ups after their return home to see how they are managing their recovery. Our new Intensive Treatment Program is dedicated to the mental health of wounded warriors and is focused on providing treatment to these men and women struggling with post-traumatic stress, traumatic brain injury and depression. The program takes a holistic approach and includes four main components: evidence-based treatment for psychological health, healing arts, wellness and community engagement.

Why is this program needed?

Dr. Sornborger: There is a serious gap in care for those returning from post-9/11 military conflicts. Operation Mend patients are chronically or catastrophically injured. Many have traumatic brain injury and/or post-traumatic stress. When they return home, they often have limited access to care and isolate themselves from family, friends and community. We have learned a great deal from
Operation Mend patients and family members. We learned that for patients to feel empowered to take on their own healthcare, they need to refocus and rebalance, as a family. They need support to do that. Operation Mend fills that gap in care.

Let’s talk about the psychological-care services that will be provided.

Dr. Sornborger: The overarching framework for our Intensive Treatment Program is really expanding and nurturing our participants’ social networks, beginning with their core social network: their families. Beyond the family, the program expands the participants’ social networks by providing attendees with a cohort that includes 10 patients and their family members, which helps reduce isolation and increase opportunities for support. We then link attendees to national veterans-service organizations and resources within their own communities, providing opportunities for them to feel empowered to access care and support.

Operation Mend originated from the Maddie and Ronald Katz family’s vision of a family-focused program. Our goal is to infuse the same focus into our Intensive Treatment Program. Family members are as much a part of the program as our patients. We take time to have conversations with family members. Sometimes it’s challenging. Sometimes it’s eye-opening for them.

What are some of the specific treatments that are provided?

Dr. Sornborger: Two anchor treatments in the new program are cognitive-processing therapy (CPT) for post-traumatic stress and cognitive training. For each, there are 12 sessions over the 21 days our patients and their family members are at UCLA. Since there isn’t a universally applied treatment model for cognitive training, our traumatic-brain-injury team — spearheaded by Delany Thrasher, PhD, director of neuropsychology for Operation Mend; Robert Asarnow, PhD, in psychiatry and biobehavioral sciences; and Christopher Giza, MD (RES ’94, FEL ’96, ’00), medical director for traumatic brain injury for Operation Mend — has developed an integrated model so our patients will

“The program takes a holistic approach and includes four main components: evidence-based treatment for psychological health, healing arts, wellness and community engagement.”
receive cognitive training for challenges related to symptoms of mild traumatic brain injury. Patients also receive cognitive-processing therapy for post-traumatic stress. CPT-intervention developer Patricia Resick, PhD, of Duke University, and Carie Rodgers, PhD, of the San Diego VA, are providing case consultation with our clinicians to provide patients with the highest quality treatment for post-traumatic stress. Sessions will address war-related psychological trauma and symptoms related to cognitive challenges such as memory and concentration. CPT and cognitive training focus on developing skills to manage these challenges. We use a variety of mobile apps to support face-to-face treatment sessions. In the sessions and activities at UCLA, our patients learn how to enhance daily life and improve psychological-health skills. After returning home, the three-week video telehealth portion helps to identify whether or not what they have learned is working.

**How do healing arts and wellness components fit in?**

**Dr. Sornborger:** This is to connect mind-body-spirit and includes art therapy and equine-assisted psychotherapy. We also offer Qigong (an ancient Chinese health practice), plus acupuncture, acupressure and meditation. We have partnered with UCLA’s John Wooden Center to provide programs such as movement therapy and rock climbing. The Wooden Center has provided an activity menu for patients and families to choose from as part of this wellness component — things like aquatic joint therapy to help with movement. As for healing arts, we incorporated the National Center for the Intrepid’s art-therapy component in which our patients create a mask that is a metaphor for the psychological challenges they have faced in war or while transitioning home. There’s a lot of research on art therapy as a medium to process trauma and psychological issues. A marriage-and-family therapist who also is a licensed art therapist is facilitating our healing-arts program. We also have partnered with Valerie Coleman, PsyD, PhD, and her team at Stand InBalance for equine-assisted psychotherapy. Her team includes four-legged animals, most often horses, and a mental-healthcare professional who is also a horseman. Many of our patients have service animals, so this is an extension of the human-animal connection, where the horse provides calming and empathic responses to the patient. Our attendees consider this one of the most healing treatment components.

**What specific expertise does an academic medical center offer for the treatment of combat veterans with severe psychological wounds?**

**Dr. Sornborger:** UCLA is a tier-one research facility, exemplifying leading-edge research and innovative technology in areas such as traumatic brain injury. Likewise, our academic partners in the Warrior Care Network have well-established research programs on post-traumatic stress and anxiety disorders. This collaboration allows us to share knowledge and spawn research programs to improve the lives of returning warriors and their families.

“Our service members and their families are very resilient. They have so many talents and are so capable. We remind them of how capable they are and how invested we are in helping them to successfully participate in daily life again.”
How do you determine who will be accepted into the program?

Dr. Sornborger: Post-9/11 warriors injured in the line of duty who are struggling with post-traumatic stress and/or traumatic brain injury are eligible. Since not all wounded warriors are in need of intensive treatment, the four academic medical centers in the Warrior Care Network spent a year-and-a-half developing the inclusion criteria and outcomes assessments we believe will demonstrate best practices for our wounded warriors. For our program, our participants must be working with a healthcare team in their communities and be able to travel to UCLA, accompanied by a supportive companion who can participate. At UCLA, before being accepted into the program, our patients will receive advanced psychological and traumatic-brain-injury diagnostics to ensure they receive appropriate treatment. Substance abuse where the impairment would impede treatment and active psychosis would exclude participation. The benefit of the Warrior Care Network is that each medical center has specialty areas. This enables the participating centers to easily refer patients whose needs warrant a specific site specialty. For example, UCLA may receive an inquiry for a warrior struggling with military sexual trauma or transgender issues. We know this is one of Rush University’s specialties, so even if a warrior is living in San Diego, we would refer him or her to Rush in Chicago. Under the Warrior Care Network, this would continue to be at no financial cost to the participant.

What characteristics would make a patient best suited for UCLA?

Dr. Sornborger: Because we have a wonderfully developed surgical and medical-specialty program, UCLA will receive more physically injured patients and those in need of advanced traumatic-brain-injury diagnostics. We will continue to refine our cognitive training, and I expect programs that focus more on post-traumatic stress will consider sending traumatic-brain-injury patients to us.

How will this network and UCLA help with the societal difficulties faced by these veterans?

Dr. Sornborger: Transitioning back to civilian life is among the greatest challenges faced by post-9/11 veterans. Operation Mend helps to provide a needed, but sometimes elusive, support system. When you add in post-traumatic stress and/or traumatic brain injury, it makes it extremely difficult for the individual to reach out to get the care he or she needs. The VA can be difficult to navigate. Through Operation Mend, and now our Intensive Treatment Program, we have an intermediate and collaborative step that offers hope to patients and their families and provides them with family-focused care that is rarely available. I know from having done this work since 2009 that our service members and their families are very resilient. They have so many talents and are so capable. We remind them of how capable they are and how invested we are in helping them to successfully participate in daily life again.

For more information about UCLA Operation Mend, go to: operationmend.ucla.edu

To learn more about the Warrior Care Network, go to: warriorcarenetwork.org

“The four academic medical centers in the Warrior Care Network spent a year-and-a-half developing the inclusion criteria and outcomes assessments we believe will demonstrate best practices for our wounded warriors.”
Engaging patients and their families in hospital-level decision-making provides unique perspectives and valuable feedback to improve outcomes.

In the summer of 2014, Aldo Palmieri, MD, a specialist in obstetrics and gynecology at UCLA Medical Center, Santa Monica, began to feel unusual abdominal pain. After a few weeks of hoping the pain would go away on its own, he finally visited his primary-care physician. The diagnosis: stage IV mantle-cell lymphoma, a rare form of non-Hodgkin's lymphoma. Within three weeks, he had surgery to remove part of his small bowel, followed by six rounds of chemotherapy and, eventually, a stem-cell transplant.

“I felt very much like a mystery shopper — the shoppers that companies bring in to ensure that their employees are nice,” he says of having his care delivered at the hospital where he works. “People did not know who I was. I did not wave around my ID to say I was UCLA faculty.” And yet, Dr. Palmieri, whose disease has been in remission for nearly a year-and-a-half, quickly found that those credentials weren’t necessary for him to receive the highest standard of care. “I had a near-flawless experience in the system. I trusted UCLA for the treatment for my condition, and that trust was never threatened,” he says. “The staff — the nursing staff, the care partners, even the person who brought my food tray when I was in the bone-marrow unit — invariably were wonderful people.”

His experience as a patient, Dr. Palmieri realizes today, had a profound impact on how he now practices medicine. “I don’t think anyone, be it a nurse, be it a care partner, ever left my room without asking if there was anything else they could do for me. It meant the world. It would be impossible...”
Voices Within

for something like this not to affect me and how I practice my craft. I now never leave a patient’s room without asking if there is anything else that I could do for them.”

In a perfect world, no other healthcare worker or member of the administration at UCLA Health would have to share Dr. Palmieri’s unique insider’s view. An increasing number do, however, embrace an emerging belief in healthcare: that the experiences, perspectives and opinions of patients and their families are vital for improving services, clinical quality and medical outcomes and shaping the overall patient experience.
THE IMPORTANCE OF THE PATIENT VOICE IS MADE CLEAR at UCLA Health from the first day of employment. A measure of that task falls on Lee Tomlinson, a patient-centered-care advocate and UCLA Health patient-care advisor. Three years ago, he was diagnosed with stage III throat cancer. Toward the end of his chemotherapy and radiation treatments, Tomlinson developed an infection that nearly killed him. “I am sure that my treatment was medically superb — I survived,” he says of the care he received at another hospital. “But the way I was treated was so insensitive, so lacking in kindness, caring and thoughtfulness, that I literally gave up hope of surviving and decided that I wanted to die.”

A friend of Tomlinson’s, a doctor, suggested that what he had been subjected to was not indifference, but rather poor customer service. “He encouraged me to become part of the solution and use my experience in customer service to talk to doctors, nurses and medical professionals and remind them of the enormous importance of care versus treatment,” he says.

Today, Tomlinson volunteers his time every Monday during UCLA Health’s “Day 1” orientation for new hires. He tells his story, focusing on the importance of compassion. “Most people get into medicine with an innate compassion, a desire to help people,” he says.

“I speak to the new hires, and I say, ‘Look, at the end of the day, this is about patients. No matter what you are doing, when you are in the presence of a patient, you need to express the compassion that got you into this business. That can make the difference between life and death for us.’”

“Lee Tomlinson volunteered to help train new UCLA Health hires in customer service after he had a bad experience while being treated at another hospital.

Photo: Ann Johansson

THE CHALLENGE IS WHEN THE MINUTIAE OF THESE INCREDIBLY DIFFICULT JOBS START TO PILE UP, AND THEY GET MORE ATTACHED TO WHAT AS OPPOSED TO HOW. SO I SPEAK TO THE NEW HIERES, AND I SAY, ‘LOOK, AT THE END OF THE DAY, THIS IS ABOUT PATIENTS. NO MATTER WHAT YOU ARE DOING, WHEN YOU ARE IN THE PRESENCE OF A PATIENT, YOU NEED TO EXPRESS THE COMPASSION THAT GOT YOU INTO THIS BUSINESS. THAT CAN MAKE THE DIFFERENCE BETWEEN LIFE AND DEATH FOR US.’"

Such a patient-centric view is diffusing throughout the healthcare system. “Healthcare has not historically looked at patients and family members as partners in improving our services. That is rapidly changing,” says Tony Padilla, chief patient-experience officer at UCLA Health.

In the past, for example, patient satisfaction was assessed only through post-care surveys. The surveys were interpreted by physicians, managers and administrators, who then tried to come up with solutions to various issues. “We have learned that when we bring patients to that same improvement table, the definition of the problem changes, and we find better solutions for improved care,” Padilla says.

AN INCREASING NUMBER OF HEALTHCARE FACILITIES nationwide, and around the world, are formalizing systems to engage and partner with patients and patient families to improve care. In 2015, the Beryl Institute — an organization focused on improving the patient experience — conducted the “State of the Patient Experience” study, polling more than 1,500 hospitals (including 773 in the U.S.), as well as long-term-care facilities and other healthcare organizations. Forty-two percent of the organizations surveyed reported having a senior patient-experience leader guiding their efforts, compared to 22 percent in 2013; 55 percent reported having patient/family advisory committees, up from 32 percent just two years earlier.

At UCLA, these advisory committees, known as Patient and Family Advisory Councils (PFACs), are led by physicians and hospital leaders and coordinated through Padilla’s Office of the Patient Experience, and they are considered essential to UCLA Health’s patient-centered culture. PFACs originated six years ago at Mattel Children’s Hospital UCLA and now are active as well in the geriatrics, neurosurgery and behavioral-health departments.
“The Parent Advisory Council (at Mattel Children’s Hospital UCLA) is made up of a group of at least a dozen very dedicated parents of some of our medically complex, medically fragile children — kids with cancer, genetic diseases, children in need of a transplant and other conditions,” says Kerry Gold, RN, administrative and pediatric-liaison nurse in the David I. Saperstein Emergency Department at Ronald Reagan UCLA Medical Center. “The parents meet monthly to discuss current issues and, perhaps, methods for improving the care for their kids.”

In 2012, a suggestion from the Parent Advisory Council led to the development of the Pediatric Passport. In its initial incarnation, the Passport was a one-page document carried by parents that contained information, including the child’s name, medical record number and diagnosis and key facts, such as whether or not the child has a central line or a catheter or is prone to frequent bouts of urinary-tract infections or sepsis.

“The Pediatric Passport is simply a form that a specialist would fill out to say, ‘This is my patient, State of the Patient Experience

Survey consisted of 1,500 hospitals (including 773 in the U.S.), as well as long-term-care facilities and other healthcare organizations.
and if this patient presents in the emergency department, this is their diagnosis, and if you need to call me, here is my pager number,” Padilla says. Beginning in January 2016, the Pediatric Passport — which has served as a model for similar passports at hospitals around the country — has become part of the patient’s electronic medical record, allowing it to be immediately observed by the triage nurse and emergency-department physician. “It is not a ‘FastPass,’” Gold stresses. “It is more of a red alert for the triage nurse that allows him or her to streamline care.”

Other suggestions from the parent advisors have led to 24-hour coverage by hospitalists in the emergency department, the addition of a white board in every patient room that displays vital information such as the names and phone numbers of the child’s nurse and care partner and updates on pending procedures and the standardization of the techniques used by nurses to access pediatric patients’ central lines.

The PFAC at the Stewart and Lynda Resnick Neuropsychiatric Hospital at UCLA is similarly designed to foster a partnership among patients, families and administrators and staff. The 16-member PFAC — comprised of eight patient/family advisors and eight Resnick staff members — meets monthly, with discussions centered on three target areas: patient safety, navigating the system and patient and family satisfaction.
“The safe discharge/rapid improvement project is something that we started,” says Resnick PFAC member Glenn Kopelson, who was asked to be a member of the council following the hospitalization of his son. “We want to develop a process for contacting patients and families post-discharge to make sure that everything is going according to their discharge plan. When someone gets discharged, the families wonder what will happen next. It is a stressful and anxiety-driven time for a parent. This is a way to help patients and families continue to navigate their treatment and to help alleviate the anxiety. A key goal of this PFAC is to make that experience better for patients and families.”

UCLA Health recently has broadened the scope of PFACs, creating the Patient-Centered Technology Council to offer input about the health system’s electronic health-record system, including its web, phone and bedside apps. One member of the patient-focused technology council is Sharon Young, MD, a physician by training with a background in emergency medicine who now works for a clinical-decision-support company. Dr. Young was recruited to join the relatively new council after she experienced difficulties with the mobile app for patients. “I kept going back and forth with a support person because I was frustrated that there were features that were not accessible through the mobile app,” she says. While initial development may have been focused primarily on the website app, “I knew from being involved in this industry that the mobile application is even more important, especially for patients in some of the lower socioeconomic demographic groups who may not have access to a full desktop.”

BEYOND PFACS, UCLA HEALTH PATIENTS NOW ARE BEGINNING to be integrated into hospital committees, where they sit alongside medical personnel. Beginning this year, the hospital’s infection-control committee will be adding at least one, and perhaps more, patient representatives. The committee, which meets monthly, is designed to present and analyze data on patient safety — specifically on hospital-associated infections, with the goal of trying to decrease these infections over time.

“These are very sensitive topics for hospitals and for healthcare workers,” says Zachary Rubin, MD, medical director of UCLA Clinical Epidemiology and Infection Prevention. “Having a patient on the committee is a great benefit to the healthcare workers on the committee because it gives us a little grounding in reality. I think sometimes we get used to seeing numbers, and we don’t realize that each number is a patient. Sometimes we forget the big picture. The patient voice is critical to designing better patient-level interventions that the patients can understand and comply with. It is not always comfortable, but that’s part of the idea.”

To help recruit new patients and families who might lend their voices to the rising chorus, the UCLA electronic-health-record website now offers a link through which patients or families can offer their services. “All UCLA Health patients can now let us know if they are interested in responding to email surveys, in attending patient-advisor events or in being on a patient advisory council,” Padilla says. He has an ambitious goal for the project: to enlist 1,000 patient advisors this year.

“We will know that our partnership with patients and families is fully mature when there is a patient representative on every improvement and decision-making committee in the health system,” Padilla says. “Patients are our most important stakeholders. They own the care and the process, just as much as the people who work here, and they should help us define how we are managed, what changes are made and what value really means to patients. Ultimately it is about partnership.”

Kathy Svitil is director of news for the California Institute of Technology and a frequent contributor to U Magazine.
As the Robert Wood Johnson Foundation winds down its renowned Clinical Scholars Program, UCLA and three other universities band together to carry on that mission to train the nation’s next generations of healthcare leaders.

When UCLA launched a project, in 1975, to train young physicians about the organization, financing and delivery of health services, the program’s founding director firmly believed that its graduates would become the architects for the future of healthcare.

“It was absolutely clear to me that the clinical and basic science of medicine can go nowhere unless it is implemented efficiently and effectively — in a way in which we can afford to pay for it and at a high quality, so that the benefits accrue to the population,” says Robert H. Brook, MD, professor of medicine and health services at UCLA and co-director of UCLA’s Robert Wood Johnson Foundation (RWJF) Clinical Scholars Program.

But 40 years ago, many of Dr. Brook’s colleagues in medicine didn’t share his sense of urgency. “Any doctor who looked at these issues, as opposed to going into private practice or doing clinical or basic research, was widely viewed as not doing anything very useful,” he says.

If that seems unthinkable today — at a time when concepts such as evidence-based, value propositions and population health dominate the landscape of modern medicine — much of the credit for the changed mindset must go to the approximately 1,300 alumni of RWJF clinical-scholars programs across the country, including the 233 who have been trained at UCLA, both in the David Geffen School of Medicine at UCLA and the Jonathan and Karin Fielding School of Public Health in partnership with RAND. The RWJF graduates have become directors of major federal, state and local health agencies and departments; hospital CEOs; leaders in the fields of health-services research and health economics; foundation executives; and leaders in academic medicine.
Among that cadre, UCLA’s program is a recognized leader in the effort, training national leaders such as former U.S. Surgeon General David Satcher, current U.S. Department of Health and Human Services Assistant Secretary for Preparedness and Response Nicole Lurie and Joint Commission CEO Mark Chassin. Many of the UCLA-trained scholars lead clinical departments at major academic centers across the country, and there are dozens who have stuck close to home, at UCLA, where they have a significant impact on every department in the medical school and in steering UCLA Health.

But after so many years of success, the RWJF has decided to wind down a number of its human-capital programs, including Clinical Scholars. UCLA will step into the breech and, with Yale University, the University of Michigan and the University of Pennsylvania, launch a new National Clinician Scholars Program. Starting in July 2016, the four participating sites are continuing the work started by the RWJF Clinical Scholars Program to educate physicians and nurses for careers as leaders, researchers and change agents who will work toward eliminating health disparities, developing new models of care and achieving higher-quality healthcare at a lower cost. Eight physicians and two nurses have been selected for the UCLA-Southern California Clinician Leaders Program cohort for 2016 through 2018.

“We are excited to build on the 40-year legacy of the Robert Wood Johnson Foundation Clinical Scholars program by preparing leaders with the needed skills to transform healthcare delivery and, ultimately, the health of our nation,” says Carol M. Mangione, MD, co-director of the RWJF Clinical Scholars Program and of the new UCLA-Southern California Clinician Leaders Program and Barbara A. Levey, MD, and Gerald S. Levey, MD, Endowed Chair. “Through this program, we will continue to produce a cadre of leaders with the robust skill...
sets that will allow them to lead teams, analyze and develop programs and work collaboratively to address the most pressing health issues for UCLA Health, our region and nationally.

**AS A RESIDENT IN UCLA’S DEPARTMENT OF NEUROSURGERY**, Jos’lyn Woodard, MD, became all too aware that she didn’t have answers to many of the questions her patients were asking. What was the prognosis, in both the short and the long terms, for the operation based on the track record for similar procedures? What was the level of risk? Given two different surgical strategies — one aggressive, one less so — how best to decide? Even among the attending physicians from whom Dr. Woodard was learning, it wasn’t unusual for her to hear two very different perspectives on the same case. She realized that was because most procedures had small sample sizes, and everyone’s experience was different.

“Neurosurgery has always been held to a high standard, because we are dealing with a patient’s most-precious organs — the brain and the spinal cord,” Dr. Woodard says. “For the same reason, the evaluation of our interventions should be held to a very high standard. For that, we need concrete evaluative tools that enable us to compare interventions for the field at large, so that neurosurgeons and neurologists can help patients make informed decisions about what route is best for them.”

With encouragement from her mentors, Dr. Woodard is entering the UCLA-Southern California Clinician Leaders Program as part of the inaugural cohort. She will be among the first from her specialty to be trained at UCLA as a clinical scholar, with the intention of creating tools that neurosurgeons can use to effectively assess their interventions so that future decisions will be more transparent. “I had big ideas in my head, but I didn’t know what to do about them,” Dr. Woodard says. “As soon as I learned more about the program, I realized this was the scaffold on which I could build my career.”

A constant throughout the history of UCLA’s RWJF Clinical Scholars Program has been its encouragement of big thinking. “When you’re training to become a physician, it’s easy to become jaded and to get the sense that you will be just another cog in the wheel,” says Stanley Frencher, Jr., MD, MPH, a 2011 graduate. “This program gave each of us a sense that we could have a tremendous impact on the healthcare system and on health in general — not just in our one-on-one interactions with patients, but also as administrators, researchers or leaders who drive the way care is delivered by other providers.”

With encouragement from her mentors, Dr. Woodard is entering the UCLA-Southern California Clinician Leaders Program as part of the inaugural cohort. She will be among the first from her specialty to be trained at UCLA as a clinical scholar, with the intention of creating tools that neurosurgeons can use to effectively assess their interventions so that future decisions will be more transparent. “I had big ideas in my head, but I didn’t know what to do about them,” Dr. Woodard says. “As soon as I learned more about the program, I realized this was the scaffold on which I could build my career.”

A constant throughout the history of UCLA’s RWJF Clinical Scholars Program has been its encouragement of big thinking. “When you’re training to become a physician, it’s easy to become jaded and to get the sense that you will be just another cog in the wheel,” says Stanley Frencher, Jr., MD, MPH, a 2011 graduate. “This program gave each of us a sense that we could have a tremendous impact on the healthcare system and on health in general — not just in our one-on-one interactions with patients, but also as administrators, researchers or leaders who drive the way care is delivered by other providers.”
Mark S. Litwin, MD (FEL ’93), chair of UCLA’s Department of Urology and himself a UCLA RWJF alum, Dr. Frencher also maintains a faculty position at UCLA. He is providing the infrastructure that enables him to conduct community-based research that aims to identify the best approaches to improving the health of the traditionally underserved population served by the new hospital.

“Stan represents the type of multidimensional leader with research and leadership skills and the passion to make a difference that we are trying to create for our community and our institution with the new program,” Dr. Mangione says.

**FUNDAMENTAL ELEMENTS FROM THE RWJF PROGRAM** will remain unchanged in the transition to the UCLA-Southern California Clinician Leaders Program. Those include rigorous master’s-level research training in health policy and management, a tailored curriculum and a strong focus on implementation science and evaluation of real-world interventions. The broad network of scholars also is being retained; there will be national meetings to bring together scholars from the four sites, along with alumni and community partners.

The RWJF also has agreed to allow graduates of the new program to be part of its clinical-scholars alumni network. “It’s incredible to look at all of the leaders in healthcare from around the country and see how many of them are RWJF clinical scholars,” Dr. Frencher says. “There’s not a time when I show up at a meeting or give a talk that people don’t come up to me and say they were in the clinical-scholars program, and they always turn out to be people who are in a unique or leadership position in healthcare.”

In two important respects, the new program is venturing into novel territory. One is the focus on interprofessional training — preparing postdoctoral nurses and physicians to serve as full partners in health-system transformation. “Historically, leadership training for nurses and physicians has been siloed,” says Dr. Mangione, who is co-directing the new program with Linda Sarna, PhD, RN, interim dean of the UCLA School of Nursing.

“Educating them in the same curriculum, with group projects on which they collaborate, will contribute to a deeper understanding of each other’s professions and provide a contextual framework for how we can be more effective in partnering with leaders from other disciplines,” Dr. Sarna says.

And, although the UCLA RWJF Clinical Scholars Program had shifted toward more community-partnered research over the last decade, the new program moves more emphatically in that direction, with much of the research and projects undertaken by the scholars conducted in the communities they serve. UCLA is being joined by a consortium of partner institutions that will be providing platforms for the project-based learning at the heart of the program, including the Los Angeles County Departments of Health Services, Public Health and Mental Health; Kaiser Permanente Southern California; Cedars-Sinai Health System; Charles R. Drew University of Medicine and Science; and the Greater Los Angeles Veterans Health System. Partners at each institution will work directly with each scholar to identify and develop projects to solve current, real-world problems and to cultivate the scholar’s unique research and leadership skills.

When Mitchell Katz, MD, was looking to make major changes after taking the top job at the L.A. County Department of Health Services in 2011, he told Dr. Mangione that the trainees going through the UCLA RWJF Clinical Scholars Program were the type of people he needed to meet his goals of improving the quality of services and making the county health system more customer-friendly.
Dr. Katz, himself an alumnus of the Stanford-UC San Francisco RWJF Clinical Scholars Program, has gone on to hire a number of the UCLA program’s graduates and is funding slots as well as mentoring scholars in the new program. “I knew that to transform the system, we needed to find really smart people who are value-driven,” he says. “The graduates of this program understand how you make change in an organization. They have leadership skills, and when they articulate what they are trying to do, others want to follow them. And they recognize that to make a difference, you have to address all of the elements that affect care.”

Meanwhile, as UCLA looks to transform healthcare delivery in its own system, it has turned to a UCLA RWJF Clinical Scholars Program alum. Robin Clarke, MD (RES ’10), MSHS, an internal-medicine physician, was hired as the UCLA Faculty Practice Group’s medical director for quality after completing the program in 2012. He is responsible for measurement, reporting and improvement programs for the group’s 2,000 physicians, with a focus on quality, value and the patient experience.

Thanks to the investigations of RWJF clinical scholars at UCLA and elsewhere, it has been clearly shown that there is much inefficiency in healthcare delivery and that advances published in the literature often are slow to be adopted, Dr. Clarke notes. As a clinical scholar, he learned about the complex factors — economic, psychological and otherwise — that work against healthcare change and how to eliminate the barriers that stand in the way of more efficient and effective healthcare delivery.

“From day-one on my job, I’ve used what I learned as a clinical scholar,” Dr. Clarke says. “The program has allowed me to practice as a provider, helping one patient at a time, while also helping me to think more broadly about systems of care — whether at the community level, the regional level or within one particular delivery system. The vast majority of physicians in this country don’t get the opportunity to think about the larger variables that drive the quality of care, but that is the kind of thinking that is needed to achieve our ultimate goal of a healthier population.”

Dan Gordon is a regular contributor to U Magazine.

For more information about the National Clinicians Scholars Program, go to: nationalcsp.org

“The vast majority of physicians in this country don’t get the opportunity to think about the larger variables that drive the quality of care, but that is the kind of thinking that is needed to achieve our ultimate goal of a healthier population.”
**A Long and Winding Road**

By Elaine Schmidt

Kelsey C. Martin, MD, PhD, has a map of Africa on the top of her right foot — an indelible reminder of the two-and-a-half years that she spent as a Peace Corps volunteer in the central-African country of Zaire. The “map” is a ragged scar left behind after a festering splinter led to an infection of “flesh-eating bacteria.” Back home in Seattle, Washington, she underwent surgery, during which doctors grafted a skin flap from her thigh over the gaping hole. Much to her delight, the resulting scar healed in the shape of the continent that she had come to love.

“It’s like my rite-of-passage tattoo that brings me back to a time and a way of life that are so different from the world I live in now and put many of my daily L.A. anxieties and concerns into perspective,” she says.

Dr. Kelsey C. Martin discovered her passion for medicine while she was a volunteer with the Peace Corps in Zaire, which today is known as the Democratic Republic of Congo.

“...and, in September 2015, assumed the position of interim dean of the David Geffen School of Medicine at UCLA. She grew up in a globetrotting household. Her father is a renowned scientist — he studies aging at the University of Washington — and her mother was an adventurous collector of folk art. During her father’s sabbaticals, the family would head off for extended trips that took them to live in Scotland, France, England, Germany and India. As a result, Dr. Martin often found herself the new kid in school. While it wasn’t always easy, she credits her nomadic childhood for sparking her interest in human behavior. One example: starting sixth grade in Paris, France. “I didn’t speak a word of French,” she says. “It was sink or swim. I would observe people and think a lot about how they behaved in order to adapt.” She quickly became fluent in French.

That came in handy when, after graduating *cum laude* with a degree in English and American language and literature from Harvard University, she volunteered with the Peace Corps. Eager for hands-on public-health work, she emphasized her mastery of French and convinced her evaluators to send her to Zaire. But when she and another volunteer arrived at Bibanga, a rural village that was six miles from the nearest paved road, she discovered that knowing French didn’t count for much; the residents talked in a native dialect, and not one spoke a word of *la langue française*.

“That was a complete immersion experience,” Dr. Martin recalls. “We were the only two white people in the village. We lived in a mud hut with an outhouse and no electricity. People would stare at us and call us ‘ghosts.’”

It was her experience in Bibanga that sparked Dr. Martin’s interest in medicine. Mothers in the province feared the autumn months because it was then that measles would erupt and kill dozens of infants, and so “we organized an outreach program and wrote grants to fund measles vaccinations,” Dr. Martin says. “That year, for the first time, no measles epidemic hit the village, and no babies died.”
Selling lives, she discovered, was more compelling than analyzing literature. Taking note of his daughter's emerging interest in medicine, Dr. Martin's father started to mail her biographies of famous scientists, which she devoured by the light of a petrol lantern.

Home in Seattle after her struggle with necrotizing fasciitis, Dr. Martin had nine months of recovery during which to reflect. She decided to go to medical school but first took a job at Yale in the lab of a researcher studying the transmission of HIV. "I fell in love with being in the lab," she says. She enrolled in the MD/PhD program at Yale University, and after graduation, in 1992, she was a postdoctoral researcher at Columbia University. There, she worked under Eric Kandel, MD, who won the Nobel Prize in Physiology or Medicine for his work on memory formation — the field that would become the primary subject of Dr. Martin's own research.

She came to UCLA in 1999 as assistant professor in psychiatry and biological chemistry and quickly advanced to become chair of the Department of Biological Chemistry. Her research focuses on the process of plasticity: how networks of brain cells store memories about experiences and, in turn, how those experiences rewire the brain. “Our brains house tens of billions of nerve cells that make tens of billions of connections with each other,” she explains. “While partly hard-wired through genetics, each neural circuit is also dynamically changed by our experiences. This influences how we feel, think, behave and perceive the world.”

Last year, Dr. Martin was appointed executive vice dean and associate vice chancellor and then, this past fall, interim dean of the medical school. "It may seem like a long and winding road, from English major to Peace Corps volunteer to neuroscientist to my interim deanship," she says, "but for me, this leadership role brings together everything I am passionate about. I am surrounded by amazing faculty and trainees who are as devoted as I am to the humanistic and scholarly mission of the David Geffen School of Medicine at UCLA, and I am very grateful for the opportunity."

Elaine Schmidt is senior public information officer in UCLA Health Sciences Media Relations.
A Late-in-Life Gift of Song

While serving in the United States Navy, Gerald S. Linder, MD '61 (RES '64), completed two years of undergraduate studies. He came to UCLA in 1956 to complete his undergraduate degree, and he remained at UCLA until 1997. After graduating from medical school, he completed his residency in anesthesia and then served as associate clinical professor from 1966 to 1997. Now retired, Dr. Linder lives in Weston, Florida. He served as chair for the 50th reunion of the medical school's Class of 1961 and for the 55th class reunion. He recounts an unusual late-in-life experience.

There are those who have the good fortune to be able to sing well from a very young age. Others are not so lucky and cannot sing at all throughout their lives. Amazingly, a few of them receive the gift of being able to sing well through an accident that affects their hearing. Such a gift is precious to them, a miracle to be fully enjoyed and shared with others.

The ability to sing well came to me late in my life following a shooting accident, and it has enriched my life beyond my expectations. While in the Navy, I was a member of a .45-caliber match-tournament team, and I continued to shoot firearms in civilian life. While shooting in an indoor range, a customized acrylic ear protector I was wearing warped and failed. As a result, I lost some of my high-frequency hearing and had tinnitus and pain in my right ear. Four years later, I awoke one morning to find that all my symptoms had disappeared.

As if that weren’t surprise enough, not long afterward, I got another. I have eight grandchildren, and I frequently got to babysit for them. They always wanted me to sing lullabies and songs to them, but I was not at all good at doing that. Then, after I recovered from my hearing loss, I discovered that my singing had greatly improved when I sang to them. This was confirmed when I took an online tone test designed by a Harvard psychiatrist who also was a musician. Not only had my singing gotten better, but I scored in the upper range of tone acuity, along with composers, musicians and professional singers. Oliver Sacks wrote about this kind of phenomena in his book *Musicophilia: Tales of Music and the Brain*.

From then on, I expanded my singing activities. Since I retired almost six years ago and moved to Florida, I have found joy in participating in choral groups that perform in many assisted-care facilities. Karaoke establishments are my favorite venues for singing solos and duets. I can simulate almost any singer except “Satchmo,” Louis Armstrong. People call me Dr. J for Al Jolson because I can emulate him so well.

In July 2015, I met Judith Schwab, my soulmate who now is my significant other, while performing karaoke. Judith was with me when I attended my 55th class reunion this April. We sing to each other all through the day and night. We sing duets together at karaoke, as well as solos. I also sing in a professional follies production, which has a new theme each year. This year, it was “Around the World in 80 Songs,” adapted from *Around the World in 80 Days*. I sang solos in each act — “Lady of Spain” and “On the Road to Mandalay.”

To hear Dr. Gerald S. Linder sing “Lady of Spain,” click on the link to this article at: magazine.uclahealth.org
Reflections: Volunteering at the Venice Family Clinic

Nancy Sicotte, MD (RES ’96, FEL’98), is vice chair for Education in the Cedars-Sinai Medical Center Department of Neurology, where she is responsible for the overall educational activities of the department, from medical students through fellowship training. Dr. Sicotte is founding director of the Cedars-Sinai Neurology Residency Training Program, director of the Multiple Sclerosis Center at Cedars-Sinai, professor-in-residence in the David Geffen School of Medicine at UCLA and site director for the third-year neurology clerkship rotation for the David Geffen School of Medicine at UCLA. In addition, she manages a busy outpatient multiple sclerosis clinic and neuroimmunology clinical-research program and has been a volunteer physician at the Venice Family Clinic for the past 18 years.

I began volunteering at the Venice Family Clinic during my neuroimaging fellowship at UCLA. It was a great way to balance the sometimes solitary and esoteric world of image processing with real-life clinical neurology, while allowing me to keep up my general neurology skills. I was inspired by Barbara Vickrey, MD, who was a faculty volunteer and clinic supervisor during my first year as a volunteer. Other longtime volunteers include Sy Young, MD, who also trained in neurology at UCLA. A more recent recruit is Ed Teng, MD, PhD, who started seeing patients with me during his residency.

I especially enjoy having residents volunteer with me so they can experience the novel aspects of how the clinic works. The Venice Family Clinic provides low- and no-cost comprehensive care to nearly 23,000 people every year. Seeing patients at the clinic is an extremely rewarding experience that allows me to provide continuity of care and feel like I am making a bit of a difference.

To other UCLA medical alumni, I challenge you to consider volunteering as well. It is a small effort that reaps big rewards, and it is a wonderful way for each of us to pay it forward for all the support we received during our training. The amazing staff is there to help guide and support you. Give it a try — you will love it.

For more information on volunteering at the Venice Family Clinic, go to: venicefamilyclinic.org/volunteers

Reunions: Save the Dates

Class of 1966: June 9-12, 2016

For more information, go to: magazine.uclahealth.org
Blanca Samira Campos, MD (RES ’11), is one of the first graduates of the UCLA International Medical Graduate (UCLA IMG) Program, developed in 2007 by Michelle Bholat, MD, MPH, and Patrick Dowling, MD, MPH, of the UCLA Department of Family Medicine, to address the state’s changing demographics and existing shortage of Hispanic doctors. After completing her residency in family medicine at UCLA, Dr. Campos worked at the Wilmington Family Health Center in Wilmington, California. Currently, she is a primary-care physician at the UCLA Family Health Center in Santa Monica, California, a junior faculty physician in the UCLA Family Medicine Residency Program and assistant director of the UCLA IMG program.

My story began 2,700 miles away from UCLA. I was born in Belize, a tiny country in Central America. My dad was a construction worker and my mom a housewife. I am the oldest of three daughters. My interest in medicine grew out of accompanying my mom to meetings and fundraisers of the hospital auxiliary. The mission of the auxiliary was to raise funds to help purchase items that the hospital in our small town would need, such as sheets, nebulizers and wound-care supplies.

Belize did not have a medical school, and aspiring physicians went to other countries, such as Guatemala, Mexico or Jamaica, for their medical education. Thanks to the generosity of the Jesuit Society in Belize and Father Messmer, a Jesuit priest and my physics teacher, I received my medical education in San José, Costa Rica, at the University of Health Sciences of Central America. Father Messmer offered to help with my tuition because he knew that my family could not afford to send me to medical school. After completing medical school, I practiced at one of the outpatient clinics of the Costa Rican Social Security Administration.

Love brought me to Los Angeles. My childhood sweetheart, now my husband, had emigrated to the United States. Once settled, I prepared for the United States Medical Licensing Examination (USMLE) board exams on my own, as well as by enrolling in Kaplan
courses, and successfully passed the USMLE Step 1, USMLE Step 2 CK, USMLE Step 2 CS and Step 3. Then, I volunteered with the UCLA Division of Pediatric Endocrinology and later worked in the Charles R. Drew University of Medicine and Science breast-cancer-prevention program.

I met Dr. Dowling when I interviewed at UCLA for the Family Medicine Residency Program. Due to personal reasons, I had to withdraw from the match, but I kept in touch with him. In 2007, Drs. Bholat and Dowling started the UCLA IMG pre-residency training program, consisting of pre-preparatory courses Basic Science Review for USMLE Step 1 and English for Health Professionals, Program A course Basic Sciences/USML Step 1 Preparation, Program B courses Clinical Science/USMLE Step 2 CK and CS Preparation and Program C course Clinical Observership.

Since I already had passed the USMLE board exams, I applied to Program C, which consisted of 60 hours per week for three months. I did my clinical observership at the UCLA Family Health Center; UCLA Medical Center, Santa Monica family-medicine inpatient service; and Olive View-UCLA Medical Center urgent care. In 2008, I applied to the UCLA Family Medicine Residency Program. My acceptance was such a blessing.

Upon completion of the residency program, I was required, as an IMG graduate, to spend 24-to-36 months working in an underserved community caring for immigrants and low-income patients who face financial and language barriers to care. Following my residency, I enjoyed working with the patients at the Wilmington Family Health Center, one of the Northeast Community Clinics and a federally qualified health center.

In 2014, I returned to UCLA as a primary-care physician at the UCLA Family Health Center in Santa Monica. I feel I have come full circle. Now, as a junior faculty member, I prepare bilingual (English-Spanish), bicultural IMGs to become board-certified California family physicians through this unique pre-residency training program. Soon, there will be 100 IMG graduates, all using their time and talents to make a difference in the communities they serve.

Marjorie Fine, MD ’75 (RES ’80), was the first woman to complete the general surgical residency at UCLA. She practiced in Santa Monica in a single-specialty group until joining the UCLA surgical faculty in 2012. Since 1992, Dr. Fine has volunteered on the admissions committee for the David Geffen School of Medicine at UCLA. She was chief of surgery at UCLA Medical Center, Santa Monica and general-surgery section chief at Providence Saint John’s Health Center in Santa Monica, California. She now works part time and lives locally.

For the last decade, first as a volunteer and then as a nondenominational mission leader, I have brought volunteer teams of specialty surgeons, nurses, anesthesiologists and lay volunteers to underserved foreign provinces to deliver direct patient care. In these settings, there is no infrastructure, no paperwork and no committees; patients in need of surgical care are the only requirement.

Last summer, Meena Said, MD ’06, joined me for a successful mission in Amatitlán, Guatemala. The mission was organized by Aloha Medical Mission. Like me, Dr. Said is surgically trained and practices in Santa Monica, California. We worked for 10 days with the team, performing gallbladder, hernia, gynecologic and plastic surgical procedures. Despite the use of older open techniques for cholecystectomies, the patients left the hospital ambulatory within 48 hours, happily walking home with modest, temporary medication to resume their lives free of symptoms. One child who underwent eight tooth extractions, under general anesthesia, by our pediatric dentist was infection- and pain-free for the first time in years. For many patients, this was the only personal medical care they had ever received. The smiles and gratitude were overflowing, along with hugs for the team.

UCLA has an impact on health from the local seaside to countries around the world. Not bad for a couple of local girls turned surgeons.

Marjorie Fine, MD ’75 (RES ’80), was the first woman to complete the general surgical residency at UCLA. She practiced in Santa Monica in a single-specialty group until joining the UCLA surgical faculty in 2012. Since 1992, Dr. Fine has volunteered on the admissions committee for the David Geffen School of Medicine at UCLA. She was chief of surgery at UCLA Medical Center, Santa Monica and general-surgery section chief at Providence Saint John’s Health Center in Santa Monica, California. She now works part time and lives locally.

For the last decade, first as a volunteer and then as a nondenominational mission leader, I have brought volunteer teams of specialty surgeons, nurses, anesthesiologists and lay volunteers to underserved foreign provinces to deliver direct patient care. In these settings, there is no infrastructure, no paperwork and no committees; patients in need of surgical care are the only requirement.

Last summer, Meena Said, MD ’06, joined me for a successful mission in Amatitlán, Guatemala. The mission was organized by Aloha Medical Mission. Like me, Dr. Said is surgically trained and practices in Santa Monica, California. We worked for 10 days with the team, performing gallbladder, hernia, gynecologic and plastic surgical procedures. Despite the use of older open techniques for cholecystectomies, the patients left the hospital ambulatory within 48 hours, happily walking home with modest, temporary medication to resume their lives free of symptoms. One child who underwent eight tooth extractions, under general anesthesia, by our pediatric dentist was infection- and pain-free for the first time in years. For many patients, this was the only personal medical care they had ever received. The smiles and gratitude were overflowing, along with hugs for the team.

UCLA has an impact on health from the local seaside to countries around the world. Not bad for a couple of local girls turned surgeons.

For more information about Aloha Medical Mission, go to: alohamedicalmission.org
On December 14, 2015, more than 50 guests attended an intimate celebration of Wendy and Leonard Goldberg’s philanthropy to UCLA, hosted by Chancellor Gene D. Block in UCLA Medical Plaza. The evening celebrated their most recent gift of $10 million, most of which will support the UCLA Goldberg Migraine Program under the leadership of Dr. Andrew Charles, professor of Neurology and the Meyer and Renee Luskin Chair in Migraine and Headache Studies.

After welcoming everyone, Chancellor Block described how the Goldbergs “have nurtured the health and spirit of our community through their distinguished careers, through their outstanding volunteer work and through their extraordinary philanthropy.”

The pièce de résistance of the event was the surprise renaming of the 300 Medical Plaza building as the Wendy and Leonard Goldberg Medical Building. Dr. John C. Mazziotta, vice chancellor, UCLA Health Sciences, and CEO, UCLA Health, also thanked the Goldbergs for their generosity, noting how important it is to the research undertaken at the David Geffen School of Medicine at UCLA. He noted that the Goldbergs’ latest gift to UCLA continues their legacy in a very substantial way.

Chancellor Block thanked everyone for coming and closed the reception with a toast to the Goldbergs for “enhancing the health and well-being of our community and the world.”

For more information, contact Karen Colimore at: (310) 267-0496
In appreciation of the support he received from UCLA over the many years of his career and to advance scholarly work in the field of neuroscience, **Dr. Arnold Scheibel**, a renowned neuroanatomist and a former distinguished professor in the UCLA Departments of Neurobiology and Psychiatry and Biobehavioral Sciences, has made two pledges to establish the Ethel Scheibel Endowed Chair in Neuroscience in the Department of Neurobiology and the William Scheibel Endowed Chair in Neuroscience at UCLA’s Brain Research Institute (BRI) — both as memorial tributes to his parents.

“I hope that these two endowed chairs will help continue the tradition of bringing gifted and creative investigators to the neuroscience research and training programs at UCLA,” Dr. Scheibel says. “After all, the brain is the ultimate source of our humanity, the instrument of our culture and the key to our continued existence as a biological race.”

Intrigued by the emotional factors that play a role in diseases, Dr. Scheibel has focused his research around his interests in both psychiatry and the neural foundations of behavior. He joined the UCLA faculty in 1955, and he dedicated 58 uninterrupted years of service to the university. From 1990 to 1995, he served as director of the BRI. In 1997, Dr. Scheibel was honored with the Distinguished Teaching Award. Among other honors, he has been elected to the American Academy of Arts and Sciences.

During his tenure at UCLA, Dr. Scheibel originated affinity groups, which have provided a culture of collaborative science across the UCLA campus and set the course for the BRI’s current premier standing in multidisciplinary and team-based neuroscience. The BRI, established in 1959, conducts leading-edge investigations and serves as a magnet for exceptional scientists, clinicians and graduate students. “Under Dr. Scheibel’s leadership, the BRI flourished and became more integrated into the UCLA community,” said Dr. Christopher J. Evans, director of the BRI, director of the Hatos Center for Neuropharmacology in the Jane and Terry Semel Institute for Neuroscience and Human Behavior at UCLA and Stefan Hatos Endowed Chair in Psychiatry and Biobehavioral Sciences. “His contributions included advancing the BRI’s mission to pursue collaborative breakthroughs in understanding the brain and to communicate the excitement of neuroscience to UCLA students and children at local schools.”

In addition, during Dr. Scheibel’s time at UCLA, the annual H.W. Magoun Distinguished Lectureship, which recognizes a prominent UCLA neuroscientist, and the annual Samuel Eiduson Student Lectureship, which honors an outstanding neuroscience graduate student, were both initiated.

His generosity and dedication will expand the legacy he created at UCLA and enable its neuroscience programs to remain at the forefront of pioneering discoveries. “It is gratifying that my gift will help UCLA for many generations to come by supporting the teaching and research activities of distinguished faculty at UCLA,” Dr. Scheibel says.

For more information, contact Alan Han at:
(310) 825-1546
On November 24, 2015, recipients of the **UCLA Leaders of Tomorrow Scholarship** — a full-tuition, merit-based award currently supporting nearly 40 medical students at the David Geffen School of Medicine at UCLA — gathered for dinner with faculty leaders. The annual dinner, held in the Gonda (Goldschmied) Neuroscience and Genetics Research Center, recognized the accomplishments of the scholars supported by this gift and provided a forum for students to engage with school leaders.

The scholarship, created in 2012 by an anonymous donor and since supported by others, has given aspiring physicians, scientists and community change-agents the gift of pursuing their dreams unburdened by debt. Beyond the financial benefits, the award serves as inspiration and encouragement for its recipients.

“It has been such an honor to be a Leaders of Tomorrow Scholar,” says Rebecca Citron, Class of 2017. “[It] has made me feel responsible for making the most of my time as a medical student and future physician and to push myself to try to make a difference. I want to live up to the name ‘Leader of Tomorrow.’”

For more information, contact Laura Pescatore at: (310) 825-1288
On November 19, 2015, the UCLA Department of Urology dedicated the newly named Steve Lawrence and Eydie Gormé Patient Center in the Edie and Lew Wasserman Building in UCLA’s Stein Plaza. Singer and actor Steve Lawrence made a lead gift to the UCLA Institute of Urologic Oncology (IUO) to honor his late wife and performance partner Eydie Gormé, who died in August 2013. The gift established the Steve Lawrence and Eydie Gormé Patient Center within the IUO, which will serve as the waiting area for the institute’s new consultation clinic.

The patient center, featuring plush seating surrounded by artwork provided by the Los Angeles County Museum of Art and a large-screen monitor presenting educational information to visitors, is designed to be a space of healing while providing added privacy for IUO patients.

The gift is especially meaningful because of the relationship Steve Lawrence and Eydie Gormé had with the building’s namesakes, Edie and Lew Wasserman. The Wassermans were fans and friends of the performing duo and often flew around the country to attend their performances.

During the dedication, guests enjoyed remarks from Dr. Mark Litwin, chair of the Department of Urology and The Fran and Ray Stark Foundation Chair in Urology; and Dr. Stuart Holden, associate director of the IUO and the Spielberg Family Chair in Urologic Oncology, who thanked the Lawrence family for their long-standing friendship. Guests enjoyed a highlight reel of performances of the singer and his late wife and partner.

For more information, contact Keri Eisenberg at: (310) 267-0050

On February 18, 2016, UCLA Health welcomed the World Presidents Organization (WPO) Angeleno Chapter and day chair Dr. Harley Liker to Ronald Reagan UCLA Medical Center for a fun and interactive look at UCLA’s medical enterprise.

WPO Angeleno chapter members got a feel for what it is like to be a UCLA medical student and physician by working on manikins, which are life-sized anatomical human models, in the UCLA Simulation Center. In the Center for Advanced Surgical and Interventional Technology, the visitors tried laparoscopic-surgery simulators and learned how minimally invasive surgical techniques reduce hospital stays, expedite patient recovery and save lives.

Host Dr. John C. Mazziotta, vice chancellor of UCLA Health Sciences and CEO of UCLA Health, provided an insider’s look at the scope of UCLA Health. Presentations included keynote speaker Dr. Neil Martin, W. Eugene Stern Chair in Neurosurgery, who captivated the audience with a demonstration of the technology used to map a patient’s brain and rehearse complex surgeries. Dr. Benjamin Wu, chairman, Division of Advanced Prosthodontics in the UCLA School of Dentistry and professor of Bioengineering and Materials Science in the Henry Samueli School of Engineering and Applied Science, offered a preview of advances to come in lifelike facial prostheses, including battery-operated eyelids for prosthetic eyes. Dana Katz, director of community engagement and buddy programs at UCLA Operation Mend, shared what inspired her to launch the Buddy Family Program, which matches Operation Mend patients with local families.

Guests shared an intimate dinner with UCLA leadership, physicians and scientists who discussed compelling healthcare topics selected by WPO Angeleno members.

For more information, please contact Nora Bok at: (310) 267-0050
Advancing Research on Women’s Health

The Iris Cantor-UCLA Women’s Health Center Executive Advisory Board held its 10th Annual “Lunch with the Scientists” on February 24, 2016, at the UCLA Faculty Center. The event featured presentations on the latest advances in research, such as how cells age at different rates and how that affects cancer risk, what is on the horizon for less-toxic breast- and ovarian-cancer treatments and a research discussion on why children get cancer.

The event recognized the $3.5 million in private funds that have been raised in support of Drs. Janet Pregler and Gail Greendale’s efforts to promote women’s-health research. Over the past 10 years, these contributions have leveraged more than $17 million in government funding. More than 50 UCLA scientists who consider gender differences in their research have been funded for innovative pilot research projects.

Ten years before the Food and Drug Administration announced that women were being over-prescribed medications or the National Institutes of Health mandated the inclusion of women in research, 30 pioneering women on the UCLA Women’s Health Executive Advisory Board began providing private funds to include female scientific models in clinical trials. The Iris Cantor-UCLA Center was recognized as one of only 19 original Centers of Excellence in Women’s Health across the country for providing the highest level of comprehensive and integrated research with clinical, educational and community practices.

The success of the UCLA Women’s Health funding model led to an invitation to participate as a United States White House iGIAN T Ambassador, a new initiative that focuses on the impact of gender/sex on innovation and novel technologies and includes national roundtables, symposia and innovation prizes.

For more information, contact Aly Shoji at: (310) 267-1826
“Let’s Talk” Series Addresses Women’s Heart Disease

The UCLA Women’s Cardiovascular Center, committed to educating women about the warning signs of heart disease and heart-healthy lifestyle tips, held an educational seminar on October 28, 2015, in the Pavilion Club of UCLA’s Pauley Pavilion to raise awareness of the warning signs and risk factors of cardiovascular disease. Heart disease, while often preventable, continues to be the No. 1 cause of death among American women.

Hosted by the UCLA Barbra Streisand Women’s Heart Health Program, the “Let’s Talk” event featured a presentation by special guest Ann Meyers Drysdale, a 1978 UCLA graduate, Bruin athlete and inductee into the Naismith Memorial Basketball Hall of Fame, who talked about the impact of heart disease on her family. A lively panel discussion was led by Dr. Karol E. Watson (RES ’92, FEL ’97, PHD ’98), director of the Barbra Streisand Women’s Heart Health Program; co-directors of the UCLA Women’s Cardiovascular Center Drs. Tamara B. Horwich (RES ’02, FEL ’06) and Marcella Calfon Press; and participating UCLA cardiologists Drs. Barbara Natterson-Horowitz (RES ’90, ’92, FEL ’95), Janki Shah (RES ’03) and Tracy Huynh. In addition to the cardiologists, Dr. Anne Saltzman — the first cardiac psychologist on staff at UCLA — spoke about managing stress, which is a major risk factor for heart disease.

This was the second in a series of conversations with UCLA cardiologists, psychologists and heart-disease survivors. The next event will be held on October 5, 2016, in Westwood.

For more information, contact Michelle Jacobson at: (310) 267-1213
Holiday Spirit at Mattel Children’s Hospital UCLA

The annual Mattel Holiday Party on December 12, 2015, gave patients and their families the opportunity to get into the holiday spirit with live music, food and fun activities. The festivities took place in the Chase Child Life Room of Mattel Children’s Hospital UCLA, where Santa passed out toys, and patients took part in events such as taking photo-booth pictures, decorating picture frames, making foam art and enjoying other craft projects.

Sponsors and volunteers who helped make the event a great success included Mattel, Inc.; The Crayon Initiative; The Painted Turtle; Lights, Camera, Cure; CHALK SHOT; Kasey Jones, Ink.; and Toys for Tots.

For more information, contact Kat Lauer at: (310) 267-1831

Top: The Mattel Holiday Party featured craft projects for guests to enjoy. Middle Left: Kristiann Kassay, an “adventure team” volunteer from The Painted Turtle, helped make spirits bright. Middle Right: Barbie entertained the children, with Robert Goodwin, executive director of Mattel Children’s Foundation. Bottom Left: Glitter glue and stickers were a few of the creative items available for the children. Bottom Right: Santa Claus passed out toys.

Photos: Don Ponturo
Lori and Jeff Frieden have made a $500,000 contribution to the UCLA Department of Urology. The gift will support the research start-up costs of a new physician-scientist, who will focus on the role of inflammation and microbiome in causing bladder dysfunction. The researcher will work under the guidance of Dr. Shlomo Raz, one of the most prominent physicians in the field of female urology and urologic reconstructive surgery.

A commitment of $1 million from Denise Friedman has established the William F. Friedman Endowed Fellowship in the Department of Pediatrics. In 2005, the Friedman family and friends established a memorial fund to support the William F. Friedman Research and Fellowship Awards, which gave its first research and first fellowship awards in 2011. With Denise Friedman’s new contribution, the fellowship was re-established and renamed. This endowed fellowship will enable the department to support outstanding fellows.

Mattel Children’s Hospital UCLA has received a $520,000 bequest from the Lee Marks Charitable Remainder Trust. Lee Marks’s daughter Mary Marks, a UCLA alumna and former employee, was instrumental in directing the gift to UCLA. This meaningful investment will provide significant resources to support the physical and emotional well-being of children of all ages.

The newly established comprehensive UCLA Food Allergy Program has been named a Center of Excellence by the national Food Allergy Research and Education (FARE) organization and admitted as an inaugural member of the FARE Clinical Trial Network. The UCLA program received $350,000 from multiple donors, including a $150,000 challenge grant from UCLA alumni Staci and Adam Miller. Additionally, UCLA received an $80,000 grant from FARE to support the program’s efforts to provide the highest quality patient-care services. The incidence of food allergies in children has increased dramatically, and UCLA’s new program will expand access to exceptional patient care, offer clinical trials to test the latest diagnostic and therapeutic advances, investigate the biological basis of food allergies to bring new discoveries to the patient bedside, train the next generation of physicians in the treatment of food allergies and educate school administrators, patients and the public about food allergies.

Mr. and Mrs. Michael Keston have made a gift of $1 million to benefit the Division of Pulmonary and Critical Care Medicine. The Kestons’ pledge will support investigations into advanced lung disease and help launch the UCLA Lung Health Research Initiative, which aims to stop the relentless progression of lung disease and enable transplant recipients to live without fear of organ rejection. The Kestons were honored at a UCLA reception that introduced the UCLA Lung Health Research Initiative on November 13, 2015. To date, the initiative has raised almost $3 million toward its goal of $5 million to support research under the direction of Drs. John A. Belperio and Joseph P. Lynch III. Other major contributors include Carole and Barry Lindsey, Linda and Hormoz Ghaemmaghami, Paul Junger Witt and Susan Harris, Kanuja and JC Champaneri, Robin and Jeff Raich and William Pierpoint.

Mr. and Mrs. Sprague with grandchildren.

For more information, contact Health Sciences Development at: (844) 474-4387

In Memoriam

Joseph Yzurdiaga, a UCLA graduate, successful investment advisor and major contributor to UCLA’s Stein Eye Institute, passed away on September 14, 2015, at his home in Montecito, California. He was 82 years old. Yzurdiaga was born in Chino, California, and served in the United States Navy prior to his investment career, which he began with Merrill Lynch, Pierce, Fenner & Smith, Inc. He later worked for several prestigious financial firms, including Crowell, Weedon & Co. Recently, Yzurdiaga and his wife Patricia gave $5 million to Stein Eye to establish the Patricia and Joseph Yzurdiaga Endowed Vision Science Research Fund. Previously, they created the Pat and Joe Yzurdiaga Endowed Cataract Fund. Upon Yzurdiaga’s passing, Stein Eye also received more than $7 million. He is survived by his wife Patricia; daughter Leslie Figari and her husband Bryan; sons Ken Yzurdiaga and his wife Dana and Mark Yzurdiaga and his wife Lisa; as well as grandchildren Linda Yzurdiaga, Michael Figari, Patrick Figari, Kate Yzurdiaga, Kevin Figari and Maddy Yzurdiaga.

Robert Draine, a longtime friend of UCLA Health Sciences, passed away on December 14, 2015. He was 90 years old. Draine was an advocate for both Alzheimer’s disease research and support for patients and their caregivers. In 2012, he provided the impetus to establish the UCLA Alzheimer’s and Dementia Care Program and was integral in promoting, expanding and fundraising for the initiative. To date, the program has served more than 1,550 patients and their families. In honor of his unwavering commitment, he was presented with a Dean’s Letter of Proclamation in 2014 for his ongoing support of the David Geffen School of Medicine at UCLA — particularly the UCLA Division of Geriatrics and the UCLA Longevity Center. Draine is survived by his wife Jackie Perkins Draine and their children and grandchildren.

The Mildred E. and Harvey S. Mudd Foundation, the Norman F. Sprague Jr. Foundation and the Caryll M. and Harvey S. Mudd Foundation have together made a pledge to support the David Geffen School of Medicine at UCLA in memory of Dr. Norman F. Sprague III (’73, RES ’78).

In recognition of this commitment, the university will name a problem-based learning (PBL) classroom in Geffen Hall — UCLA’s transformative new medical-education building — in memory of Dr. Sprague, who pioneered arthroscopic surgery and performed the first procedures at UCLA, where he also served as a clinical instructor. In making the gift, Dr. Sprague’s family noted the PBL teaching methodology, in which small groups of students apply medical concepts as a team, aligned strongly with Dr. Sprague’s values and that he — who “always loved a great view” — would have appreciated the beauty of the Westwood skyline as seen from the new classroom bearing his name.

Photo: Courtesy of the Sprague family
My new husband and I were returning from our amazing honeymoon spent lounging on the beautiful beaches of Bali. The flight back to Los Angeles from Taipei, Taiwan, is long — about 14 hours — and, as we soared over the Pacific Ocean, I was getting tired. Yawning, I turned off my TV to get some rest before I had to go back to work the next day.

I had been napping for just a few minutes when I was awakened by the urgent voice of a flight attendant over the intercom: “Is there a doctor or a nurse on the plane?”

My heart raced as I raised my hand. This was the first time I had ever been called on to help outside of the hospital. Now that I was in my last year of residency, with four years of rigorous training in internal medicine and pediatrics under my belt, I felt that I was well-equipped to handle whatever situation presented itself.

A look of relief spread over the flight attendant’s face when he spotted my hand. “Yes! Please come right this way!” he called out. “We have a lady who has abdominal pain, and we don’t know what to give her.”

As I followed him to the woman’s seat, I ran through a differential diagnosis of what she could have. But my first glimpse of her stopped me in my tracks; she was pregnant. As med-peds doctors, we see everyone from newborn babies to elderly adults. Everyone, that is, except pregnant women.

“How much time do you have?” I asked her. “I am here to help.”

She shook her head, indicating that she did not speak English. Terrific. It was time to haul out the Mandarin that my parents had so desperately tried to teach me. I took a brief history in between her episodes of pain, which were coming every two minutes. She was in her third trimester and had been having this pain for a few hours, and it was becoming more intense and more frequent. Everything she told me confirmed what I feared — she was in active labor.

The flight attendants brought what medical equipment there was on board, and I found that I had everything I most needed: gloves, clamps and scissors. For pain, there was only Tylenol — it would have to do.

I struggled to remember what I learned from my OB rotation in medical school. I now had to examine her to see how far along she was, but where would I do this? The woman had no room to lie flat. The flight attendants moved us to the middle of the plane. “We’ll drape some blankets over this row,” they said. I looked anxiously at all the passengers around me. So much for patient privacy, I thought. I laid her down and examined her. I felt the baby’s head. The cervix was completely dilated. The baby’s delivery was imminent. When I told the woman, she shook her head no.

“It’s impossible,” she told me.

“Why?” I asked.

She lifted her shirt and pointed to the horizontal and vertical scars on her belly — C-sections.
A VBAC, or vaginal birth after C-section, is dangerous. If one is attempted, women are monitored closely in the hospital to make sure they do not have a complication that obstetricians fear — uterine rupture — which could cause potentially fatal bleeding for both the mother and baby. The more C-sections a woman has had, the higher the risk. And vertical incisions of the uterus portend a 10-percent risk of uterine rupture.

We asked the pilot if he could land the plane as soon as possible. “I’m sorry,” he said. “We’re over the middle of the ocean. The closest airport is Anchorage, Alaska, but we are still four hours away.”

I started sweating. Should I have the woman push? Or just breathe through her contractions? I took what seemed the less-risky route and told the woman to just breathe through her contractions. With time, her contractions became longer and more intense. She screamed through each of them. The air was hot and stifling in our makeshift tent, and I could feel the eyes of the other passengers on us.

It was the longest four hours of my life. When the pilot announced that we were starting our descent to Anchorage, I felt a huge wave of relief. We were almost there. But when I looked at the woman to reassure her, my smile faded. The baby was crowning. Now, there was no other option but for her to push.

“Mom, the baby is here,” I told her. “You have to start pushing.”

“No! I can’t!” she cried. “The pain is too much. I’m going to die! I can’t get it out of me, the doctors have told me this before!”

But we had no choice. The baby was on its way.

As the baby emerged, I saw a translucent cord around its neck. Remembering what I had seen during deliveries I had assisted, I unlooped the cord, and the baby wiggled its head free. The woman pushed a few more times, and the baby came out and gave a loud cry.

Our fellow passengers clapped and cheered, and I quickly clamped the cord and cut the baby free. Much to my relief, she looked completely healthy. I gave her to the flight attendants to warm her up and finished delivering the placenta as the plane landed on the ground.

When we rolled to a stop, paramedics came rushing onboard. As they wheeled the mom and baby away, I suddenly realized how tired I was. I breathed a huge sigh of relief and collapsed onto the seat next to my husband, who was grinning. “Wow!” he said. “What a trip.”

Improvisation was the name of the game when Dr. Angelica Zen was called into action to assist a woman in labor during a flight from Taiwan to Los Angeles. After landing, Dr. Zen enjoyed a quiet moment with the flight crew.

Photos: Mike Tipp; (second from bottom) Edmund Chen/AP Video via AP Photo
While a volunteer with the Peace Corps in the 1980s in Zaire — today’s Democratic Republic of Congo — Dr. Kelsey C. Martin created a set of visual aids as a teaching tool for midwives and child-healthcare workers. This page focuses on family planning and encouraging the spacing of children two-to-three years apart.